

***A STUDY OF FAMILY PROBLEMS ABOUT
REARING OF MENTALLY RETARDED
STUDENTS IN RURAL AREAS OF LATUR
DISTRICT***

A dissertation for the award of
VIDYAANISHNAT (M.Phil.) degree in Sociology

By

Shri Sirsat Prakash Govardhan (B.Com.,M.S.W.)

Under the guidance of

Dr V.V. Kulkarni (M.A.,M.S.W.,M.P.S.,M.Phil.,Ph.D.)

Submitted to

The Department of Sociology

The Faculty of Moral and Social Sciences
TILAK MAHARASHTRA UNIVERSITY, PUNE

March 2009

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FORM ' B '

I hereby declare that the thesis entitled *A STUDY OF FAMILY PROBLEMS ABOUT REARING OF MENTALLY RETARDED STUDENTS IN RURAL AREAS OF LATUR DISTRICT*, completed and written by me has not previously formed the basis for the award of any degree of other similar title of this or any other University or Examination Body.

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This is to certify that the thesis entitled ***A STUDY OF FAMILY PROBLEMS ABOUT REARING OF MENTALLY RETARDED STUDENTS IN RURAL AREAS OF LATUR DISTRICT*** which is being submitted herewith for the award of the degree of Vidyanishnat (M. Phil.) in Sociology of ***Tilak Maharashtra University***, Pune, is a result of original research, completed by ***Shri Sirsat Prakash Govardhan*** under my supervision and guidance. To the best of my knowledge and belief, the work incorporated in this thesis has not formed the basis for the award of any degree or similar title of this or any other university or examining body.

Research Guide,

(DR V.V.KULKARNI)

PLACE -
DATE

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Place : Pune.

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Mr Prakash Sirsat

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CHAPTER ONE

***THEORETICAL FRAMEWORK, REVIEW OF
LITERATURE AND VARIOUS DIMENSIONS
OF MENTAL RETARDATION***

Mental slowness in children is one of the most pressing problems that confront parents at home, teachers in the school and social workers in the field of social education. India needs a clear national policy outlining the State's obligations to the mentally handicapped and ensuring their fundamental rights to education, vocational training and employment, to protection from exploitation, to medical care, to economic security and to as normal life as possible. These rights are laid down in the United Nations Declaration on the Rights of the Mentally Handicapped and should be ratified by India. Mentally-retarded child is capable of growth, development and learning. Socialization and Normalization patterns obviously differ from family to family, especially between the social classes. The issue of social class, particularly in relation to socialization patterns, is perhaps most relevant to the case of the mildly subnormal. It is a controversial area in which many assumptions are taken by many to be fact.

Of all the handicapes, the mental handicap constitutes the most serious and difficult problem. Mental handicap is defined as significantly subaverage general intellectual functioning, existing concurrently with deficits in adaptive behaviour, and manifested during the developmental period.¹ The mentally retarded person is an individual who is fundamentally the same as a normal person, who from birth or from very early age, is lacking in intellectual endowment; it is a condition of incomplete development of mind of such degree or kind as to render the individual incapable of adjusting himself to his social environment in a reasonably efficient manner.

The community as a whole, even the educated elite, have a very vague idea about mental handicap, usually equating it with psychiatric dysfunction where intellectual function is disturbed, as contrasted to subaverage intellect which is found in mental handicap.

1. Grossman, "Manual on Terminology and classification in Mental Retardation**", Amer. Asscn. On Mental Deficiency, Baltimore, Maryland, USA, 1973.

As a result, the degree of self-sufficiency from the point of view of his economic and social level happens to be at a much lower level. He is slow in developing compared to the other person of his own age. Because of his limited capacity he becomes a victim of his own environment. In this sense, he comes to be identified as an individual who is unable to guard his rights or accepts responsibilities. Most people also do not know that the mentally handicapped have potential abilities, and not just disabilities. These abilities can be developed with appropriate education and training to enable the mentally handicapped to become happy, productive and integrated members of the community.

Mentally handicapped people have the same right to live a full and happy life as anyone else; in many instances they need more support to enable them to do so. The social worker, the nurse, the health visitor, the teacher, the doctor and the psychologist are among the principal professional workers involved in the day-to-day lives of the mentally handicapped.

Mental slowness in children is one of the most pressing problems that confront parents at home, teachers in the school and social workers in the field of social education. Many a teacher is familiar with the child who cannot keep up with the rest of his class: similarly, many a parents with the child whose talking or walking is delayed. These children who are slow in the development of their faculties are called the mentally retarded^Arnold Gesell described the mentally retarded child as one in whom "the rate of development is primarily affected; retardation is nearly always the most obvious symptom." "The amount of retardation and the degree of distortion", he said, "depend upon the etiological factors, their nature and severity and time of occurrence in the life cycle."² Because an etiological definition of mental deficiency is difficult due to varying causes, mental retardation is usually described in terms of intelligence quotient (I.Q.), which is a ratio between the mental age (maturity) and the "actual or chronological age, expressed as a percentage value. Psychologically a mentally slow child is one whose I. Q. is below 80. Mandel Sherman classified mental deficiency as follows :³

2. Gesell, Arnold and Amartruda, Catherine S., "Developmental Diagnosis", Harper and Brothers, New York, 1949, p. 109.

3. Sherman, Mandel, "Intelligence and Its Deviations". The Ronald Press Company, New York, 1947, pp. 126-27.

Below 28 I.Q. Idiot

28-48 I.Q. Imbecile

48-70 I.Q. Morons

70-80 I.Q. Borderline defective

For the purpose of treatment the morons and imbeciles are classified as low grade, middle grade and high grade. Thus, mental retardation is of varying degrees and ranges from a condition slightly below normal to that of extreme mental deficiency. Mentally defective children of all grades are not a waste: low grade imbeciles, high grade morons and borderline defectives are edu-cable and can benefit by instruction under supervision in the words of Sherman, 'the children in general, who have an I Q. of less then 50 cannot adjust without a great deal of supervision and are often institutionalized. Those with I.Q. over 60 can adjust with fair effectiveness when they are well supervised and especially when they have been trained vocationally.⁴

Classification of Mental Defect

(a) Administrative Grouping—Legal definitions of idiots, imbeciles, feeble-minded - (Britain). This classification has no scientific value.

(b) In America—Biometrical Consideration—According to I.Q.S

(c) Congenital and acquired 'Amentia

(d) Tredgold's classification — Primary and Secondary Amentia:

(i) *Primary Amentia*—(A) Simple, (B) Microcephalic, and (C) Mongolian

(ii) *Secondary Amentia*—due to organic disease of the brain

(e) Subculture and Pathological Amentia (E.O. Lewis's Classification)

According to E.O. Lewis, many defectives appear to differ quantitatively rather than qualitatively from their non-defective fellows; indeed, they are often regarded as merely the tail end of a normal variation, and such have been termed by him as "Sub* cultural" defectives.

"After making allowances for factors that influence scores in intelligence tests, it seems to me (E.O.'Lewis) that a conservative estimate of the proportion of the population with 60

4. Ibid pg 326.

per cent to 85 per cent of normal intelligence would be 5 per cent various names have been given to this group of the community." "Oligophremia", on the contrary comprises not only this group but the lower grade mental defectives, Americans refer to this group as "morons". In England, 'background* 'dull' or 'retarded'." E.O, Lewis suggested the term "Sub-cultural".⁵ According to E.O.Lewis, the number of the 'Subcultural' group in any community may be said to an index of the general level of intelligence of the whole community. This cannot be said of lower grade defectives—idiots and imbeciles. The large majority of these are due to pathological factors, or if the condition is inherited, to genes that are comparatively rare. This group forms an integral part of the general population.⁶ The right approach to the 'Sub-cultural' section of the community is that of regarding it as an integral part of the general community. The problem of the Mentally Deficient can be solved by their segregation. When dealing with the Subcultural group the solution cannot be one of segregation, but must be that of assimilation into the general community.⁷

Intelligence —Sub-cultural Deficiencies

Intelligence is generally assessed by a number of different tests designed to measure different aspects of intellectual function, resulting in an intelligence quotient (IQ). An IQ of 70 or less is taken as mental handicap, when combined with difficulty in adaptation *i.e.*, in the ability to meet the demands of the environment. An IQ under 50 is considered severe mental handicapped for planning purposes, as these individuals will always need special services, while those in the range of 51 to 70 are considered mildly handicapped, and some of these may be able to function adequately in an environment which is intellectually non-demanding.

The psychological assessment of deficiency is, however, dependent upon the social criterion. The complex question of the nature *vs.* nurture (heredity/environment) case for intelligence has not yet been fully resolved. Most of the sociologists would come down firmly in favour of a stressing environment as the most important factor in development.

In reviewing the literature on deprivation, Rutter⁸ states "a deficiency in stimulation and necessary life experiences is likely to be largely responsible for. those cases of intellectual

5. Lewis, E.O, Journal of Mental Science Vol. Xc VII, No. 408, July 1951.

6 Journal of Mental Science, Vol. Xc VII, No. 408, July 1951, p. 470.

7 *Ibid.*, p. 413

8 Rutter, M. (1972) Maternal Deprivation Reassessed, p. 118 Harmondsworth, Penguin Books.

retardation due to deprivation. Perception privation is important in causing certain types of developmental and intellectual retardation." Such sub-normality is often termed 'sub-cultural sub-normality*'. This is usually associated with a low socio-economic background.

The manner in which assessments are undertaken obviously vary, but a wealth of sociological research would seriously call into question that a child's abilities or future potential can be measured with precision at any given age. Clarke and Clarke⁹ state, "Long term studies in particular have shown that the concept of a necessarily constant IQ during the years of mental growth or mental decline is the exception rather than rule."* Not only are there numerous problems concerning testing someone's IQ at a particular age but there is also the problem of tests being culturally biased. A specifically Binet IQ test would be of little value if applied to an African tribe, Indian tribe, likewise we cannot expect the same IQ test to give a valuable measure of the intelligence of different sub-cultural groups within the same country. Tests are often conducted outside any meaningful context. It is not only the validity of testing that has caused concern, but also the long-term effect of the resulting label of sub normal. The social adjustment of the subnormal children is a very serious problem. Its seriousness can be partly understood if we discuss at some length the lot that commonly befalls them. No provision worthy of the name is made in this country to meet their special needs and they are generally asked to answer demands and expectations beyond their power. The result is that they fail in life. The failure in social adjustment may be either a social or antisocial in significance. In case where it is only a social, a deficient child is a burden to his family and not infrequently proves too heavy to be borne by a family of limited means.

As a consequence, many deficient children are obliged to accept begging, as their means of livelihood. Binet-Simon devised standardised tests to measure an individual's intelligence and he introduced the concept of mental age. He based his concept of mental age and age ascertainment tests on the fact, that the majority of children are of average intelligence, *i.e.*, they possess the mental age which is common to all children of that chronological age. It was, however, known that some children possess more intelligence and some less than their chronological age. When Binet invented scale for measurement of intelligence in terms of mental age, it was possible to measure the amount of a child's superiority or inferiority over

9. Clarke, A.D.B. and Clarke, A.M. (1969) Recent Advances in the study sub-normality, p. 34, 2nd edit. London; National Association For Mental

average children. He regarded any child of nine or under who was retarded by more than three years as feeble-minded. The reason for the difference in the absolute amount of retardation in years which constitutes mental deficiency in children of different ages is to be found in the fact that as subnormal child grows old, tested by Binet-Simon Scale, he shows greater and greater retardation in years. What remains fairly constant is the ratio between the mental and chronological ages of an individual.

To avoid decimal, Stern multiplied the ratio by 100 and called it intelligence quotients (IQ). As the fact of constancy intelligence quotient was grasped, mental deficiency was expressed by the amount of IQ with greater exactitude. Terman considers that children whose IQ is below 70, *i.e.* below seventieths of their chronological age, are definitely feebleminded. According to Terman, the IQ of imbeciles ranges between 20 (or 25) and 50 and that of idiots is below 20 (or 25). Such gradations in the mental deficiency are based on the actual differences in individuals, their power to preserve themselves or in the case of children, their ability to learn and how to preserve themselves in the social milieu.

According to British Mental Deficiency Act of 1913, there were three main categories of mental handicap—feeble-minded, idiots and imbeciles. The feeble-minded were provided with an education, but the idiots and imbeciles were not. "Idiots are persons in whose case there exists mental defectiveness of such a degree that they are unable to guard themselves against common physical dangers; imbeciles are persons in whose case there exists mental defectiveness which, though not amounting to idiocy, is yet so pronounced that they are incapable of managing themselves or their affairs or, in the case of children, of being taught to do so; feeble-minded persons are persons in whose case there exists mental defectiveness which, though not amounting to imbecility, is yet so pronounced that they require care, supervision and control for their protection or for the protection of others or, in the case of children, that they appear to be permanently incapable, by reason of such defectiveness, of receiving proper benefit from the instruction of ordinary schools. For several years prior to the 1913 Act, intelligence and individual differences had caught the imagination of several learned men. Gallon introduced the theory of normal distribution, now famous as 'bell curve.'*

Others who contributed towards the science of intelligence testing were Cattell, Binet and Simon. While Cattell was a main contributor, and applied the term 'mental tests' to his work, it was Binet who made the significant contribution.

Their text, entitled "Mental Defective Children", was strongly against education of the feeble-minded, and openly declared that because intelligence was a static commodity, it could not be improved and consequently neither could be child.

Undoubtedly, Binet gave a great deal to the study of intelligence, and his phrase 'mental age' is still widely used, but the use of such tests in the determination of a child's* future has been seriously criticised. In the early years it was usually medical people who did the testing. In the wrong hands tests can be widely inaccurate, and even when administered by trained personnel, their scientific and predictive limitations are well known.

Prof. Mittler,(1973), and Clarke and Clarke, (1973,) make the following observations.¹⁰ "The intelligence test has very little to say about an individual's strengths and weaknesses and, therefore, contains little information that will help the teacher to design a programme for the individual child. Although it has its place at the first step in assessment process, it is now seen to be little more than an instrument of classification which should not be used to predict a child's future development, or to determine his place in the educational system."

Sir Cyril Burt attempted to introduce a scientific element into the measurement of intellectual capacity, and until recently his experimental data provided a sound basis on which eminent psychologists based their own theories. He was undoubtedly a supporter of the genetic inheritance factor as being the major determinant of intelligence, and as such followed in the footsteps of Gallon and Darwin.

Nearly three per cent of the population the world over is afflicted with mental retardation or mental deficiency. Surprisingly, the percentage does not vary much either for Western countries, the developing or the under-developed countries. India has 13 to 18 million mentally retarded people in Gujarat alone the population is of three to four lakhs and in Ahmedabad city, with its population of 27 lakhs, 30,000 to 40,000 people are afflicted.

The American Association for Mental Deficiency defines mental retardation as "below .average general intellectual functioning, originating on the developmental period associated with impairment of adaptive behaviour. According to the World Health Organisation, the

10. Mittler, P (1974), **Progress and Problems in the Education of the Mentally Handicapped**, paper given to the 5th **European and International Seminaj and** exhibition. **Hester Adrian Research Centre.**

mental sub-normality consists of two categories : due to environmental causes with no central nervous system (CNS) impairment mental retardation and due to CNS disorders (mental deficiency).

The intelligence described in these definitions can itself be defined as the ability to solve problems, adapt to new situations, form abstract concepts and profit from experience. The prime function of the CNS is adaption of organism to its environment. The intelligence described in the Indian situation are : (a) nutritional deficiencies during pregnancy, (b) malnutrition during the first two years of life, (c) delayed or difficult labour during N/delivery, (d) infections of brain and severe illness during childhood, (e) head injury by falling or accident, and (f) untreated epileptic fits. In addition, sometimes they are due to other causes of unknown origin.

Education and Care Vocational Training

The National Policy— Welfare Services

Like other countries India's proportion of mentally retarded reaches to about three per cent of the population which would give India roughly over 13,000,000 retarded, mostly children. Retarded children are those who cannot assimilate the regular school programmes of education and in about 25 per cent of the cases cannot even learn to read and write effectively. In our modern times this means a great economic and social burden on our nation. It is true the predominantly village life of India lessens the burden of these mentally handicapped children on the community since slow non-competitive rural conditions do not challenge and show up weak intelligence and social unadaptability as urban life does. Still, we cannot ignore the problem of retarded children in the urban area where they might be more numerous than the estimated three per cent due to the poverty that brings on malnutrition and other diseases that affect the inheritance and development of the intelligence of our city children.

What is India presently doing for these children ? Happily, there has been a tremendous upsurge of interest in the problems of these children within the last three years, both in Government as well as private agencies. Before 1965 there were about 22 institutions in various parts of India catering to the needs of these children. Almost a third of these were concentrated in Bombay city which has been in the forefront in this pioneering effort dating back to the beginning of this century. The sizes of these institutions, however,

are very small and all together have a strength of less than 1,300 children. Starting with the opening of the first All India Week for Retarded Children in December 1963, there has been a phenomenal growth of institutions, associations and projects for the welfare of the mentally deficient. February 1965 saw the first AH India Seminar at Chandigarh and the organization of an association on a national basis. At least half a dozen new schools and homes including the 'Untkanna' home in Nagpur and the privately endowed new school in Ahmedabad have been established in this short period. The teacher training diploma course in Bombay was recognised by the State of Maharashtra. The Nandanvan School run by the Matru Sewa Sangh of Nagpur received an American grant of Rs. 6 lakhs for the rehabilitation of the adolescent mentally handicapped, the first such project here in India.

Earlier Survey

The first scientific medical survey of the incidence of phenylketonuria was conducted by the Vellore experts on mental retardation along with educational surveys in several cities. Local associations have been formed in Bombay, New Delhi, Madras and Bangalore to promote the welfare of retarded children. The Bombay association in particular seeks to find rehabilitation projects and jobs for the adult and adolescent retarded.

Up to five years ago the lot of the mentally handicapped was cast with the handicapped children in general including the blind, deaf and dumb and the orthopaedically handicapped. The result was that little time was allotted to their problems as compared to the others whose numbers were far larger and who were better able to evoke sympathetic considerations. Even at the present time the social security department for the education of the handicapped still unfortunately handles the problems of the mentally retarded as subsidiary matter to the other handicapped area. There is very little in common between the educational problems of the physically handicapped and those mentally handicapped except for the fact that the mentally handicapped may be at the times multiple-handicapped.

Intelligence varies by so many small steps that there seems to be sharp break between mentally retarded and the border line dull and the normal. This kind of distribution has suggested to researcher worker that some form of mental retardation may be genetic or inherited through a very complex mechanism in which genetic elements may take part. The genetic type of mental retardation is variously called endogenous or familial. The endogenous mentally retarded must often fall in the upper range of retardation. Mental

retardation was formally called feeble-mindedness and its three fold classification in to morons, imbeciles and idiots has now given way to more euphemistic and meaningful descriptions such as educable, trainable and custodial or moderate, severe and profound mental retardations.

Welfare services

“Economic development has little value unless it is linked with social welfare services including mental health measures embracing clinical work and community mental services. The extent to which mental deficiency is recognized and dealt with as a separate problem in any country will depend not only on that country’s general level of development, but particularly on the effectiveness of the social welfare services and whether these may be used where applicable by all category before the general welfare services had developed , this group had developed , this group tended to be specially excluded from participation in subsequently developed services” (WHO) A national policy and plan urgently needed. A group of experts from the different disciplines concerned with mental handicap worked out a comprehensive plan, under the joint sponsorship of the Directorate-General of Health Services, the World Health Organization, and the All India Institute of Medical Sciences.¹¹

The various aspects concerned were : national policy, prevention, medical services, education and vocational training, training of personnel providing" this, employment, residential facilities, legislation, insurance, social security, committees for co-ordination, Dtenning information and advice, the roles of the individual, the community, voluntary agencies and the government and finally priorities fraction.

There is a necessity of the improvement of mental hospitals, and the provision of institutions for mental defectives and psychiatric out-patient clinics, there is urgent need for State Governments to apply their minds to the provisions and establishment of preventive social psychiatric or mental health institutions. India needs a clear national policy outlining the State's obligations to the mentally handicapped, and ensuring their fundamental rights to education, vocational training and employment, to protection from exploitation, to medical care, to economic security, and to as normal life as possible. These rights are laid down in the United Nations Declaration on the Rights of the Mentally Handicapped, and should be ratified by India.

Preventive Steps

The establishments of child guidance clinics which are to a large extent institutions for providing guidance to parents and teachers on sound principles of child upbringing and for promoting healthy parent-child and teacher-child relationship, is another most important and beneficial measure. Medical care should be geared especially to prevention, early diagnosis and treatment of all treatable conditions, primary and secondary. Education of the community, the peripheral worker such as the community health volunteer, the *anganwadi* worker, the **Dai** and all peripheral cadres of the health and social welfare services, is needed towards this end. They should be trained in prevention of mental damage, and recognition of the abnormal child, who should be referred to the nearest primary health centre for diagnosis, treatment and advice.

The primary health centre doctors should get orientation courses which would enable them to deal with all disability. This subject should also be stressed in the medical curriculum. Emphasis should be on adequate medical services available as near the home of the disabled as possible. Harmful circumstances and harmful social arrangements must be identified and counteracted before they have had a chance to produce illness and disorder. Primary prevention seeks to reduce the risk of social maladjustment in the whole population by fostering in individuals and families the ability to handle major crisis in life, severe illness social deprivation, economic reverses.

Post-graduate centres as regards post-graduate training institutions for such education have been established by some of the State Governments, and one at Bombay. In Pondicherry the centre has established a post-graduate institute and research centre. The conditions are truly deplorable in many of our mental hospitals where over-crowding of patients and dearth of doctors—most of whom are not qualified psychiatrists—are the worst features.

The family physician with a basic understanding of psychiatry, has a central role to play in identifying an emotional or mental problem, referring it to the community mental health services, and later, participating in treatment during the rehabilitation phase. As another step in the right direction, local mental and general hospitals should be built adjacent to each other. The local or regional mental hospital may be an outgrowth in expanded form of the psychiatric unit. The psychiatric treatment services should be established in centers of population on a regional and decentralized basis. In the preparation of the 4th Five Year Plan, the Planning Commission has laid down the broad objective in the field of public health.

Firstly, on safe water supply and promotion of measures to improve the drainage and sanitation in big cities and towns. Secondly, to promote integrated and adequate health facilities in rural and urban areas as far as possible.

Education and the Mentally Handicapped

For many centuries, attention was paid to the blind and the deaf-mute on the one hand and the low-grade idiots on the other. Mental illness was a matter of mystery for many years. It was considered devil's work or God's curse. In 1779, a group of hunters searching for game in the wooded country of the South of France came across a boy of about 12 years of age who had been living wild for a good deal of his life. Speech was non-existent, and it seemed that little could be done in the way of rehabilitation. It was a landmark in history of education when Dr. J.M. Itard, a young French medical advisor, undertook to educate the wild boy of Aveyron. "It was fortuitous, perhaps, that the wild boy was discovered at a time when the philosophers of French educational thought were being influenced by the work of Rousseau and Locke, There was a great amount of positive thinking and optimism about the extent of human potential.'

The work of the philosopher John Locke (1632-1704) is worthy of amplification, because it relates directly to the theories of knowledge that were popular at the time. In his voluminous, "Essay concerning Human Understanding", Locke says that originally the mind is akin to a white paper that is void of all impression. It is experience which determines the many things we know, and the reflection upon this experience that enhance its effectiveness. No one is born possessing innate knowledge; it has to be learned, This was the base line upon which Dr. J.M. Itard formulated his developmental programmes for the 'Wild boy'.¹² However, in early 19th century itself Edward Seguin, one of the students of Itard, followed his lead in the prospect of training the mentally retarded. The influence of Itard and Seguin encouraged others to undertake experimental work, in particular, Dr. Cuggenbuhl and his institution for cretins situated in Switzerland, and Dr. Saegart who in 1842, founded the first school for mental defectives in Germany. Perhaps the most famous disciple of Itard and Seguin is Maria Montessori.

12. Segal, S. (1967), No child is Ineducable—Special Education—Provision and Trends, pp. 33-45, London, Pergaroon Press.

Since the days of Itard and Seguin, almost every country has been actively involved in its attempt to cope with the problem of the mentally retarded including their education, training and rehabilitation in the community. Education of the retarded must be understood in its broadest possible context. Education does not limit itself to only academic or mere textbook learning; rather it is more concerned with the all-round development of an individual. Not only have they limited intellectual and learning capacity which makes it difficult for them to handle the symbols in relation to reading, writing and arithmetic, but they are also incapable of having mature social and emotional relationship with peer group or others. The retarded has poor self-concept and lacks self-confidence in solving problems or getting along with others.

Lack of research in the field of education has left the problem of mentally retarded out of sight. Their problems should be studied with the following objectives in view :—

- (a) To locate the causes of mental deficiency and to devise preventive and ameliorative measures.
- (b) Early identification : Wise adjustment to the social and economic life of the community.
- (c) Social problems of crime, alcoholism, delinquency prostitution, unemployment are closely connected with feeble-mindedness. To minimise these evils a scientific study of the problem becomes a necessity.
- (d) To live in an atmosphere of happiness is the birth-right of every child. The public must learn that even a mentally handicapped child has a mind which can be educated and can be a social asset and not a liability.

Western countries have special legislation which gives every defective child the special care and training he requires.

In England, the Wood Committee (1924-1929), was set up to investigate and determine the incidence of feeble-mindedness, and to examine provisions for educating them. This period of time was a stagnation period as far as special education was concerned. The recommendations of the Wood Committee were in line with the philosophy of Cyril Burt, and that was a call for normal schools to provide for a much broader spectrum of mental handicap than just the feeble-minded. It is interesting to add that while the Wood Committee was deliberating, another educationally oriented committee, the Hadow Committee reported in 1926. The significant factor surrounding this report was the effect

it had upon the re-organisation of the old elementary schools. The Hadow Report contributed significantly towards changing this system to one of promotion by age rather than ability. Despite the recommendations of the Wood Committee, very little was done to improve the situation until the 1944 Education Act. The 1944 Act did a lot towards closing the educational gap by making several important provisions.

Previously the age of entry to school, for handicapped children, was seven years. This was reduced to five years, and so brought it into line with the starting age of normal children. "It took the 1944 Education Act to waken people to the needs of all children. Local education authorities were obliged to provide special educational facilities for every child who required them, a provision that would take into account the age, ability and aptitude of the child."¹³

The Act of Parliament was to herald a major change in the educational provisions for mentally handicapped children. Provisions to this, junior training centres and hospital schools had been the responsibility of the health authorities. However, it was not until April 1971, when the Act came into force, that local education authorities completely took over the education of all mentally handicapped children.

In a similar fashion to the junior training centres, hospital schools were expected to offer education and training to pupils with varying levels of intelligence and ability. Before 1970, the majority of staff were untrained in special education methods. They came from varying backgrounds of experience, including nursing. In 1975, the Department of Education and Science produced Pamphlet No. 60, which contained much helpful advice on curriculum planning for the less severely handicapped child. It failed, however, to provide much guidance in the method of teaching the profoundly handicapped.

Principal of Normalization

Mentally-Retarded child is capable of growth, development and learning. The main idea of giving special education in normal situation to him would be to help him to develop as a person so that he can manage his daily personal affairs and regular work and can get a job according to his potentialities, through his psychological abilities dealing with reasoning, recognition, language communication, numerical comprehension, or differential aptitude may

13. Dent, H.C. (1975), *The Educational System of England and Wales*, pp. 125-138. London, University of London Press.

never reach the desired level, The difference between the normal and the mentally retarded is more one of degree than of kind. Hence their education is not different in its aims and objectives from the education of any other group of children. The aim is to teach a mentally defective the art of living, to enrich his mind by using all capacities and potentialities and to help him to become a useful member of the social growth. Even the most severely or profoundly retarded is assumed to have some capacity for developing higher levels of skill progressively.

Grunewald's¹⁴ usage of the notion of 'normalisation' has presently been an outstanding strategy by all as one of the aims of education. He states— The principle of normalisation is applicable both to the development of the retarded individual (child or adult) and to the needs of parents—the validity of the principle is not negated by the fact that the majority of mentally handicapped persons cannot become fully adjusted to society. The term implies rather a striving in various ways towards what is normal—the principle of normalisation applies in reality to all children and young people.'

Normalisation does not imply any denial of the sub-normal person's handicap. It involves rather exploiting his other mental and physical capabilities so that his handicap becomes less pronounced. It means also that he has the same rights and obligations as other people so far as this is possible. Normalisation envisages "making available to the mentally retarded patterns and conditions of everyday life which are as possible to the norms and patterns of the main stream of society." (Nirje, 1969)." Socialisation is not merely a one-way process of filling an empty vessel. It is a reciprocal process of interaction and draws all members of the family into it.

14. Grunewald, K. (1969). **The Mentally Retarded in Sweden. In Recent Advances in the Study of Subnormality, pp. 23-24. (Ed. Clarke. A.D.B. and Clarke, AM) London : National Association for Mental Health.**
15. Nirje, "The normalization Principle and its Human Management Implications" In R.B. Kugel and W. Wolfensberger (eds), **Patterns in Residential Services for the Mentally Retarded, Wellington, President's Committee on Mental Retardation, 1969, p. 18U**

Hannum's (1975)¹⁶ case studies do, however, reveal that learning progress, however slow, is possible and that many parents do try in their socialization patterns to apply the notion of normalization.

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"The difference lies in the expectations : with a normal child ten stages of development merge and pass, one knows that in due course toilet training will be achieved, speech will come and the usual social skills will be acquired. The mentally handicapped child often moves ahead so slowly that one despairs of ever achieving the next stage."¹⁷ "Normalization (thus) is a process that employs as culturally normal means as possible to bring about as normal functioning by the retarded person as possible." (Neisworth and Smith, 1978, p. 87) Socialization and Normalization pattern obviously differ from family to family, especially between the social classes. The issue of social class, particularly in relation to socialization patterns, is perhaps most relevant to the case of the mildly subnormal. It is a controversial area in which many assumptions are taken by many to be fact.

Integrated Education

Education is a philosophy designed to help the young child reach its own potential and to enjoy a quality of life that comes through self and environmental knowledge. Education is seen by most parents as a preparation ground, in which their children get the requirements for competition, and, hopefully, success in adult life. This observation is valid for normal children, and to a certain extent for the mentally handicapped also. The concept of integrated education is an off-shoot directly emerging from the principle of normalisation.

Formerly, mentally retarded were always considered separately from the regular school patterns. However, the recent trend is quite in the opposite direction. Social acceptance, is as wide a sphere as possible, is therefore, an integral part of the school curriculum

16. Hannum, C. (1975), Parents and Mentally Handicapped Children, pp. 73-80, Harmondsworth. Penguin Books.

17. J. Neisworth and R.M. Smith, Retardation : Issues. Assessment and Intervention. New York : McGraw-Hill, 1978.

whether it is semantically defined or unconsciously carried out. Any school that does not give a high priority to social training, and does not have a programme of activity taking the children into the community is failing in its educational philosophy. Grunewald (1980)¹⁸ has identified certain stages of development. First the diagnostic stage where the diagnosis are made and plans are formulated to meet particular needs. The second stage is that of specialization where particular needs are met by special solutions specific for those needs.

The third is called the stage of differentiation in which stage it is realised that a particular service cannot be standardised for all recipients. The relevant factors in this respect could be different age groups, degree of retardation, and the like. The final stage is a composite one characterised first by decentralisation of services to retarded with those similar services available to the non-handicapped in the community.

The integrated education asks for special classes of schools within the grounds or in the premises of the regular schools with the idea that special education be integrated into general education as fully as possible. From the parent's point of view, integrated schooling appears to be less stigmatising. This will also extend an opportunity for the non-retarded children to have some interaction with the handicapped children. The Government of India has also recommended integration of schools which involves taking in mentally handicapped children in the schools for normal children, where they would take part in all activities and in classes in which they are at par with the other children. Special 'resource' teachers and special "resource* classrooms have been recommended for the handicapped where they can be separately taught in classroom subject in which they cannot participate equally with other normal children. The government has agreed to bear the expenditure involved here. Till recently education for retarded children in most countries did not form a recognised component of the-national or any State plan of the education ministry. However, situation is changing fast and more countries are favouring an educational scheme which recognises that exceptional children need to be integrated with the so-called normal children in schools in such activities as games, physical education, school assembly, recreation and hobby activities.

The integration plan, however, has its usual difficulties as well. Prof. Miki (1980)¹⁹ has also expressed his doubts about the success of the integration programme in the field of education

19. E. Y. Miki, "On the Principles of Curriculum of Education for the Mentally Retarded" Digest, 9, Issue 1, 1980, pp. 77-80,

for the mentally retarded. According to him the characteristics of the aims and contents for the education of the mentally retarded has been slighted. He argues that the curriculum for the mentally retarded must be such as will be conducive to the saving of the limited mental energy of the retarded and the main emphasis would be on teaching minimum essential contents and training an individual according to his abilities which would help him in developing as a person and to get a job in the future. In a recent empirical study, Nalwa and Sen (1979) in fact, found, that instead of mainstreaming the retarded, the special schools in a non-institutionalized setting were most beneficial for the retarded. In any case, the integration of retarded children into regular schools is highly unlikely to be complete so as to include all the severely and profoundly retarded.

Education and Training

The importance of detecting mental defect cannot be overemphasized. The well informed and alert teacher should be able to detect mental deficiency in its early stages. If the child is allowed to drift along with normal children, not only will he not be able to keep pace with them in studies but untold damage will be done to his personality. Development of inferiority feelings is inevitable due to criticism, unfavourable comparisons or punishment. This will lead to further warping of the personality. Complaints are frequently made of restlessness and lack of concentration. Very often this is the result of unsatisfactory methods of teaching. Admittedly it is difficult to keep a class of forty-five children uniformly interested when their mental ages and their attainment ages vary very greatly as is often the case. A feeling of social rejection or being a social outcast often leads to behaviour problems like mischiefs, truancy, lying and stealing. Those in whom an intellectual development is low but not so low as to amount to feeble-mindedness, form an important group in the school population; their I Q. ranges from 70 to 90. They are the last benchers. A diagnosis of dullness does not necessarily imply that the child is without life or spirit, slow of motion or sleepy. Many dullards, despite their limited intellect, are mentally alert and consequently a source of puzzlement to their parents or teachers who find it hard to understand how they can be astute in practical things, yet extremely dull in dealing with abstract matters, or why they should make so little progress in school work when they display so much interest and activity. It is easy to be misled by a bright manner, verbal fluency, mental liveliness and a degree of self-confidence; the true nature of the case can be determined by the use of a valid intelligence scale, and confirmed by finding of associated backwardness in school subjects, especially in the mastery of arithmetical processes, and by retardation in general

knowledge ability to attend to personal needs or take responsibilities

A considerable proportion of delinquent children, and consequently of the approved school population, are found to be dull in intellect. For the most part they are the progeny of dull parents who lack the ability to train or discipline them. Inadequate provision for the dull in the educational system also conduces to habitual truancy and wandering and hence to larceny or other offence as a form of creation or a means of subsistence. The dull child is a slow learner, but is educable, requiring special methods of education limited to his capabilities.

Measures to Meet the Problem of the Mentally Handicapped Children

MO) Early detection of mentally retarded children is very essential. This can be brought about by obtaining the services of a qualified psychologist, preferably attached to the school. In the absence of such a service, health visitors may serve the purpose. The teachers during their training must have intensive training in child psychology.

(6) *Special Classes*—*Vfe* know that learning ability is influenced by many factors other than intellectual ability; by the child's state of physical health, by the encouragement and opportunities given to him by his parents, by his adjustment to his environment, his adaptability to social demands, and by the stability and balance of his emotional life.)

Careful division into *A*, *B* and *C*, streams, the use of individual teaching and activity methods, which allow children to work at their own pace and on projects which interest them, usually overcome the difficulty, and an experienced teacher who is a good organiser can arrange that the backward as well as the bright child is fully occupied. The provision of remedial teaching and special classes, of course, helps enormously. Special Classes not only help the child to develop his mental capacity to its fullest extent, but they prevent anti-social behaviour by ensuring that the dull child gains satisfaction in his school life, and so is not so liable to seek satisfaction through delinquency, truancy and the like.

It is essential that the classes are small so that the child can have a great deal of individual attention. By remaining in the same class throughout his secondary school career, he gains a feeling of security and a sense of belonging. By joining the general school activities, or joining his age group for certain subjects such as, physical training, dancing or cooking, he **feels** that he is part of the school and is isolated by virtue of his incapacities. The stigma is much less than in a special school. The success of these classes varies according to the ability and enthusiasm of the teacher. It is, of course,

essential that the curriculum should have a practical bias. Even if the special class child can never be a good reader, he or she may become an excellent gardener, or cook or needle woman.

Simple English and practical Arithmetic are taught, but a minimum standard only is aimed at. Simple dramatic work, choral speech, rhythmic work, dancing and some form of sense training are all valuable to this type of child. Above all, as the dull child is usually so immature in outlook and emotional in development generally, a wise teacher can teach simple standards of conduct and manners which can improve the general poise and self-confidence of the child considerably. Physical development is, however, seldom retarded, and when sexual awakening takes place they may lack normal control and are often suggestible and very impressionable. They need careful and simple sex education and a good deal of training in mothercraft. They make excellent mothers when they are older, and if a pride in home-making can be developed in school-days, their later development may be very, satisfactory. These children will, of course, benefit perhaps more than any others by the raising of the school leaving age, as they are usually so very immature at 14 years of age. The important point is to link the natural interests of this age with simplified material. The use of newspapers, magazines, fashion paper for instance, can be useful. An intelligent use of the radio is a useful educational aid, and any method of presenting material pictorially, *e.g.*, by the cinematograph, the epidiastope or by posters, helps to bring the facts home to the child. Opportunities to pay visits of interest, to see and handle models, and to carry out simple projects should be encouraged. The dull child, just as the very young child, learns best by the use of his senses, by feel and touch by active rather than by passive means. He is seldom-and attentive listener and is poor at following verbal instructions.

Special class teaching demands much ingenuity and resourcefulness and brings its own rewards. One must remember that dull children may suffer from severe emotional inhibitions which prevent normal development.

(c) *Special Schools*—Another measure of great importance which would go a long way in meeting the problem would be the establishment and administration of special schools and perhaps of hostels for mentally infirm children. Children are frequently frank and critical in their opinions. Their views may be invited by asking them to write essays on such subjects as the ideal school, co-education-; home-work, punishment, premises, size of the school and amenities, the subject chosen depending on the age of the child.

The usual curriculum provided for the mildly and moderately retarded would not suit those youngsters with profound or severe retardation who most often need assistance in such basic skills as sitting up, chewing, swallowing, or going to the toilet. These developmental areas are the concern of the special educators who are to decide on the type of the curriculum needed, how such a curriculum could best be delivered, and what would be the facilitating environment most congenial to the government of training programme for the teachers entrusted with the care of the children. However, among the retarded population, only 5 per cent is assumed to be beyond any hope who need custodial care. Nevertheless, India being the second most populous country in the world, its proportionate share of the severely and profoundly retarded becomes increasingly alarming. The nature of the care and training required for different categories of the retarded is not the same. Early identification and intervention would benefit the mildly retarded. Special education and training may be given to this group following the principle of normalization as far as practicable. The moderately retarded need special educational programme which should aim at development in major learning areas. In addition to basic education in the three R's training in self-care skill needs to be given. This should include major developing areas like motor integration, perceptual and motor skills language and communication, and conceptual skills. Special curricula may be developed and standardised for this purpose, benefiting from the research findings by psychologists and educationists.

In the U.S.A. the concept of integration has been embodied in federal legislation in 1975 which is deemed to be implemented by PL. 94-142, Education for All Handicapped Children Act. The basic intention of this law is to prevent an individual from being stigmatised through classification and labelling. The public schools (government schools), have been entrusted with education and training to provide appropriate, individually designed, instructional programmes for all children, including the moderately retarded, to the maximum extent possible. More and more emphasis is now being given on the provision of instructional programme for mildly retarded school-age children. Very often parents repeat over and over again a description of some small accomplishment of their child, completely ignoring the fact that it may be everyday performance of normal children half the age of their child.

The insistence that they believed something more could be done for the child is frequently expressed in terms of trying Glutamic Acid, endocrine therapy, etc., and even

wanting to "offer^{1*} their child for some surgical or medical "experimentation". In each case, with quantitative variations, the manifestation of such anxiety is due to intense guilt and conflict in regard to the impulse to reject the child. Parental rejection always exists to some degree even though unexpressed or disguised by over-concern and protectiveness.

It is basic principle of mental hygiene and personal counselling that when a problem situation arises we may either try to change the individual, so that he will be able to handle the situation, or we may attempt to alter the conditions under which he functions and with which he has to contend. To do the latter, we try to reduce the number and the intensity of frustrating elements by simplifying the individual's environment so that the solution of his problem is again within his power.

As far as we now know, we can do very little to alter the basic intellectual handicap of the mentally retarded. We can do a great deal, however, to influence many of his social reactions, particularly by controlling the kind of social relationships, which he experiences with others from the very beginning of his life and which determine his basic attitudes towards other people. And we can also make certain adjustments in his immediate family atmosphere, as well as in the broad social milieu in which he lives.

The early home training must be designed to give him a sense of basic security through genuine acceptance and affection by his own immediate family. We have come to recognize that normally a child accepts our standard of behaviour and ideals of conduct and submits to the restrictions which we place upon his behaviour only because he is motivated by affection and by a desire to please a loving parent. This applies also to the mentally retarded child except that in his case the need for affection is even greater, as his handicap limits his self-sufficiency in other areas and cuts him off from other possible sources of satisfaction. But at the same time as his need for affection is more, parents find it difficult to give him that much affection, because to most of them, a retarded child is a lost hope as well as a continuous and ever-repeated disappointment.

Situation, which makes for social maladjustment and transforms an ineffectual but otherwise inoffensive retarded child into a serious social problem, a complication which in its turn, makes the youngster even less acceptable to his already ashamed and disappointed parents. It is very easy to have the retarded child become the symbol of many of the more general frustrations of life and thereby constitute at once a bond and a barrier between the husband and the wife. The issue of the child's defectiveness frequently seems to become quite

unconsciously "the pawn in the battle between martial partners." Some provision must be made to secure an enlightened sympathy and a genuine understanding, not only by those who are in charge of our welfare agencies, our educational systems and the police courts, but also by the medical profession, institutional personnel, and especially parents. Specifically, of course, the problem of the retarded individual, during his early years at least, is primarily a problem of his family. It is the family, therefore, that needs the utmost help in learning to accept the feeble-minded child, because on this basic acceptance will depend the success of all subsequent care and training.

Vocational Training and Rehabilitation of the Mentally handicapped

Wolman (1977)²⁰ interpreted the meaning of rehabilitation as a set of services and activities designated to help the disabled people to achieve optimal adjustment. In the field of mental health, rehabilitation has been defined by Freedman, *-et al.*, (1975)²¹ as a concerted attempt to order the environment, so as to compensate or at least to minimise the residual social and psychological difficulties, to take advantage of the patients* assets and to develop or redevelop his skills.

The traditional forms of psychiatric treatment concentrated on personality recognition and resolution of intra-psychic conflict. To day, the treatment is more concerned with increasing the functional capacity of the patient, so that he may lead his life as normal as possible. 'Habitation' and 'rehabilitation', rather than 'cures*', have become the organizing goals of many treatment efforts.

Mental retardation is a symptom of cerebral dysfunction caused by impairment in the brain cells owing to various diseases . epilepsy, encephalitis, meningites, polimyclitis, measles and jaundice, during pregnancy of the mother, and also by accidents, genetic abnormalities etc., occurring either after birth or at the development stage. Therefore, now a days the mentally handicapped are also known as the *developmentally sub-normal'. degree of retardation depends on the severity of the disease or the developmental impairment. Thus, the intellectual capacity has been underdeveloped from birth, hence the mentally

20 The Wolman (ed.), International Encyclopaedia of Psychiatry, Psychology, Psychoanalysis and Neurology, Vol. 9, Van Nqstrand Reinhold Company, New York, 197*, p. 409.

21 Freedman, M.A., *et. at.*, Comprehensive Text book of Psychiatry, Vols. MI Ed., The Williams and Wilkins Company— Baltimore, 1975, p. 164.'

handicapped have never experienced normal development or normal intellectual ability. Therefore, any programme or treatment adopted to bring them towards normality should more appropriately be termed 'habitation'⁵ rather than 'rehabilitation', because it is not a restoration of any capacity during a given life span. Nearly 87 per cent of the mental retardation is of mild degree and these people can be trained and usually remain in society as self-reliant, albeit below-average normal members. The remaining 13 per cent belong to either of the moderate, severe or profound degree of retardation. Four per cent of the retarded people have to be institutionalised, but this is expected to decrease as alternative patterns or care in the community are developed. As there are varying degrees of retardation, any treatment, education, training or habitation programme has to be planned according to the varying degrees of capacity.

Those severely retarded are mostly below IQ 25 and have the intellectual capacity of a child of between two years to four. They cannot be educated nor trained in any skilled activity. They have to be trained to look after themselves, and most of them need custodial care if parents cannot manage them. Fortunately this category constitutes hardly 10 per cent of the total population of the mentally handicapped.

The second group of the mentally handicapped is of moderate intelligence with IQ ranging from 25 to 50. Their behaviour and performance are more or less those of a child of 4 to 8 years. They are not capable of normal education, but can be trained in many crafts and in simple repetitive jobs under personal supervision. Most of them can be made productive and can be rehabilitated in the best possible manner in a sheltered workshop, but are incapable of adjusting in open employment. This category constitutes about 40 per cent of the total of mentally handicapped persons.

The third category is the best amongst the mentally handicapped persons with the IQ varying between 50 to 75. These people can develop and behave as a child between 8 years to 12 years. They are capable of receiving special education (up to level of HI or IV std.) and can learn routine, crafts and trades in a sheltered workshop under personal supervision. They are also able to perform similar jobs in open employment if suitable opportunities are provided to them. More than 50 per cent of the mentally handicapped constitute this category. They can be purposefully integrated into society.

The Sheltered Workshop

Vocational rehabilitation depends on many factors other than just the intelligence of the

retarded. Moreover, in the present highly industrialised society, job opportunities exist for all levels of ability or skills. Purely repetitive routine operations can be successfully performed by the stable mentally retarded with measured intelligence level of about 5 years. Therefore, many such mentally retarded can become partially or wholly self-supporting, provided they have been properly trained and placed in suitable jobs and they are given the necessary aid, supervision and protection by parents, relatives and friends and provided they are not handicapped by personality disorders or serious sensory defects. If they are helped in understanding this limitations, interest and capacities and taught through concrete meaningful experiences, they can be made productive workers.

Vocational training is the only method of educating and making the mentally handicapped economically and socially self-dependent, though the training given to each individual may vary. There is no such thing as the perfect ability or disability but only varying degrees of ability. This is very true of the mentally handicapped. To rehabilitate them it is essential to design and plan training programme in such a way that these varying degrees of ability and potentiality are developed to their fullest possible extent. "A sheltered workshop is a work oriented rehabilitation facility with controlled working environment and individualised vocational goals, which utilises work experiences and related services for assisting the handicapped person to progress towards normal living and a productive status."²²

Some 60 trainees at a vocational training-cww-production workshop have been able to save and deposit as much as Rs. 23,000 in bank accounts from their earnings within a span of two years. The amount may not be big, but the very fact that the trainees could earn, save and deposit is no mean achievement in itself, when they happen to be mentally retarded the 'discards*' of society.

Money-wise, the amount is definitely not large, but for the 60 trainees at the B.M. Institute's multi-category workshop here it facilities for receiving sub-contract work from industries nearby and also having opportunities of employment in urban, semi-urban and rural areas. Therefore, programmes in each workshop should not be identical,

22 ivatia, Nandini P., "Vocational Training and Habilitation of the Mentally Handicapped". The Indian Journal of Public Administration, Special Number, Administration of the Disabled. Policy and Organisational Issues. July-Sept. 1981. Vol. XXVII, No. 3.

The Family as a Base of Rehabilitation

From the psychological point of view, stigma is preceded by three stages in human relationships—prejudice, discrimination, and segregation or isolation. Prejudice is a hostile attitude created by judgement, based on certain norms. Prejudice is the most important motive force which results in discrimination and segregation. Stigma is the extension of prejudice behaviour to its extreme where there is a blind desire to mark the object of prejudice, so that he will for ever be recognised as abnormal and unnatural. The degree of stigma varies from country to country and, in the same country, from area to area and from community to community. In communities with little contact with modern civilization, stigma has been found to be absent or negligible. So rehabilitation of the mentally retarded is a complex and continuing two-way activity, wherein the retarded have to be trained to become members of the society and society has also to reorient its thinking towards the retarded'.²³

The problems encountered by mentally handicapped people and their families are not easily coped with by a single agency, with the consequent involvement of others who have their own expertise in different areas. Foremost among those who must be prepared to carry a significant burden of habilitation or rehabilitation programme are the parents of the mentally retarded. With love and sympathy, they can help their children to achieve nearly complete independence during life, leading to adult security and emotional stability. It is absolutely unrealistic to think that retarded person's behaviour is the direct result of his handicap. He is the product of his environment as any normal-person. Parental attitudes play an important role in the success or failure of the programme.

Apprenticeship Scheme and In-Plant Training Suggestions

Formal apprenticeship is a long-term programme of education which necessitates carefully planning and administration if it were to achieve the primary goal, that of producing a continuous supply of skilled craftsman to meet the present and future requirements of industry. It embodies certain basic features which are found in whole or in part, in effective apprenticeship training programmes existing in India today. Apprenticeship is sometimes confused with short-term training of machine operators and semiskilled workers.

23. G.N. Narayan Reddy, Rehabilitation of the Mentally Retarded—Problems and Suggestions. The Indian Journal of Public Administration. Special Number July-Sept. 1981. Vol. XXVII, No. 3.

The Apprenticeship Act, 1961, and in-plant training in industries came into being to train normal people for various jobs, and the government identified 103 trades and recruited people for training in these various trades. In 1975, the Government of India announced a 3 per cent reservation of jobs in the public sector of industries for the blind, deaf and the physically handicapped. Hence they became eligible for recruitment under the Apprenticeship Act, with suitable modifications. Training needs of the mentally retarded vary from one part of the country to another.

In view of this no attempt has been made to offer any cut and dried solutions to training problems. The mentally retarded, however, were not considered for the scheme as the specified trades were not suitable for them. The major hurdle was that they did not know how to select the mentally retarded as the capacity and performance of each retarded person varied. In the early part of this century, preventive medicines were introduced to assist man to control some aspect of his physical well-being. Instead of waiting until they become ill, people were urged to take measures beforehand to ensure their health. Rules of diet, dental hygiene and physical fitness were made public. These rules were based on scientific discoveries relating specific causes to effects. If certain illnesses were caused by Vitamin deficiencies, it seemed logical that good health could be maintained by the consumption of an adequate vitamin supply.

Now, although there are still severe limitations in knowledge, a man can not only be treated for physical illness, but also assisted to maintain physical health. More recently, psychological science has shown signs of following a similar trend. The apparent increase in mental illness, at least in the Western World, has prompted psychiatrists and research psychologists not only to seek improved methods of treatment, but also to formulate laws of behaviour which can be offered as principles of mental health. Knowledge of the Laws of human behaviour is beginning slowly to accumulate. Because of the limitations of research methods, only a single aspects of personality can be investigated at one time, and the tendency is, therefore, to attempt to relate specific causes of behaviour to later generalized effects. (For example, a child who fails in school despite an adequate level of intelligence is sometimes presumed to do so because he is resentful of his teacher.) Nevertheless, some principles have emerged gradually from research which have been incorporated with confidence into rules of mental hygiene.

It was accepted that when a child is born he has certain strengths and weaknesses that

are dominant in his physical and emotional make-up. As a result, from the beginning of his life a relationship is established between him and his environment in which his strengths and weaknesses are given recognition. This recognition does not necessarily mean acceptance on the part of adults, but could in fact be in the nature of limitation which will discourage the child. As a result of this relationship, a unique; pattern of behaviour is developed which takes cognizance of the child's original predispositions. In other words, his unique demands on the environment create unique responses. This process has a commutative effect which shapes his attitudes and influences the development of personality.

Despite the lack of scientific precision in this process, and the possibility of erring in the selection of significant aspects, some important observations regarding the etiology of personality adjustment have been made consistently enough to be incorporated into principles of mental health. It is from this process that some of the present thought has arisen regarding the importance of an infant's experience for his later adult life.

Infancy and Mental Health

It was Freud who first convinced people that adverse experiences in infancy could lead to serious maladjustment in later life. In reference to these early experiences which he believed were forgotten because they were repressed, he stated : "We must assume, or we may convince ourselves that the very impressions we have forgotten have nevertheless left the deepest traces in our psychic life, and acted as determinants for our whole future development."²⁵ The general implications of this theory, developed from the introspection of disturbed adults who recalled childhood experiences under hypnosis, are generally accepted as workable clinical hypotheses. However, much of the substance of the theory, such as the experience of sexuality by infants, is still questioned, and the possibility of finding scientific proof of Freud's assumptions seems remote.²⁶ Freud's tremendous contribution to psychology has been his emphasis on the importance of early childhood experiences.

It has been inferred that the mother is the initiator of psychological development, and that without her a child, therefore, cannot develop normal psychological attributes. Margaret Ribble²⁷ is one of the most enthusiastic proponents of the theory that psychological tie between a mother and child is the key to sound emotional development from birth. The continuous flow of mother-love to a child is thought to guarantee healthy development and to be the essential stabilizing force in his life. She hypothesizes that a primary danger exists at

birth and she states, "the appropriate expression of ipother-love is a basic dynamic factor in overcoming the innate potentiality of the infant for anxiety and the tendency to regress to a simpler level of function." She assumes that a child has three psychological hungers—for oxygen, feeling and eating. His specific psychological needs are to feel secure, to get pleasure from bodily functions, and to feel he is a going concern in the world human beings. The three hungers are satisfied by following the rhythm of a child's "inner needs"* for actual food and also for stimulation. The hunger for stimulation is satiated by sucking activities, cuddling, adequate sleep, and adequate routine care in the form of bathing and elimination. This care is called "mothering". Ribble states :

"The art as well as the science of mothering is to initiate and give momentum to the first functions of the child as they develop in sequence, but two situations must never be allowed to come about—the over-development of the child's emotional attachment for his mother, or a ruthless weaning from her."

The mother is the basic factor in early emotional social and mental development. Any distortion of the mother relationship makes a body anxious.

Infants who do not have a direct emotional attachment to the mother show various forms of distorted—behaviour either in their eating and elimination or lose in their speech or locomotion. Later on in life these children have great difficulty in building up their first relationships with other members of the family group and are unable to find the emotional outlet which they so urgently need. The mothering thesis further supported by the observation that children separated from their true mothers can maintain their mental health if a substitute mother is provided within a short time after separation. This is particularly true of children placed in a foster home where they remain until return to their own parents or placement with an adopting parent.

Blatz offered a concept of the mental health of infants as part of his general theory of security. This theory has the advantage of providing an explanation with practical application to both, good and poor mental health. Briefly, the security theory is as follows.²⁸ Mental health is defined as a "serene state of mind arising from the willingness to accept the

25. Freud, S., *The Basic Writings of Sigmund Freud*, edited by A.A. Brill, New York : Random House, 1938.

26. *Ibid.*

27. Ribble, M.A., *The Rights of Infants*, New York : Columbia University Press. 1943, p. 104.

consequences of one's own decisions and actions.*' As this is dynamic state, man is always seeking serenity and finds it only temporarily as he faces new and changing situations in his daily living. In contrast to well children are babies who do not develop a core of security and who, remaining in a constant state of uneasiness or anxiety, show symptoms which indicate mental ill health. Such infants employ regressive actions as permanent and predominating aspects of personality. Their state of ill health can be described as a disturbed state of mind arising from a lack of feeling of self-worth and a suspicion that their world is untrustworthy.

The Foundation of Mental Health in Children

The Foundation of healthy social attitudes and skills is the degree of trust that the child develops. This to say that the individual's mental health and achievement of abundant living depends to a large extent on his relations with other people. It has become increasingly clear that the years of childhood are crucial for the mental health of the individual. Adjustment is cumulative, every experience being assimilated in terms of what has gone before. The best guarantee that the individual will be able to adjust satisfactorily at any stage of his development is that he has been able to meet and deal with the problems of all previous stages of development. This places a very strong emphasis on the early years, for it is then that the foundations are laid and the directions started that will have a great deal to do with what kind of an adult the individual will eventually become. This is not a new emphasis;" for centuries people have been aware of the importance of childhood experiences. But we are just beginning to see what kinds of experiences the child needs to ensure that he achieves on 'abundant Life/ And the kind of meaning we give to mental health or abundant living helps to determine our views of child training and education.

Mental hygiene can be given a basically static and negative meaning. It is the purely preventive idea—the prevention of mental illness. From this base, education, especially in time, becomes a series of attempts to keep the child from being bad, and maladjustment from happening. But children can be good and still be unhappy. Children can be helped to avoid the common 'problem' behaviour and still fall far short of mental health.

28. Blatz, W.E., *Understanding the Young Child*, Toronoto : Clarke Irwin & Co., 1944.

Positive Approach

A positive mental hygiene approach to child training and education is based on a number of assumptions or expressions of faith. These can be stated briefly. The child is neither good nor bad by nature but possesses almost infinite possibilities of either. What he becomes depends on what happens to him in the process of growing up. Nothing is more important than individual personality, but the individual can only fulfil his potentialities as he relates himself to others. When the individual fails to satisfy his needs and wants, he can be neither happy nor efficient; that mentally healthy. When he attempts to satisfy his desires in ways that do not fit in with the society in which he is living he is said to be maladjusted. It is only when he achieves satisfaction of his motives in a way that does not conflict with society that he can be said to be mentally healthy. This is to say that the individual's mental health and achievement of abundant living depends to a large extent on his relations with other people. The child is neither social nor unsocial at birth. He has it all to learn. This learning is slow, gradual cumulative process which starts very clearly and goes on for the rest of his life. But the early stages are crucial, for what happens then determines to a large extent what will happen later.

Foundations—Healthy Attitudes

The foundation of healthy social attitudes and skills is the degree of trust that the child develops. If he is fortunate enough to have parents who care for his needs in a warm, friendly, affectionate manner, he will have a good start. However, if he lacks, this kind of care he will have a handicap which he may never overcome. Studies of children who have been separated from their mothers and been cared for by others who have not adequately taken the mother's place, show that these children have great difficulty in relating themselves in any intimate way with other people. There is a trend in child training and education to-day which seems to say that frustration in any form is bad for children, and that they should be given whatever they demand, and he allowed to do about what they like. This is neither necessary nor desirable. On the contrary, children need to be helped to accept frustration, to learn, that living makes demands on them and sets limits to what they may do. It is better for the child to learn early that life consists of two kinds of activities, those that he can do or not as he likes, and those that he must do if he is to enjoy life. When the child has learned to depend on and trust other people, especially his own parents, then he is ready to begin developing a trust in himself that is another necessity for his -mental health.

Religion and Mental Hygiene

To be more concrete and direct, what we have implied is that religious education needs to be considered in a context of mental hygiene in which we take into account the whole development of the child including especially his feelings and attitudes. He moves step by step in his development, building on what has gone before. And religion is not separate from all this accumulating experience but the very warp and woof of it. The child who feels accepted, player. But neither can we expect to make an Einstein of every child who goes to school, intelligence is part of a child's biological inheritance. Nothing we can do as parents or teachers will increase nature endowment.

But more than native capacity is involved in superior achievement of any kind. Van Cliburn would never have become a world-renowned pianist or Bob Feller a major league player if they had not discovered and developed their talents. So with academic the ability to do difficult intellectual work. It must be discovered and nurtured through the richest possible educational experiences at home and at school. It must be developed through hard effort. Otherwise mental power remains inactive and inert an unchanged battery.

How do parents know if their child is academically talents ? If the youngster is old enough to be in school, teacher may volunteer the information or answer a parent's question about his child's abilities. If the school makes special provisions for the gifted, obviously the child who is in this special programme is through to be gifted.

The school's judgment is usually based primarily but not entirely, on intelligence tests. Naturally tests are not infallible, and recently there has been criticism of group tests, as giving somewhat inaccurate individual measurements. Individually tests administered by a competent psychologists are preferable, especially for younger children, but they are expensive. Schools with adequately financed testing programmes provide for both kinds and base their estimate of a child's academic aptitude not on a single group-test , but on a series given over a number of years. Testing, of course, is not the only means of discovering academic talent or giftedness. To the perceptive parent or teacher the exceptional child reveals his intellectual superiority in many ways. He is unusually alert and observant.

One youngster for example, learning the word mice, remarked, 'My what a funny way to say mouses'. The child with intellectual gifts is also highly curious about happenings around him and stubbornly probes for the 'how and why' of things. He has unusual ability to

grasp and deal with abstractions, such as time, space, and numbers while other children who are interested in pictures of objects, are likely to be interested also in maps, calendars and clocks. Bright children generalize their experiences. They see and think about the consequences of events or acts and they perceive and describe rather involved relationships. Children and youth with intellectual gift often have large vocabularies, which may include technical terms associated with a particular interest. A ten year old boy who is fascinated with the weather and reads the weather reports in the daily newspaper uses such words as cumulus, cirrus, temperature and gale. In general academically talented children find real joy in rigorous mental activity. They like working on intricate problems and puzzles.

Yet occasionally a child of high intellectual ability shows few if any of these traits. The reasons are various. It may be that his home and school environments are intellectually sterile, offering him no stimulation. Or he may have had some unfortunate frustrating experience, probably in school. Teachers and parents should always be alert to discover these "sleepers" or under achievers, and stimulates them to stretch themselves. When we parents know we have a bright child, what can we do to help develop his gifts ? In most of our homes there is probably too much talk about stars of the sports and entertainment world and too little about great scientists, thinkers, humanitarians, artists, and admiring Dilip Kumar, Devanand or Ashok Kumar. But children should hear admiration expressed for people like Dr. Radhakrishnan, Swami Vivekanand, Gandhiji and Albert Schweitzer.

Nothing, of course, is so important in fostering the life of the mind as are good books and quality magazines. When parents themselves are in the habits of reading even the youngest child wants to read. Reading extensively to children, discussing the stories with them, and talking about characters, actions, ideas and meanings are fine ways to help young minds grow. Children should be supplied as abundantly as possible with attractive books appropriate to their level of maturity. Discussion of ideas and current events should be an every day affair in the home, and trips to the library fairly routine. If parents are interested in lectures, forums, theatres, study discussion groups, or exhibits and concerts, children will come to regard cultural and intellectual interests as normal desirable activities. Travel, too, is an enriching experience. When the family plans a trip what could be more stimulating than reading in advance about history and geography of the region you will visit ?

Learning Difficulties

Schools are institutional set up by society to help the young acquire the skills, knowledge, and attitudes needed in adulthood. Learning is the main business in school. Most children expect to master reading and writing and they also expect to master to acquire knowledge about the world in which they live. Besides, they take delight in developing new ways of thinking and of getting along with people. In the mental and economy of youth, learning is a central theme, its relating to mental health is deep and pervasive. Success in school can be and often is emotionally strengthening. A child's emotional stability is damaged by poor learning situations. For a long time, educators have been familiar with the importance of health to children in school. Because they have understood that better healthy children learn well than sick-children. The close relationship between learning and physical health was appreciated first; but more recently the quality close relationship between learning and mental health has been increasingly understood. The pressure of many parents for achievement at school illustrates, among other things, the need for more teacher-parent communication regarding the school's aims and methods, particularly in view of increasing appreciation of the individual difference in children. Teacher's awareness of mental health significance of daily class-room practice is growing. Efforts to measure the results of preventive programmes for mental illness and emotional disturbances in school setting are being reported in the literature.

Academic achievement is the primary goal of the teachers but at the same time they also feel to spend time after emotionally disturbed and aggressive children to whom they feel in their duty to offer help; but they also feel the time spent in this will divert them from the major goal of importing academic achievement. The school is in a unique position to identify the emotionally disturbed child since it is able to observe for several hours a day, his reactions to his teacher, his class mates, and to himself. In addition, modern educational theory regards each child as a unique individual with his own particular needs, problems and characteristics. Good teaching is conceived of as an attempt to understand these individual differences. Academic achievement in a child is enhanced, not hindered, but reduction of anxiety and feelings of aggression. The problem, so real to the teacher, is not between helping academic achievement and furthering the mental health of his pupils, but between the latter and the methods used to measure and promote achievement. Examination marks are considered by teachers; pupils and parents—as having an objective validity which they simply do not possess.

School System

The use of marks as a measure of comparison between pupils in a class is of little value to educators. Parents expect marks and class standings and passing from standard to standard. This leads to unfair competition among teachers and pupils. Children become frustrated and tend to give up studies when they are failed. Even those who pass out often fail in the long run by their emphasis on excelling over others, rather than experiencing the inner satisfactions of acquiring knowledge. Also, with the use of parent systems of examinations the child will develop a pattern of doing only as much as required to 'pass'. These standards become irrelevant when he leaves school with the result that he is not likely to go for further education or training. In times of rapidly changing society it is essential that learning continue throughout life. As a result, it should be shaped according to the environmental conditions of learning that each child's highest development will be promoted. Certainly so far as the severely emotionally disturbed child is concerned, the school is likely to be in the front line in identifying him and referring him for diagnosis and treatment.

Learning Difficulties Can Cause Strff •

There is also a great need for intensive investigation of the learning difficulties of individual children. Of course, not all learning difficulties are due to inexperienced teachers, poor methods, or badly constructed courses of study. Often the cause lies within the child's perpetual difficulties. Reading is a process of deriving meaning from certain marks on a piece of paper. Basic to reading is familiarity with words, both those which are heard and those used in expressing oneself. Among the factors underlying children's reading difficulties are faulty perception—visual and auditory. Some children are less acute in attaching meaning to the word they hear, or in distinguishing the differences between the sounds of words. There is a much higher proportion of reading disabilities among boys than among girls. The superior verbal ability of girls as compared with boys is reflected in their greater achievement in reading. Though Thorndike²⁹ (1934) reported two studies in one of which the difference favoured the girls and in the other the differences favoured the boys; Potter (1914) and McLaren³⁰ (1950) found no sex differences in reading achievement, a much larger number of

29. Thorndike, E.L., *et al.*, *Prediction of Vocational Success** New York : Commonwealth Fund, 1934.

30. McLaren, V.M , Socio-economic studies and reading Ability—A Study in Infant Reading. *Studies in Reading*, Vol. 2 (compiled by W.D. Ritchie) London : University of London Press, 1950, pp. 2-62

studies have produced findings which show the girls to be superior to boys in reading skills. McIntyre and Wood³¹ (1935) studying 33,000 Australian subjects, found significant differences favouring girls in speed of reading though not in vocabulary. Poor reading may be a sign of specific language disability: It may be just one bit of evidence that the pupil's failure is due to a lack of association difficulties or emotional difficulties. The treatment which such a boy or girl will need is very different from that which will help a student whose poor reading is caused by prolonged school absences, lack of inferior teaching and these must be confused with one another..

Perceptual Difficulties

The basic difficulty in spatial relations is that the child does not learn from the usual clues visual, auditory, muscle sense (kinaesthesia) and to locate objects in space relative to himself and other objects. The perceptually handicapped child difficulty in grasping these relationships and also perceiving motion. One is likely to get the impression of general immaturity. The ordinary developmental stages have likely been delayed, perhaps accompanied speech defects and motor development. His posture be poor because he is unable to co-ordinate the side his body. Posture is the basic muscle pattern out of which all other patterns of movement develop. It has been found repeatedly that boys, at least at the elementary school level and up, do better than girls on most performance tests. It is now thought that this is due to their superior spatial ability. How early in the developmental process this sex difference appears is not, as yet, known. The evidence on this point is too sparse to permit any definite conclusions.

Me Namar³² (1942) in his analysis of the data collected for the standardization of 1937 revision of the Stand ford Binet Scales found that no such items as form boards, puzzle boxes, assembling objects and slot mazes, the boys always scored higher than the girls, both in speed and accuracy. In the Second Scottish Survey³³ (Thomson 1940), the males performed consistently and significantly better than the girls on the battery of performances tests. Philip³⁴

31. McIntyre G.A. and Wood W. The Standardization of an Australian Reading test, Aust. Coun Educ, res, J935, Set. No. 39.

32. Me Namar, Q , The Revision of the Stand ford Binet Scale. Boston, Houghton Mifflin, 1942

33. Thomson, G.H , An Analysis of Performance Test Scores of a Representation Group of Scottish Children, London, University of London Press, 1940.

34. Philip, C.T., A Mechanical Aptitude Test, Indian J. PsychoJ., 1949,24, 96-99.

(1949) developed a pencil and paper test of mechanical aptitude for use in selecting high school students for mechanical Courses. **The** test attempted to measure the capacity for perceiving concrete objects in space. He compared the performance of 800 boys and 800 gi'rls on this test and found that the boys obtained higher mean across than the girls. His findings suggested that this test measured something other than intelligence.

Psychiatric Factors in Learning Difficulties

A type of psychiatric disability that interferes with learning is Juvenile Schizophrenia. In this case, the child's academic learning problem is of secondary importance to his grave prognosis. It is usual to keep such a child at school, unless his behaviour blocks the progress of his class mates. The evidence presently available suggests that childhood Schizophrenia occurs more frequently in boys than in girls. Bradley³⁵ (1941) compiled the cases reported by two Investigators, Grunthan³⁶(1919), Potter³⁷ (1933). A total of 96 children were reported in these studies as Schizophrenic and of these 72 were boys and 24 girls. He states that the direction of the sex difference was consistent through all of the studies, suggesting that childhood Schizoyhrenia may be 2 or 3 times as common in boys as in girls. The child whose perception is impaired will have difficulty perceiving that a group of two objects occupies less space and makes a different configuration from a group of four objects. His concepts are narrowly classified and rigidly maintained. Perpetual difficulties inhabit concept formation. The perceptually handicapped child may not be able to recognize a group of similar objects as a class, or a single object as part of a class. He has difficulty in relating cause and effect. He cannot focus his attention on his goals which' are important to his personal adjustment. "The perceptually handicapped child may be emotionally unstable, *i.e.*, easily aroused emotionally and fluctuating quickly from one emotion to another. This has been found in brain-injured children. What has been called "the catastrophic reaction" *i.e.*, sudden explosive crying or disintegration of motor activity. More cautious authorities refer to them as having "Minimal brain days function." These defects may appear singly or in various combinations in different children. Some of the children appear to be distractible, unable to keep their attention on anything for more than a very short time.

35. Bradley, C, Schizophrenia in Childhood, The Macmillan Co., New York. 1941.

36. Grunthan, M, Uber Schizophernic in Kindersater, Ztschr. F. Psychiat., 1919, 46, pp. 206-240.

37. Potter, U.W., Schizophrenia in Children. Amer. J. Psychiat. 1933, 12, J253-1270

Parent-teacher Go-operation

The ultimate measure which schools may take to strengthen a child's mental health is to work with his parents^ Parent-teacher communication will do more than anything else to reduce learning difficulties for the school child and to promote his achievement and mental health. Parents are accustomed to see the marks as a means of judging the academic standing of their children. When the parents see the marks, they may look at them and summarily blame or praise the child or show indifference. In the end, parents shift to the school the responsibility for rearing their children. Teachers often feel, in tune, that the home is expecting too much of the school. Such situations indicate that there should be closer co-operation between teachers and parents. The parent-teacher co-operation can stimulate the parents to their responsibilities towards intelligent understanding of their children and to obtain better school conditions by giving teachers new insights. Working with parents is a two-way affair in which mutual respect is essential. They will benefit from co-operative planning instead of being torn by conflict as their grown ups at cross-purposes. This does not mean that the school then will have less responsibility, but rather that the school and home as a partnership will co-operate in understanding the student his needs, his attitudes, and what to do about his educational growth.

Parents and teachers can co-operate more fully in the matter of character, sex and religious education. Many parents have been expecting the school to do their work for them in these matters. The place for the main work in character education is the home. Sex education cannot be effectively a part of the school curriculum but should be a parental responsibility.

Learning Processes and Mental Retardation

Lack of intelligence with incapacity to learn is loosely assumed to be associated with poor ability to form connections between facts or events connected in space and time. The process might be defined as the relatively permanent modification of reactions as a result of experience. Causes of learning deficiency present an equally complex picture. Apart from the effects of intellectual handicap, it is well known that different individuals have different rates of learning. Johnson³⁸ (1955) lays out a system of functions related to learning. Retention and recall are mentioned, but acquisition is analyzed in more detail. Other

38. Seguin, E. (1846): *Traitement moral, hygiène et éducation des idiots et des autres enfants arriérés*, Paris; J.B. Ballière.

relevant processes are considered to be conditioning, trial and error imitation, tuition reaction formation, thought, reasoning, reorganization and insight, creative imagination and judgment.

It would be possible to extend any analysis of the literature on deprivation and backwardness to a considerable length. However, although research continues and definitive statements cannot yet be expected in this confused field. Permanent nature of backwardness resulting from emotional deprivation is questionable, and the effect of a change in environment can be shown to be therapeutic. Emotional deprivation, where a child is deprived of affection or rejected and frustration, can also be shown to have damaging effects, but it cannot be said with certainty that such effects are necessarily permanent. The emotional impediments to learning have only recently had such attention, but for many years competent workers have taken the view that defectives are poor learners for emotional reasons. SeguireV. 39 work (1846) was an early example of this. which should emerge during a preliminary psychological investigation.⁴⁰

40. Jolles, f. (1947) : "The Diagnostic Implications of Rorschach'i **Test in Case Studies of Mental Defectives**", **Genet, Psycho), Monogr.** 36, pp. **89-197**,

CHAPTER 1: PART B- Review of literature

Sen (1980) quoted Lyman who commented, "Mental retardation is perhaps the greatest single source of human suffering. The child born mentally retarded is not only a tragic human figure in himself, living yet not living, since he is never to be what he could have been, but he is the innocent agent of profound and endless suffering to his family and a perpetual burden to his society." A large number of previous studies have emphasised that the birth of a handicapped child precipitates major family stress. Some may stoically bear the misfortune, and try their best to draw out the residual potentialities in their child. Others rave and rant against fate. Ultimately, all their wrath may fall on the already hapless child, who is seen as a serious threat to parental ego, as a child represents an extension of the parents's self (Ryckman & Henderson, 1965; Kravaceus & Hayes, 1969; Chinn, Winn & Walters, 1978). Many authors (Olshansky, 1962; Farber, 1963; Tew, Paynes & Lawrence, 1974; Martin, 1975) have described various pathological aspects of family reactions, such as chronic sorrows, frequent parental quarrelling, a serious danger of a break-up of the marriage and poor mental health of the parents in families with a handicapped child.

Family life as a form of group living requires its members to make specific adjustments and readjustments to one another and to preserve a state of emotional balance in terms of behaviour and attitudes, obligations and restrictions. Any change introduced into the family group upsets the acquired equilibrium and makes new demands upon the adaptive capacity of its individual member. Sometimes the change is met by a smooth adjustment and sometimes it is not. Such family events as a birth of a handicapped child, the loss of a parent, the emotional estrangement between husband and wife will have far reaching emotional repercussions upon each member of the family and complicates the accustomed way of life.

Many western studies have compared families with their retarded children at home and at institutions (Carr, 1974). These studies were necessitated by the fact that more and more emphasis was being given to the relatively more beneficial effect on the retarded child, when he/she is kept in the family rather than in an institution. Researchers compared the effects on the families of, for example, a retarded child in an institution or one brought up at home, of children with different types of handicap, or of a handicapped or a normal child. With the increasing emphasis in recent years on the benefits of home care for the retarded, has come increasing concern with the effect that this may have on their families.

In general, most families want to keep their retarded child at home and most of them adjust to doing so. Besides, India is a country with traditional values and strong emotional bonds in the families. In India, the teeming millions of the mentally handicapped cannot be provided with institutional services because of the paucity of institutional care (Sen, 1988). Skeletal institutional services, even whenever available, are only for handicapped children; and the adult retarded do not find a place in such institutions (Sen, 1981). As a result, the main burden of retarded children and retarded adults falls on their families. Many of them live a vegetative existence with no hopes or aspiration or ambition for the future. Survival for them, all along, becomes very difficult, even impossible, but for the support of their families. The handicapped are looked after and cared for mainly by their families. However, the profile of the parents of these handicapped individuals is very difficult to perceive, for it is different from that of the parents of normal children. These parents do not and cannot have any hope or expectations from their children. It seems that they are always occupied with their handicapped children. The situation is obviously more difficult for the parents where the child is more severely retarded; parents have more problems of behaviour and management, for example, in feeding, dressing and toilet training the child. Often the families are large and already beset by a multiplicity of other problems.

These families should get the services they need and deserve in terms of financial, emotional and social support. The world would look rosier to these parents when they realise that they are not alone with their problem and that they will have help in their task of bringing up their retarded child. In spite of all the difficulties, embarrassment and a sense of guilt and humiliation, inconveniences and problems of management, most families manage to adjust to having a mentally handicapped child and a majority of parents wish to keep them at home. But at what cost?

Most studies have examined the effects of a retarded child mainly in terms of feelings and attitudes of their family. The impact may be felt on the relationship between the two parents. A retarded boy living at home affects marital integration, especially in lower class families, more than a retarded girl. This effect increases as the boy grows older (Farber, 1959).

A recent article published in the *Saturday Times of Times of India* (February 25, 1989), illustrated the agonies of the parents involved. One mother said, "Two days after the child was born, the doctor informed me that he had Down's Syndrome, a form of chromosomal abnormality. My initial reaction was utter disbelief, despair, and depression. I felt there was

nothing worth living for in life. Along with this arose another thought: my responsibility as a parent to help the child grow and develop as best as he can, " A father said, "Who knows how long one is likely to live. You can't depend on relatives to take on the additional responsibilities of a retarded child. Hence, I have insured myself heavily". Another father said, "As a father, I have been running around for 15 years trying to find a job or vocation (for a retarded son). Let me tell you, nothing is available in India". For most parents of mentally retarded children, it is almost a dead-end situation. With growing mentally handicapped children, education, vocational training, social interaction, home training, sex, marriage, progeny are some of the daily issues confronted by many couples.

Social isolation, too, is often thought to be a part of the penalty parents must suffer for having a handicapped child. Some parents may be put off by the birth of a handicapped child, from adding to their families. Social withdrawal symptoms become a natural concomitant for parents. A professionally trained mother said that she had stopped socialising altogether. Social attitudes, too, reinforce the handicapped situation of the children as their parents experience a sense of being different, in a detrimental sense. Sometimes these children are ridiculed as idiot or imbecile by an unjust neighbourhood.

Coping with chronic problems, which seem to have no solution, leads to intolerable stress. Having a severely mentally retarded child has been recognised as one of the most stressing chronic problems. Studies conducted for evaluation of stress among the parents of mentally retarded children confirmed that the presence of a severely retarded child places significant stress on the parents, which increases their vulnerability to depression and even to psychiatric breakdown.

There is a need for ways to deal with the psychodynamic problems of parents with retarded children. "The parents are often viewed as being problem ridden, anxious and maladjusted" (Wolfensberger, 1967). Sharma and Gupta (1985) demonstrated a deleterious effect on mental health status of the parents of the handicapped child.

Parents of mentally handicapped children face a variety of problems which are quite different from ordinary parental experience. For example, bringing up a mentally handicapped child involves more physical work, more mental strain and more social and financial responsibilities. In addition to these, the slow growth of the handicapped child makes the parents feel frustrated and apprehensive about their child's future. Concern about his or her independence, work, and marriage becomes particularly acute. The increased tension and stress may lead to family disintegration and marital breakdown. The constant

care necessary for the severely mentally handicapped child, frequently has a damaging effect on the mother's health. These parents need to be helped with their emotional problems, to ensure that the retarded child is neither rejected nor overprotected to the neglect of the other normal children in the family. Siblings of handicapped children have also been reported to be adversely affected, as they feel neglected, jealous, embarrassed or aggressive towards him or her. Social relationship and activities of parents become considerably restricted.

Recently, a study was conducted by the present authors on the agony of the parents of the mentally handicapped. This study is reported here. It investigates the problems that the parents of the mentally handicapped face in their day to day life. Information regarding parent-child interaction was collected during an informal interview and also with the help of a tape recorder. Two visits were made in respect of each of the 30 families. The first visit was in order to fix an appointment with the concerned family according to the convenience of all the members of the family. In the second visit the actual information was collected.

It was found that the nuclear family, the total number of children was two to three, and in the joint family there were five to seven children. More frequently, the mother's age at the time of birth of the retarded child was 33 to 35 years, and in 90 per cent of the instances, this child was the last born. The average age difference between the subjects and other siblings was 8 to 12 years. The educational qualifications of the father of these mentally retarded individuals varied from matriculation to professional qualifications (including an Electrical Engineer). An interesting fact that emerged with respect to the mothers was that, most of the mothers were educated; but not even one of them was working. About 80 per cent of them were graduates and 6.6 per cent had even done post graduation; still all of them were only housewives (non working).

Perception of mental retardation

The first question that was put to the parents was, how they perceived their child's illness. Out of the total sample, 93.3 per cent of the couples reported that it was due to the Karma of their previous birth. They attributed their child's handicap to their 'sins' in the previous birth and believed that the wrath of God manifests itself in the form of their child's mental retardation. Most of the parents who believed in the theory of Karma, had at some time or other performed religious rites and rituals, and every now and then, went to 'ojhas' and 'pundits' to perform some religious ceremony, which they believed, would somehow rectify

their child's condition. About 19.4 per cent of these couples told the investigator that they regularly visited temples and priests.

Problems faced by other siblings in the family

Most of the families interviewed were nuclear with only parents and siblings living together. The parents reported that due to the handicap of one child, their other children suffered a lot, since there was no way they could divide their attention and time equitably amongst all their children. The handicapped child had to be given maximum attention and time, which left very little time for the parents to spend with the other children. In fact, some parents felt that due to their child's handicap, they had neglected their other children. They ran from pillar to post for treatment of any kind, medical or religious and had, consequently, very little time to spend with the other children.

Another critical problem emerged with regard to the siblings of mentally retarded children. Some of these children had sisters of marriageable age and the fact of mental retardation in the family was enough to frighten all eligible men from getting married in the family. In one case the father reported that, on three different occasions people had approached him for his daughter's hand, but after coming to know that the son i.e. the girl's brother was mentally handicapped, they withdrew the proposal. The reason being that if the brother suffered from a problem like mental retardation, chances were there for the girl also to develop similar problems later on. Further, according to them, it was quite possible that children born to the girl could also be affected by the same problem.

The parents also reported that the handicapped child was not very well adjusted to their siblings in the family. One mother narrated an incidence where the mentally retarded, in a fit of anger hit his younger sister with a brick, causing a deep injury which needed five stitches. Nearly 93.3 per cent of the parents reported adjustment problems between the siblings and the mentally retarded child.

Regarding the general temperament of the child, 76.7 per cent of the parents reported that their child became aggressive with a little provocation and become violent on many occasions. At times, the situation became so unmanageable that the child had to be locked up separately in a room. One of the parents reported a real incident. The parent once sent their son to the market in order to get some household things and gave him Rs. 207- for the same. He lost the money on the way. When he got back home, the father scolded him a little, the boy, in turn, blamed

his mother and said that the mother was careless because his pocket was torn, which caused him to lose the money. This started a scuffle between the son and father. The son became so aggressive that he picked up a stick and beat his father. Being physically stronger than others in the family, the boy became uncontrollable; neighbours had to intervene in order to stop him and the father felt very insulted. The father told the investigator that there was no respite from such situations and there was no escape or any hope or improvement. On the other hand, it is true that, when the child senses that he is not accepted wholeheartedly by his family, that he is covertly (even though not overtly) rejected, he erects a barrier of antagonism around him.

Nearly 66.7 per cent of the parents reported that their child suffered from some sort of physiological problems which caused them great concern. Sleeplessness and stereotypic movements were the main physiological problems associated with their children. One of the parents complained that their child suffered from sleeplessness, and at times could not sleep for two days in a row. He had to be kept under constant medication for his sleeplessness. Whenever the intensity of this problem enhanced, the parents had to keep awake with him, which fatigued them constantly. Nearly 40 per cent of the parents complained of stereotypic movements and repetitive talking. Stereotypic movements include the movement of head and hand. One of the parents reported that their child had a body movement that was highly repetitive. She also said that the child kept on repeating the same question again and again and did not stop even after being provided an answer. The investigator noticed that the boy kept on asking his mother "who is this" throughout the interview. Besides he tried to stop the mother from talking, kept on pulling her and disturbed her throughout the interview.

A very important behavioural problem that emerged during the entire interview, concerned the sexual behaviour of the mentally handicapped. Nearly 96.6 per cent of the parents reported that their children had certain problems regarding sex. Nearly all the mentally handicapped were aware of the opposite sex, but did not know any appropriate way of behaving with them. At times they indulged in very peculiar behaviour that embarrassed the other members of the family. "One of the parents reported that whenever any of their daughter's friends came to their house, the retarded son behaved in an odd fashion, trying to physically touch the girls. As a result, the parents had to instruct their daughter not to invite her girl friends home.

Moreover, all the retarded persons belonged to that age group where they saw a number of people of their own age getting married. Witnessing this they often told their

parents that they too wanted to get married and insisted on their parents finding a girl for them. An interesting observation made was that nearly all the parents wanted their retarded children to get married. They would not have minded getting their son married off to even a mentally handicapped girl or a physically handicapped girl.

About 83.3 per cent of the parents reported that their sons masturbated without showing any discretion with regard to time or place. If stopped, they became abusive and aggressive. A further anxiety arose because there were girls and other young children at home who saw their retarded brother and picked up these undesirable habits from him.

A number of social problems are conspicuously associated with the problem of mental retardation. Nearly all the parents expected their children to gain some amount of social independence. With a view to gaining this, they had, on advice of the school authorities, sent their handicapped children to make small purchases. But when they tried this, most shopkeepers refused to deal with the mentally handicapped children. Further, those who were good enough to deal with them, took advantage of their handicap and cheated them either by giving less money or giving less in weights of the commodity purchased.

Another important problem mentioned by about 93.3 per cent of the parents was that their child's handicap had limited their own social activity. Most of the mothers were graduates but could not even think of taking up jobs or work outside, because the retarded children demanded constant attention and supervision. They could not work even if their social and economic conditions demanded they worked. Further, 63.3 per cent of the parents reported that they could not go out even for social occasions or parties or marriages. Moreover, neither could they invite any one to their residence, nor take the child along with them or leave him alone, because his awkward behaviour at such gatherings would be embarrassing. One of the parents specifically mentioned that it had been six years since both the husband and the wife had gone out together. Usually, they avoided going out anywhere altogether, but if it could not be avoided, then one of them would go alone, leaving the other to look after the boy. Going out with the child was also not possible, as the child's handicap attracted too much adverse attention from people. Most of the parents felt that they had learnt to accept their child's handicap. In fact, they had adjusted their life routine around their child's demands and tried to lead a normal life.

The age of the handicapped boys ranged from 16-23 years; yet many of them were not independent even in their day to day routine. As many as 43 per cent of the parents

reported that they had to help their child with his day to day chores like going to the toilet, combing, dressing up, eating, etc.

A major source of parental agony and apprehension was about the* child's future. The parents felt that they would look after their son till death. But who would look after their handicapped son, taking the responsibility of the mentally handicapped son after their death? This anxiety was nearly suffocating them.

Due to constant influx of new cases, the parents had repeatedly been asked by the school authorities to remove their child from school after he had his limited vocational training. About 36.0 per cent of the boys in the present sample had learned some vocation like printing, chair weaving, candle making etc., but still did not know where to go and look for jobs. The parents repeatedly gave examples of institutions that employed physically handicapped and asked whether there were any similar institutions, for the mentally handicapped as well.

During the course of interaction with these handicapped boys, it was noticed that they had an inclination to work', but no opportunity to do so was provided at all. In one of the cases the parents had deposited an amount of Rs. 50007- as security money with an electrical switch making company, but the authorities ultimately refused to give the handicapped boy a job.

Research on families with disabled individuals: review and implications conducted by Lina Kashyap presents an overview of 36 published studies and doctoral dissertations identified on families with disabled individuals. The review covers the general aspects of the research studies and trends in the major findings. Implications are drawn for social work intervention, teaching and social policies. The author observes that of the four categories of the disabled, the mentally handicapped and their families have received the maximum attention from researchers. The effects on the family of the presence of a disabled member have been studied with reference to inter-relationships and expectations of parents from their disabled children, and effects on practical aspects of daily life. Areas that have remained unexplored are sibling relationships and those between the disabled adult and his/her spouse, children and other members of the extended family.

A paradox of the phenomenal advances in medical and engineering sciences, in technology and research, is the increasing number of disabled individuals. There has been a gradual

increase in the incidence of these conditions as a result of improved methods for early detection, diagnosis and treatment and intensive public education. The control achieved over contagious diseases has also led to an increase in life expectancy.

However, the concern today is not just to save life; the quality of survival is now regarded as of equal, if not of greater significance. Hence, the realisation that physical restoration is only one aspect of total rehabilitation; inseparable from it are psychological and social adjustments. A vast number of disabled individuals are being cared for by their families generally throughout their life-time. Yet, until the early twentieth century, very little was known about their social non-medical needs or about the needs of their family members who cared for them or about the manner in which the perceptions and attitudes of the family influenced their overall rehabilitation.

The past few decades have seen tremendous changes in the philosophy and provision of services for such individuals. There has been a definite movement away from the concepts of custody, care and treatment to the concepts of prevention, education and rehabilitation. Institutional services, till recently, were the major forms of specialised care provided to such individuals. In recent years, there has been a growing movement towards de-institutionalization and the development of community-based rehabilitation services. This trend has received impetus from an emphasis on the 'normalisation' principle, which seeks to promote conditions which would allow such individuals to develop their full potential and live as ordinary a life as possible. Another major change has been the growing emphasis on a multi-disciplinary team approach, in which each specialist contributes his or her knowledge and skills towards providing comprehensive rehabilitation services. There has been a growing recognition among specialists that these individuals cannot be viewed as isolated entities, but need to be seen within their familial and societal contexts because of the reciprocal and interdependent relationships between such individuals and their families, and the influence that the family exerts on their overall rehabilitation. Since the family can play a vital role in supporting such members, its direct involvement in the rehabilitation process, as an active partner in the multi-disciplinary team, is increasingly considered necessary.

At the same time, it is being accepted that the presence of a disabled family member disrupts family equilibrium. The reactions of the family to this member are as crucial as the

actual impact of the presence of such a member on the family's daily life. Therefore, families need guidance, training and comprehensive counselling in order to meet their own needs, as well as to adjust to their member's condition, and to function effectively as a member of the rehabilitation team. Thus the disabled individual needs to be seen in his or her familial and societal context, and professional intervention needs to be focused not on him or her alone, but on his and her family also taken together as a unit.

Definition of key concepts

In the literature on the disabled, the terms 'impairment', 'disability' and 'handicap' are often used synonymously and interchangeably. They are not synonymous. Impairment refers to any loss or abnormality of psychological or anatomical structure or function (WHO, 1980). Disability refers to any restriction on, or lack of ability (resulting from impairment) to perform the activity within the manner or within the range considered normal for a human being (WHO, 1980). Disability, therefore, refers to any limitation experienced by the impaired person with reference to his physical function, whether locomotor or sensory, or affecting any specific organs. The effects of the disability generally extends beyond a particular pathological condition and embraces the psychological, educational and vocational aspects as well. The term handicap refers to a disadvantage for an individual with an impairment or disability, that limits or prevents the fulfilment of a role that is normal, depending upon sex, age and social or cultural factors (WHO, 1980). A disabled person feels handicapped or is made to feel handicapped. Thus, more than the disability, it is the psycho-social handicap that adversely affects the life of the disabled, as it has its root in the stigma attached to disability or impairment.

The primary goal of intervention programme is to prevent or reduce the occurrence of an impairment, prevent an impairment from developing into a disability, and prevent the deterioration of a disability into a handicap. Thus, rehabilitation refers to the restoration and development of disabled persons to their fullest physical, mental, social, vocational and economic potential and the prevention of their disability from turning into a lasting handicap, or at least reducing its handicapping effects to its minimum. Four categories of disabilities have been considered in this paper, namely, blindness, deafness, orthopaedic handicap and mental handicap. When a person has visual acuity of 20/200 or even less, he is considered legally blind (India: Ministry of Labour, 1978). If the visual acuity in the better

eye is 20/70 or less, he is considered to have impaired vision, and visual ability is substantially reduced. Visual impairment also includes loss of peripheral or central vision.

The deaf are those in whom the sense of hearing is non-functional for the ordinary purpose of life (Brill, 1974). These are people for whom the sense of hearing is so impaired as to have-precluded normal acquisition of language hearing. The hard of hearing are those, in whom, the sense of hearing, though defective, is functional with or without a hearing-aid.

The orthopaedically handicapped are those who have a physical defect or deformity which causes interference with the normal functioning of the bones, joints and muscles (India: Ministry of Labour, 1978). There are a variety of orthopaedic handicaps, such as those caused by congenital anomaly like club foot, absence of limbs, etc., impairments caused by diseases like poliomyelitis, bone tuberculosis, etc. and impairments from other causes like cerebral palsy, amputation, etc. A mentally handicapped person is one who has sub-average general intellectual potential and slow intellectual development, which may be the result of genetic factors, trauma, organ damage or social deprivation (Barker, 1987). The retardation may be of different degrees ranging from a mild form of mental retardation or dullness to severe retardation. This paper attempts to examine the type of research studies done in India on families having disabled individuals, indicate significant trends in this field, and point out gaps in research.*

For the review, only those studies have been selected which are wholly or partly concerned with some aspect of the effect on the family of the disability of a member, and/or the influencing factors within the society and the family, leading to problems in coping with such members and/or the family's coping strategies and/or the professional intervention for helping the family to cope. Although there are quite a few studies which have focused on surgical and technological research and innovations in the educational and vocational training of this special group, as well as on demographic or socio-economic, or personality characteristics of such individuals, they have been excluded from the review, unless these characteristics have been looked at by the researchers in their studies as precipitating factors within the family, or as influencing the family's coping strategies. By and large, master's level research has not been considered, but doctoral dissertations have been reviewed. The review has been limited to the more general aspects of the research studies and only main findings have been included.

The disabled, their needs and problems have drawn more attention from researchers in the present decade, as is evident from the fact that of the 36 studies reviewed for this

paper, as many as 25 of them have been undertaken in this decade. Of the four categories of the disabled, the mentally handicapped and their families have received the maximum attention, as 21 studies deal with some aspect relating to such individuals and their families. Only four studies could be found on the visually handicapped and their families and four on the orthopaedically handicapped and their families. In four more studies, the sample consisted of an equal number of individuals from the four categories. Only three studies could be located on the hearing handicapped and their families.

Nine studies have been conducted by multi-disciplinary teams and these were hospital or clinic based. One team was from the National Institute of Visual- Handicap. All the remaining studies have been conducted by researchers from single disciplines, foremost among them being psychologists, followed by psychiatrists. Other disciplines which are beginning to show interest in research in this' field are professional social workers, child development and home science specialists, occupational therapists and medical teams.

Overview of research findings

Research on families having disabled members has been reviewed with reference to the following aspects:*

1. The effect on the family of the presence of a disabled individual.
2. The influencing factors within the family.
3. The family's coping strategies.
4. Professional intervention for helping the family to cope.

It may be noted, that some studies have been cited in more than one area, depending upon the number of aspects examined by them.

Effect on the family of the presence of a disabled individual

No family is prepared for the presence of a disabled person. Therefore, the occurrence of a disabling condition in a family member shakes the family to its foundations. The perceived condition of the disabled person affects not only every member of the family, but the reactions of each of these will, in turn, have their effect on each of the others including the disabled person. It, thus, affects family inter-relationships and may call for an adjustment of certain family functions. It will affect the family's expectations from their disabled family

member. It will also affect the practical aspects of the family's daily life.

Seven studies have focused on the effect on the family of the presence of a disabled member. Of these, four are on families of mentally handicapped children (Gera, Wellington & Purohit, 1978, Seshadri, Verma, Verma & Per-shad, 1983), Behere & Sinha, 1985, and Rastogi, 1984); two on families of deaf children (Kashyap, 1983, 1986); one on families of adults suffering from head injury (Sabhesan, Arumugham, Andal & Natarajan, 1988); and one on families of different categories of disabled children (Gandotra, 1984). As the family is a system of inter-dependent relationships, it follows that the presence of a disabled person in it affects the relationship between all its members.

Gera et al (1978) studied the social interaction between 15 pairs of mother-mentally retarded child in a simulated game situation. It was observed that the mother's perception of dependency in the retarded child seemed to have a positive correlation with her verbal interaction with the child in a game situation. The mother's verbal interaction had a negative association with the child's verbal interaction. But her non-verbal interaction was positively associated with the child's non-verbal interaction.

One medium of interpersonal interaction is communication. Kashyap's study (1983) on 100 deaf children in the age-group of 5 to 14 years, studying in special schools in Bombay, has brought out the nature and extent of communication between mother-child, father-child and child-sibling dyads. It was found that there was a greater amount of communication between mother and child than between father and child. Of the three family members, the deaf child expressed himself to the greatest extent to the mother, next to the sibling and least to the father. On the whole, the overall extent of communication within the family was at a medium level. It was low while communicating in situations related to eliciting action from the child and in situations related to helping the child understand self. It was medium in situations related to information exchange, explaining cause and effect relationships and for eliciting emotional expression. There was also a high degree of reciprocity between mother-child and between father-child dyads. A high degree of such reciprocity coupled with just low or medium levels of communication from either person in the two dyads, led to a low level of responsive communication from the other. The conclusion arrived by the researcher was that the initiative in raising these levels must obviously rest with the parents.

Kashyap has also talked about the relationship between other family members. The mothers of 30 per cent of the children studied, expressed their concern over the fact that there

was a decrease in their interactions with their other children. Sibling relationship was also affected. The mothers of more than half the children in the study, reported that they had to cope with sibling rivalry between their deaf child and their other children. The study by Sabhe-san et al (1988) of seventy-five male agriculturists who had suffered head injury and who were followed up for one and a half years, has brought out that psychological sequelae, particularly cognitive disturbances and disturbed interpersonal relations, were some difficulties prevalent among the patients and they affected their occupational resettlement. The first two studies have depicted that there is a reciprocity in the level of interaction between members of the family and the disabled individual.

Seshadri et al. (1983) studied 30 families having a mentally retarded child, They observed that the children's degree of mental retardation had not affected the marital adjustment between the parents, as there was no significant marital disharmony in the sample. Kashyap (1986) has brought out similar findings in her study of 100 school going deaf children. In her study, too, a majority of the parents felt that the presence of the deaf child had not affected their marital relationship.-However, of significance, were seven mothers and four fathers who confided that they had come closer to their spouse in their common concern over the deaf child, and an equal number of parents stated that their marital relationship had deteriorated. It can, therefore, be surmised that, the presence of a disabled member will not create marital disharmony in a stable marriage, but it may precipitate conflict between marital partners when their personalities and interactions have already predisposed them to conflict.

Most families have some expectations from each of their members. The occurrence of disability in a family member, however, calls for considerable adjustment on the part of the family regarding its hopes and plans for that individual's future. Bchrc and Sinha (1985), who studied the expectations of 38 parents of mentally retarded children, have stated that a majority of the respondents were illiterate and had unrealistic expectations from their child as well as the clinic. Most of these unrealistic expectations were that, their mentally retarded child would be able to take education on par with other normal children, and be able to share the financial burden of the family. Parents also expected a miracle cure following the administration of 'brain tonic' demanded by them from the clinic.

There is a variation in parental expectations from their deaf children, according to

Kashyap's data (1986). While 39 per cent and 36 per cent of the mothers and the fathers, respectively, had positive expectations from their deaf child, the remaining parents had low, or unrealistic or no expectations at all. In this sample, the mother's expectations were significantly related to the child's age group, but not the father's. Moreover, the parent's age and educational level did not affect their expectations from the deaf child.

The presence of a disabled person can have an effect for better or for worse on some of the practical aspects of daily life, such as social life, leisure time activities, household responsibilities, work-life, etc. Gandotra's study (1984) has made an analysis of the problems faced by 25 home-makers having disabled children. The sample consisted of five families from each of the groups: orthopaedically handicapped, blind, deaf-mute, mentally retarded and cerebral palsy affected. Deaf-mute children were perceived as the least dependent on others for carrying out day to day activities and the cerebral palsy children, the most dependent. So according to this study, the nature and extent of the disability affected the problems faced by the family members. The main problems identified were in the areas of direct care, social contacts, inadequacy of day care facilities for the disabled family member, lack of funds, time and expense of treatment and physical health of the home-maker.

In Kashyap's study (1986), mothers of almost half the deaf children reported an increase in household responsibilities. A few complained of deterioration in their social life and leisure-time activities. Three mothers- stated that they had to give up their careers because of the deaf child. Half the mothers and a quarter of the fathers felt an adverse effect on their health. Rastogi's study (1984) of the personality patterns of parents of 50 mentally retarded children reports that, both the parents of mildly retarded children obtained high scores on scales of anxiety, phobia and depression. A higher degree of neurotic traits were found in the mothers of retarded children rather than in the fathers.

From the above review it is clear that only very little and very limited research has been done on disabled people and their families. Not all categories of the disabled have been included in the research either. Though there is some research on the inter-relationship patterns between disabled children and their families, specifically the parents, research is also needed to understand the inter-relationship patterns among

other members of the family, for example, between the disabled child and its siblings, as this will have implications for professional intervention. Moreover, the inter-relationships between a disabled adult or a disabled parent and his/ her spouse, children and other members of the extended family are still unexplored empirically, in spite of the growing number of adults disabled due to accidents, which create a family crisis, needing professional intervention. Also, many disabled persons are now marrying either similarly disabled partners or able bodied persons. Interpersonal relationships in both groups need research for more effective intervention.

The expectations of family members with reference to all the disabled groups need study. It would be of relevance to determine the nature of basic family functions which such families are able to perform, the degree to which they perform certain functions, and the factors influencing their performance, as it will have implications for professional intervention as well as for social policy. For example, the economic function is basic to all families. During his or her early years, a disabled child usually makes greater demands on the family's financial resources by way of medical care, prosthetic aids and appliances, special educational services, transport costs, etc. The ability to provide these facilities would depend upon the economic and employment status of its members, and the number of children it has. Not only does the disabled child increase demands on the family's financial resources, he may also decrease its productive power when members have to give up lucrative jobs or promotions to take care of the needs of the disabled person.

The effect, of the presence of a disabled individual on the practical aspects of daily life also needs deeper research for all the disabled groups. Such studies would indicate the type of support services needed by the family. It would also give some indication of the family's reactions to the disabled person and its capacity to cope with the situation.

Influencing factors within the family

A number of factors within the family influence its perception and coping strategies *vis-a-vis* the disabled individual. It is obvious that certain factors influence the type of problems faced by a family having a disabled person and the coping strategies used by it. These factors could be related to the family's characteristics, such as composition, mobility, socio-economic status, stage of the family life cycle, role expectations and role behaviour,

reactions to the disabled person, etc. Fourteen studies have dealt with the influencing factors within the family. Eight studies are on parents of mentally handicapped children, two are on parents of deaf children, one each on blind women and on families with adults recovering from head injury. In two more studies, the sample consists of groups of children having different types of disabilities. One major influencing factor is the attitude of the family towards the disabled individual. It is interesting to note that 12 out of the 14 studies in this area, have examined only this factor. Only two studies, Gandotra (1984) and Kashyap (1983), have discussed other influencing factors.

Parental attitudes towards mentally retarded children were reported as negative by Chaturvedi and Malhotra (1983), Rastogi (1981) and Prabhu (1968). Rastogi also observed that mothers had more negative attitudes than fathers. According to Jehan and Ansari (1981) and Desousa and Iyer (1968-69), a majority of the parents had a rejecting attitude, though a few parents did have an accepting attitude towards their mentally retarded child. In complete contradiction to these studies, Seshadri et al (1983) report that most mothers of the 30 mentally retarded children in their study, had favourable attitudes towards their mentally retarded child. It is of interest to note, that only Seshadri et al used the Parental Attitude Scale (Bhatti & Narayanan, 1980), for investigating this aspect, whereas, all the other researchers used either the interview schedule or a structured questionnaire. Seshadri's findings also showed that the higher the education, the more favourable the attitudes. Also, the child's degree of retardation was not correlated to parental attitudes. A study by Mudgil, Singh and Srivastaya (1982) of 100 mentally retarded children, from a child guidance clinic, has related child's behaviour to parental attitudes. The authors in this study have surmised that psychological symptoms, such as hyperactivity, bed-wetting, temper tantrums, aggressiveness and anti-social behaviour could be a reaction to the disease and are partly caused by parental attitudes of rejection and indifference.

Ishtiaq and Kamal (1981), in a comparative study of mentally retarded and blind, children, found that the former faced more negative attitudes from their families than the latter. This study used the case-history method to analyse the social climate of the respondents. In a study of attitudes of parents of deaf and hard of hearing children towards total rehabilitation of their children, Nigam and Kakar (1981) found that the parents were more interested in 'medical and surgical treatment' than in 'educational treatment', though most of them reported satisfaction about their overall treatment. Forty out of 45 blind

women employed in a sheltered workshop and contributing to the family income, when interviewed by Sethuram (1979), felt that their employment had not changed the negative attitude of their parents and relatives towards them. Sabhesan et al (1988) reported that, from among those male agriculturists who had recovered from head injury, those who were overprotected by the family took a longer time to go back to work and that, this protective attitude was often derived from certain culture-sanctioned concepts about the nature of head injury.

Gandotra's (1984) analysis of the managerial behaviour of 25 home-makers, who had a major role in the care of a disabled family member, indicated that the extent of the problem faced by homemakers in caring for their disabled child, was related to the economic status of the family, family structure, extent of help received by her from other members of the family and lack of awareness about facilities available in the city. Her follow up study showed that families could tackle the problem of rehabilitation of the disabled person better when they became aware of the available facilities.

Gandotra's study also considered the age of the disabled persons, and the nature and extent of the disability as other influencing factors. Thus, in her sample, the deaf-mute group had the lowest disability score and the cerebral palsy group the highest. In contrast to this data, a study by Channaba-savanna, Bhatti and Prabhu (1985), on attitudes of parents towards their mentally retarded children, showed that the degree of retardation did not affect the attitudes, and neither did the socio-demographic variables of these families. The authors have surmised that in their sample, the attitudes were dependent on the parents' level of knowledge of the handicap and, therefore, removal of misconceptions brought about a positive change in them.

In her study of deaf children, Kashyap (1983) observed that among 55 per cent of the families, both parents had poor knowledge of the disability, and only one mother had a good knowledge of the disability. The rest had only average knowledge. Of the parents who had poor knowledge, the majority did not see this lack of knowledge affecting their ability to cope with the disabled child. However, among those who had average knowledge, the majority felt that this lack of information adversely affected their coping ability. This implies that only when parents have some knowledge of the disability, do they realize that the lack of full knowledge, affects their communication and interaction with the disabled child.

Most of the studies reviewed have focused on the attitudes of parents and family as an

influencing factor and only two studies have indicated other influencing factors. More studies for all categories of the disabled and their families are required, which will comprehensively study this area, as only thorough knowledge of the factors influencing the family's coping strategies will enable professional intervention and service provision to be more need based and thus more effective. The family's perception of the availability of and extent of usefulness, of supportive and educational services also needs to be explored empirically.

Family's coping strategies

Disability in a family member is a major crisis in the family and all families go through a reactive period of mourning, but eventually most of them evolve strategies for coping with this situation. Knowledge of the family's manner of and the extent of ability to do so, will throw light on the type of professional intervention needed by it in this endeavour. In spite of the importance of this topic, there is an absolute paucity of research in this area, which is evidenced by the fact that only one research study has examined this topic.

Only Gandotra (1984) has studied the ways and means used by 25 home makers to cope with the problems arising from the presence of a disabled person in the family. Her case studies on these families show that, the high priority goals of the families studied were to make the disabled person self-reliant with respect to daily needs and to find employment for him. Towards this end, families secured the necessary aids for their disabled family members and made relevant changes in certain household facilities. A lot of time and expense was spent on their treatment and members of the family did overtime jobs in order to meet financial needs. Gandotra reports that in some families, home makers were relieved of some of their household chores, so that they could have more time to meet the needs of the disabled family member. Other family members also helped in the disabled child's care. Education and vocational training were provided by most families for their blind, deaf-mute and orthopaedically handicapped members, but only a few families did so for their mentally retarded and cerebral palsy members. They made efforts to help the disabled person to be self-employed or to get a job outside, though not all families succeeded in this endeavour. Finally, all families made efforts to provide for the future financial security of the disabled person.

The important area of coping strategies has been almost totally unexplored empirically. Research in this area is important, because it is necessary to know in some depth, the

family's actual coping strategies in dealing with the presence of a disabled member. Such data would help in arriving at a typology of families, based on the extent of their coping abilities. For example, there will be some families who will be able to cope with the situation with their own resources, while others will be able to cope only with the help of professional intervention and other available services. There will be still others who will not be able to cope with the situation at all and will require services on a more permanent basis. The characteristics, ability to cope and manner of coping of all three types of families will differ, and will have implications for the type of professional intervention and ^supportive services needed.

Professional intervention for helping families to cope

Many families seem willing to assume total responsibility for their disabled member, despite considerable financial, physical and emotional burdens. However, since most families need some guidance to assume such a role, it is desirable that they get to know about the rehabilitation facilities available. Comparatively speaking, the family experiences little difficulty in obtaining a diagnosis. The major problems encountered are in the area of availability of therapeutic services. Families need help in coping with a painful situation in a way most constructive to their disabled member as well as to the family as a unit. They need help in understanding their disabled member, guidance in the use of resources, encouragement for active participation in remedial programmes and support and acknowledgement for the care provided in the home.

From a review of research on professional interventions, one thing that stands out is that in this aspect too, the mentally handicapped group has received maximum attention from professionals. Of the seven studies reviewed, five are on mentally handicapped persons. Except for one study which assesses an intervention programme for mentally retarded children, all the other studies have assessed parent training programmes.

Mehta and Ochaney (1984), Singh and Kaushik (1982) and Kaushik (1984) have evaluated training programmes in which parents of mentally retarded children were trained in behaviour modification techniques. Kaushik (1984) felt that the critical factor in the programme was the method of training. Singh and Kaushik (1982) observed that the demonstration procedure was very important for teaching behavioural skills. Mehta and Ochaney were of the opinion that the involvement of one or both parents, as co-therapists, contributed to the success of the programme.

The parent-training programmes assessed by Embar (1979), Parikh (1981), and Siddique, Sultana and Ahmad (1984) for parents of mentally retarded children, had a more broad based approach. Though the techniques used in different programmes differed, as did the assessment tools, all the studies reported an improvement in social behaviour of the mentally retarded children and the parents' ability to cope with them as a result of the training. There was positive acceptance of the programmes from the parents. Siddique et al, found that the younger the child, the better were the effects of behavioural training given by the parents on the advice of professionals.

Deshmukh and Rawat (1977) had experimented with teaching simple passive exercises to rural illiterate mothers to work on at home with their polio affected children. They found that these mothers were able to follow the exercises so well, that they were able to prevent complications in their children, such as deformity or contractures. They concluded that rural people can be taught simple physiotherapy methods that achieve the same results at home as in a modern hospital. Mathur, Choksi and Singh (1986) have focused-on a community based rehabilitation programme for rural blind individuals and have surmised that community based programmes are definitely effective in terms of cost benefit and rehabilitation measures in the home environment.

The maximum attention of professionals has been on the mentally handicapped and their families. Here also, the emphasis has been on educational programmes for training parents in behaviour modification techniques. The outcome of different kinds of professional interventions with all the categories of the disabled and their families, such as individual, group and family counselling programmes, vocational rehabilitation programmes, community based rehabilitation programmes, programmes enhancing parent-child relationships, parent education and community education programmes, etc. need to be assessed in terms of their usefulness and effectiveness. A variety of research methods such as need survey, monitoring programmes, documentation of services provided, implementation, evaluation, process analysis of the delivery system, research on utilisation of services, cost benefit analysis, follow up research, etc, could be used, depending upon the type of intervention to be assessed.

Implications for social work practice, teaching and social policy

One of the basic needs of the disabled people and their families is to receive comprehensive, instructional and therapeutic counselling to enable them to meet their own needs and to achieve a wholesome adjustment to the disabling condition of their family member.

The social work professional trained in working with individuals and families, is well equipped to provide family counselling services to families having disabled individuals. Family centred programmes are viable means of reaching the disabled person, because, though the primary thrust of therapeutic attention is directed towards the family, its ultimate goal is to reach the disabled individual through the family. As the approach of most of the other specialities in the field is client or patient centred, the social work professional can be a vital link between different professionals and the family and the disabled individual on the one hand, and between the family and its disabled member on the other. In addition, professional social workers also have the necessary skills to participate actively at the community level in developing local services, advocating on behalf of the rights of the disabled and working to prevent the occurrence of the chronic problems through programmes of community education. The social worker's role as a team member, is gradually being recognized as a significant one in the rehabilitation process by social workers themselves, as well as by the other members of the rehabilitation team.

From the review of research on the effects on the family of the presence of a disabled person, it is quite clear that the presence of a disabled person affects family relationships. The entire inter-relationship pattern in the family needs to be strengthened, specially parent-child, sibling and marital interrelationships. It is seen from the studies that family expectations, specially parental expectations, are mostly negative or unrealistic, except in a few rare cases. Therefore, many parents will need guidance in setting up realistic expectations about their child's performance and accomplishment. They often need encouragement to believe in the possible achievements of their handicapped child. They need guidance in understanding the limitations imposed by the child's handicap on certain aspects or the child's development, as well as his or her capacities for full growth in most areas. Therefore, a major task of the social worker would be to help parents resolve feelings about their child's handicap, in terms of its effect on the practical aspects of daily life and parental expectations.

The fact that the practical aspects of daily life are negatively affected, has implications for social policy in terms of the need to provide support systems such as day care services,

respite care, etc. This could also suggest the need for a scheme to give aid to families having severely disabled individuals. Counselling services would also be required to look after the mental health of the caregivers.

The review on precipitating factors within the system, has pointed to the adverse attitudes of society towards the disabled. This has implications for social policy in terms of the use of mass media for community education. For social workers, it shows the need for organising community education programmes for specific groups of people in whom attitudinal changes are sought.

The findings have pointed out that families do not have much knowledge of the disability of their family member and its consequences on his or her development and prospects. This shows the need for family education programmes, to give the whole family a better understanding of the ramifications of the disability. This will, in turn, inculcate more positive attitudes. As the essence of professional social work is to help families to help themselves, the study on the family's coping strategies has clearly pointed to the type of help that families require, both from the support services and from the professionals. This should give clear indications for social work intervention.

The review of research on professional intervention for helping families to cope had some interesting findings, which have implications for social work intervention. Firstly, it has shown that parents are ready to accept professional intervention. Secondly, the fact that programmes directly involving parents were more effective than those where parents were mere passive receivers, shows the need for professional intervention to be experiential. One study has also brought out the need for treating parents as active partners in the rehabilitation process and not just as care-takers or go-betweens. Thirdly, parent education/training programmes helped parents to cope better with their child, but did not change attitudes. Social work professionals need to keep all these points in mind while designing intervention strategies.

One of the main reasons why fewer professional social workers have ventured into this field, as compared to other fields, such as child or women welfare is that, social work practice with this special group has not received adequate back-up from professional social work training programmes. According to the University Grants Commission's Curriculum Development Centre for Social Work Education at the Tata Institute of Social Sciences, there are barely two schools of social work in India, which offer practice-based courses on social work intervention with the disabled and their families. Social workers desiring to work with the specific problems experienced by disabled children, adults and

their families, would require, in addition to generic social work knowledge and skills, some specialised knowledge and skills, which would equip them to provide appropriate and useful information, counselling and support to this special group.

The social work tasks that have been drawn up based on the review of research in this area, have provided clues regarding training that will be required to prepare social workers for working with the disabled and their families. Broadly speaking, the training inputs will have to be in the areas of knowledge, attitudes and skills. Knowledge covers the needs and problems of families having disabled individuals, factors influencing their coping strategies and information on available resources. Skill training will be required for selection and use of appropriate intervention strategies. Attitudes essential for being sensitive, emphatic and positive towards families of the disabled and for effective social work intervention, will need to be inculcated first in social workers themselves, before these professionals can attempt to change family and societal attitudes towards this special group of people.

Since independence, there has been a marked development in the national concern for the disabled in India. However, the trend in the planning and administration of services for the disabled, is more towards a centralised approach to the problem. At present, different types of national schemes, programmes and concessions have been formulated for education, training and employment of the disabled. Four national institutes for each of the four categories of disabled have been established, to serve as apex bodies to develop manpower and suitable service models, and to serve as premier information and documentation centres. Serious attempts to formulate a national policy for the disabled during the International Year of the Disabled in 1981, failed to produce anything tangible. Also, though some of the national schemes and programmes for disabled persons indirectly benefit their families, there are no family-based schemes or programmes in spite of the pressing need for such services as studies in this area have shown. The purpose of this review has been primarily to summarise the findings of available Indian research studies on families having disabled individuals. What has emerged is a clear picture of the areas studied and the gaps in research in this field.

From among the four categories of the disabled, the mentally handicapped and their families have received maximum attention from researchers. The effects on the family of the presence of a disabled family member, have been studied with reference to inter-relationships between different members of the family, the expectations of parents from their disabled children, and the effects on practical aspects of daily life. Areas that have remained unexplored are sibling relationships and those between the

disabled adult and his/ her spouse, children and other members of the extended family. The effect on family functions also need to be examined empirically. The attitudes of society, as well as the family have been researched to some extent, but not other influencing factors. The family's coping strategies is one area which, though very important, has been almost left unexplored. Research on professional intervention on helping families to cope, has been very limited, considering the variety of interventions made by professionals from different disciplines. Finally, the review has given good indication for the direction that social work practice and teaching should take. The implications drawn for social policy and intervention need further prompting and action on the part of all the professionals involved in the rehabilitation of the disabled and their families.

CHAPTER ONE C: *The Association Between Mental Retardation and Psychiatric Disorder: Epidemiological Issues*

It is well known that mentally retarded individuals are at risk for the development of a wide variety of emotional and behavioral disorders (Matson & Barrett, 1982; Sigman, 1985; Szymanski & Tanguay, 1980). The magnitude and importance of this problem have been emphasized by two relatively recent trends. The first has been the deinstitutionalization and "mainstreaming" of retarded persons. The second has been the development of separate service delivery systems for the developmentally disabled and mentally ill. These two trends in health care have contributed to the growing realization that a significant proportion of developmentally disabled individuals have coexisting psychiatric disorders. Besides "falling between the cracks" of the separate health care systems, these individuals have exposed the fact that many professionals in both systems have serious gaps in their training and skills (Cushna, Szymanski, & Tanguay, 1980). In the last two decades, it has also become clear that carefully designed epidemiological research addressing this strong association between mental illness and mental retardation has been limited in quality and that many studies have been plagued with major methodological problems.

One such problem is how to define mental retardation. The criteria used to make the diagnosis of mental retardation can produce dramatic differences in the measured prevalence (Mercer, 1973; Tarjan, Wright, Eyman, & Keeran, 1973). For example, it is critical whether mental retardation is defined in purely psychometric terms or includes a dimension of adaptive behavior. Rutter (1970) has gently argued that using adaptive behavior criteria to select a retarded population will produce spuriously high rates for behavioral and psychiatric disorder. Other important variables

related to the measured prevalence of mental retardation are age, socioeconomic status, degree of handicap, and the mutability of tested intelligence (Russell, 1985). Much epidemiological research has failed to account properly for these variables.

A second major issue is the tremendous heterogeneity of the retarded population. Many studies have simply lumped together all individuals with an IQ less than 70 as their research population. The fact that two individuals (one mildly retarded and one severely retarded) are dramatically different in almost every dimension is often not appropriately dealt with in research designs. A third problem has been that most research has dealt with institutionalized or referred subjects, samples that are hardly representative of the general population of retarded individuals. This is particularly true of research examining psychiatric disorders.

Finally, and perhaps most important of all, is the issue of psychiatric diagnosis itself. Diagnostic criteria, of known or unknown reliability, have varied dramatically from study to study. This is over and above the issue of whether standardized assessment was part of the research design and the very real clinical and research problems of identifying symptoms and disorders within this population. Keeping these four major problem areas in mind (and the fact that there are many others), we examine three basic epidemiological questions, summarize what we do know about the answers to each question, and relate the above problems to what differing results have been obtained. Finally, some recommendations for future epidemiological research are presented.

The three basic epidemiological questions to be considered are deceptively simple.

1. What is the prevalence of psychiatric disorder in mentally handicapped individuals?
2. Are specific *types* of psychiatric disorders associated with mental retardation?
3. What are some of the mechanisms that may underlie the association between retardation and psychiatric disorders?

This selective review focuses on studies involving children and adolescents and refers frequently to a series of studies conducted by Rutter and his colleagues OR the Isle of Wight in England (Rutter, Graham, & Yule, 1970; Rutter, Tizard, & Whitmore, 1970; Rutter, Tizard, Yule, Graham, & Whitmore, 1976).

The Isle of Wight study, although conducted more than 20 years ago, deserves a brief description. It probably remains our single best source of information on the association between mental illness and mental retardation in childhood and attempts to address and actually study some of the methodological problems referred to previously. The Isle of Wight study avoided some of the problems of sampling bias by studying an entire age cohort—that of 9,

10, and 11 year olds. The age cohort design allowed comparisons between retarded children and the nonhandicapped peers. The study of psychiatric disorder was a two-stage design, employing in the first stage screening questionnaires when obtaining psychiatric symptom ratings from both teachers and parents. In the second stage, an intensive psychiatric assessment was conducted with direct interviews and the collection of other measures. All assessment techniques were studied for reliability and validity. A comprehensive range of assessments were obtained from a variety of sources including both parents and teachers. The wide range of assessments allowed examination of important associated factors such as neurological and educational handicaps. In regard to cognitive functioning, children were classified on the basis of measured IQ. Thus, the results from the Isle of Wight should not automatically be interpreted as applying to individuals class-

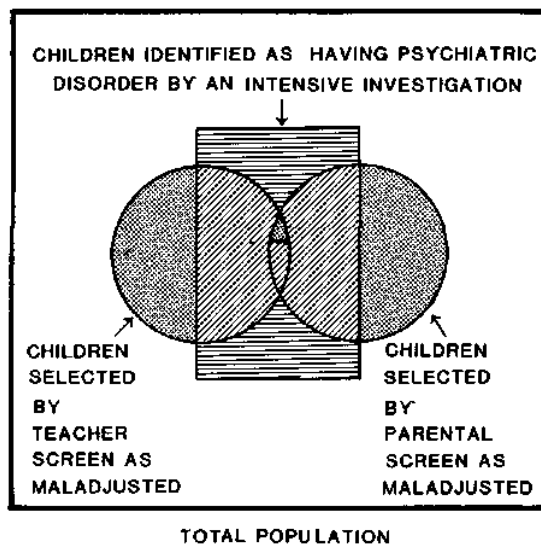


FIGURE 3.1. Representation of the relationship of the teacher screen, parental screen, and intensive investigation in the multistage-multimethod procedure used by Rutter and his colleagues. The importance of an epidemiological design using more than one stage and more than one source of information is shown in Figure 3.1. The figure illustrates in graphic form the estimated prevalence of psychiatric disorder among all children in the Isle of Wight study and from a subsequent study in London using a similar methodology. The parental screening questionnaire and the teacher screening questionnaire identified approximately equal numbers of children but they were not the same children! In addition, only about half the children identified by screening were later confirmed by intensive investigation to exhibit a psychiatric disorder. Finally, the screening procedures missed a significant number of children who on direct

examination were found to have psychiatric disorder (false negative). These are all important findings that must be kept in mind when evaluating the methodologies of studies reporting prevalence figures for psychiatric disorders among persons with mental retardation.

The prevalence of psychiatric disorders in the total population of 9, 10, and 11 year olds on the Isle of Wight was found to be about 1%. In contrast, the rate of psychiatric disorders in children with IQs less than 70 was 30% based on parental report and 42% based on teacher report with similar rates on direct interviews (Rutter, 1970; Rutter, et al., 1970). Thus, psychiatric disorder was found to be over four times more frequent in intellectually retarded children than in children with normal intelligence. Recently, the Isle of Wight results have been more or less confirmed by a longitudinal birth cohort study by Koller, Richardson, and colleagues, which has followed a sample of all retarded individuals born during a five-year period in a British city (Koller, Richardson, Katz, & McLaren, 1982). Overall rates of behavioral disturbance, were 2,5 times greater than a matched control group and severe behavior problems were seven times more frequent. Other studies, generally based on selected or referred samples, including work by Phillips and Williams (1975), Chess (1970), Jacobson (1982), Szymanski (1980), and others, have reported rates of psychiatric disorder varying from 10 to 80%. Rates for adult populations may be comparable or somewhat higher than for children (Reiss, 1985; Lund, 1985). In short, depending on issues of sample selection and definitions of disorder, a population of mentally retarded individuals may exhibit rates of behavioral and emotional disorders averaging between 20 and 40%—all significantly higher than a comparable population of individuals of normal intellect.

A related question is the relationship between differing levels of IQ and psychiatric disorder. An interesting finding from the Isle of Wight studies was that the association between behavioral disturbance (almost all types) and intellectual functioning held for higher as well as lower levels of IQ. For example, Table 3.1 summarizes teacher ratings for the items "miserable," fighting, and poor concentration for boys at five different IQ levels (from Rutter, 1970; Russell, 1985). It can be seen that the frequency of behavioral deviance is inversely related to IQ and this relationship holds at all IQ levels in an almost linear fashion. Studies that have examined similar symptoms at different levels within the retarded range have reached generally similar conclusions (Jacobson, 1982). As IQ level drops, the level of severity of most types of behavioral disturbance increases. However, the pattern of actual symptoms may vary considerably. For example, stereotypes and self-injurious behavior are more common in severely retarded than mildly retarded individuals (Corbett 1977; Jacobson 1982).

Another important consideration in reviewing research in this area is, once again, the heterogeneity of the retarded population. There is considerable evidence that more severely

handicapped individuals (IQs less than 50) may exhibit somewhat different types of psychiatric disorder than individuals in the mild range of mental retardation. Corbett reported findings from a large epidemiological study based on 175,000 residents of the Camberwell district of London (Corbett, Harris, & Robinson, 1975; Corbett, 1977). This study only looked at individuals with IQs less than 50 and used a methodology similar to the Isle of Wight.

In their sample, psychosis (including autism) was diagnosed in 17% of the children, hyperkinetic disorders in 4%, and severe stereotypes in 10%. Only 4% of the sample were diagnosed as having a neurotic disorder and only 4% as having a conduct disorder. This pattern of disorder is considerably different from that found in most studies of children predominantly in the mildly retarded range and in the general population. Of particular note are the high prevalence rates of childhood psychosis, hyperkinetic disorders (as diagnosed in Great Britain), and severe stereotypes in the severely retarded children.

Having established that psychiatric disorder is more common in mentally retarded children and adolescents and that a wide variety of nonspecific disorders is seen in this population (with the exception of the more severely retarded), the third and final basic question is what mechanisms underlie the strong association? The answer to this question is complex and at best the evidence is incomplete. As may be expected from the fact that such a broad spectrum of psychiatric disorders is seen in the retarded and that the retarded themselves are such a heterogeneous group, it is clear that there are multiple factors involved. Figure 3.2 addresses this issue by summarizing some of the epidemiological data relating to psychiatric disorder in children and adolescents. As described previously, the rate of psychiatric disorder in a mentally retarded population may be four to five times greater than in the general population (Rutter, 1970). Another finding from the Isle of Wight is that children with a chronic physical disorder (e.g., asthma) may be twice as likely to develop behavioral and

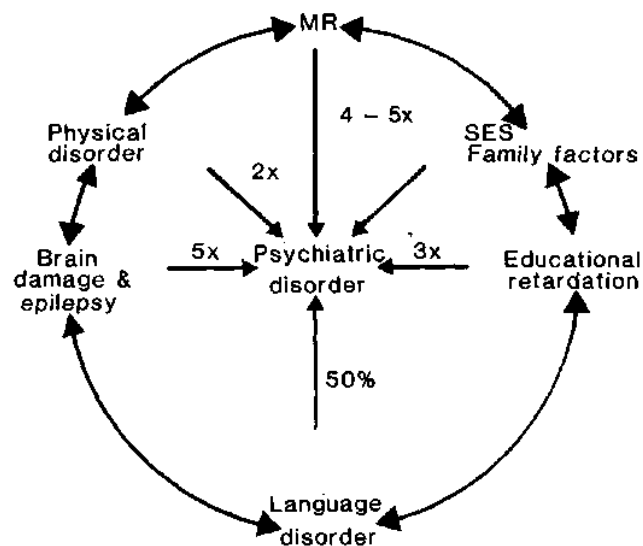


FIGURE 3.2. Summary of epidemiological data on psychiatric disorders in children and adolescents. From "The Mentally Retarded, Emotionally Disturbed Child and Adolescent" by A.T. Russell, 1985. In M. Sigman (Ed.), *Children with Emotional Disorders and Developmental Disabilities: Assessment and Treatment*, p. 130. Orlando, FL: Grune & Stratton. Adapted by permission.

emotional disorder; and, if the central nervous system is involved (e.g., epilepsy), the rate more than doubles (Rutter, Graham, & Yule, 1970). Cantwell and Baker (1980) have found that in an unselected population of children with language disorder half meet DSM-III criteria for a psychiatric disorder. The Isle of Wight and a similar study of London children found that reading retardation (over two years behind on standardized tests, adjusted for IQ) was associated with increased rates of psychiatric disorder, particularly of the conduct type (Rutter et al, 1976). It is well known that socioeconomic and family factors are strongly associated with psychiatric disorders although it is difficult to assign numerical risks to these factors.

Looking at these associations from the other direction, and particularly from the viewpoint of mental retardation, only confirms the importance of all these factors. It is not uncommon that retarded children have other disorders of the central nervous system. Many have language handicaps or learning disabilities beyond their cognitive limitations and are likely to come from lower socio-economic backgrounds. It is likely that any combination of these factors in a single child greatly increases the risk of development or associated psychiatric disorders.

One implication of these findings is that future epidemiological research, if it is to be helpful in elucidating these (and other) mechanisms, must include measures and methodologies that will allow them to be assessed. For example, an epidemiological study of psychiatric disorder in the retarded could include an independent assessment of language disorder in order to understand this association better.

What lessons can be learned from this brief review in regard to future epidemiological and clinical research? Several issues stand out.

1. Of critical importance is the use of well-defined diagnostic criteria with appropriate measurement of diagnostic reliability. DSM-III with its multi-axial structure is a logical choice and can be applied successfully to the majority of retarded persons. A multi-axial system is probably best able to capture the complexity of these cases. If modification of criteria is required, it should be held to a minimum, be straightforward, and be described

clearly. If new and unfamiliar criteria are developed, comparability with other studies of psy- chopathology will be almost impossible,

2. Hand in hand with the first recommendation is the need to use some of the standardized diagnostic tools (again modified only with great caution) now being used in modern epidemiological research with nonretarded subjects. These include structured or semistructured diagnostic interviews and rating scales. For example, the Beck Depression Inventory has been used success fully in a mildly retarded adolescent population (Beck, Carlson, Russell, & Brownfield, 1987) and in an adult population (Kazdin, Matson, & Senatore, 1983) with considerable success. The use of structured interviews and other similar tools with the retarded need to be evaluated as soon as possible. Exam ples of recent efforts in this direction are the PIMRA interview (Matson, Kaz din, & Senatore, 1984) and the Aberrant Behavior Checklist (Aman, Singh, Stewart, & Field, 1985).
3. The time has come to move away from just the measurement of behavior problems and toward the ascertainment of the presence or absence of specific psychiatric disorders. Every effort should be made in future research to use methodologies that lead to specific psychiatric diagnoses. It is one thing to describe a subject as sad and withdrawn and another to obtain enough reliable data to make a diagnosis of major affective disorder according to specific diag nostic criteria. It is only with this approach that we will be able to investigate specific treatment interventions for specific disorders.
4. We need to use great care not to confound problems in adaptive behavior with psychiatric disturbance and vice versa. How we do this will affect the selec tion and diagnosis of a retarded sample.
5. Sample sizes must be large enough to analyze separately data depending on the level of retardation. The developmentally disabled are different in more ways than they are alike, and these differences must be accounted for in any research design.

It is of course not enough, even with improved research designs, simply to add to the quantitative statistics concerning the association of mental retardation and psychiatric disorders. Multidimensional studies are needed to examine such variables as institutional versus home care, risk and protective factors, family factors, and treatment interventions. With an increased knowledge base from such research efforts, we may be better able to meet the complex needs of the under-served population of persons with both developmental disabilities and psychiatric disorders.

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CHAPTER TWO

RESEARCH METHODOLOGY

2.0 Introduction

Knowledge that comes out from application of scientific methods is often general in nature. When such knowledge is tested or verified again and again this leads to formation of theories. A systematic presentation of theories of any particular subject is called discipline.

In this way application of scientific research leads to knowledge of systematic body of knowledge consisting of concepts, theories and principles leads to development of different disciplines.

In short the search for knowledge through objective and systematic method of finding solution to a problem is research.

2.1 Definition

In this regards, some of the important definitions are as follows:

“Scientific Research consists of obtaining information through empirical observation that can be used for the systematic development of logical related proposition attempting to establish casual relations among variables.”- Black and Champion

“Research is considered to be the systematic and intensive process of carrying out scientific method of analysis. It involves a more systematic structure of investigation resulting in some sort of formal conclusion.” John Best

2.2 General Characteristics of Research

Research is a systematic process

It is an application of scientific method

It is directed towards finding solution of some of the problems

It adds to existing knowledge

It involves scientific thinking

2.3 Social Science Research

Social Science Research is systematic method of exploring, analyzing and conceptualizing sociological phenomenon. Especially, it explains the human life in order to extend, correct or verify knowledge of human behaviour and social life.

2.4 Important three steps in Social Science Research

Formulation of hypothesis based on past studies

Objective of the study derived from hypothesis

Methodology of the study which mainly consists of target area, target population, sampling design, criteria of selection of sample, criteria of selection of target population, tools of data collection, method of data collection, analysis and interpretation of data, conclusion and generalization, aims and objectives of the study. On this background, the purpose for selection of the topic was as follows:

In the initial stage, when the researcher selected the research topic related to the holistic understanding of mentally retarded children, the researcher began with the following aims and objectives in order to carry out the research study.

1. To study socio-economic condition of the families of mentally retarded children and to prepare a Socio-economic profile of the study population.
2. To explore the factors associated with the child delivery and its relation with Mental Retardation.
3. To find out the health, living conditions and behavioural problems of mentally retarded children in their families and communities.
4. To collect the detail regarding mentally retarded child, his/her daily activity, health problem, psychological status, future and family efforts to cope up with the situation.
5. To excavate the attitude of family members, community people towards Mentally Retarded Children in their surrounding.
6. To draw the conclusion and to give appropriate recommendation to the concerned body on the issue.

2.5 Inspiration for the Research Topic

Social Problems are embedded in the structure and culture of society. Being a Social Worker, one should be able to identify the social problems, which are embedded and also should be able to develop the appropriate methodology, tools to explore the problem more, so that the problem can get opportunity to be discussed and to be considered a problem. Accordingly, the measures to intervene the problems are undertaken. The issue of mental retardation is also considered as a taboo in Indian Society. Though, people are able to reach the moon and also are busy with studying about the life in other planets, they are not considering the large section of society, which is needed to be studied, the mentally retarded people. So, to explore the holistic areas regarding mental retardation including their history to future, this research was conducted.

As regard to the mental retardation, parents are not aware about the potentials with mentally retarded child. They are either over protected by sympathetically or they are neglected with apathetically. Both are the extremes that are creating problems more seriously in the society. In urban areas, there are at least some facilities available. But in rural areas, these facilities are grossly lacking. As a result, this problem remains unsolved in all corners of the nation. Therefore it felt necessary to analyze the present situation and the conditions of mentally retarded children, this study was undertaken.

2.6 Pilot Work

One can observe the situation of mentally retarded population in rural areas. The grave poverty, absence of facilities, ignorance of parents, neglected attitude of the society, these are the variables that are operating directly or indirectly on the mentally retarded problem. Considering the situation and the personal experience working with the families having mentally retarded child, some basic information was collected and accordingly the questionnaire was prepared. For this study, interview with help of schedule was not possible because most of the parents were illiterate and they may not be able to give the real information about the present situation. Hence, the draft questionnaire was prepared and it was tested in Nilanga Block. About 20 interviews were conducted on pilot basis.

Based on the feedback received from the parents, appropriate corrections were made in sequencing the questions, wording of the questions, diluting the language of questions and where it was felt that the open end question are not providing adequate information, these questions were given various alternatives. As regard to the responses, almost all possible answers were considered and based on these considerations, the questionnaire was finalized.

2.7 Area of the Study

a) Universe

Universe covers the whole defined area/fields on which study is based and it is the whole population out of which sample is selected. Accordingly, all the mentally retarded population of the Latur district is the universe of this study.

b) Study Area

As the study area is mainly concerned with disability, which exists in all the population. However, it was decided to take three blocks for study purpose. The main intention of selecting these three blocks, i.e. Latur, Ahmedpur and Nilanga is that in these blocks, no facility is available for either treatment or training. The public health facilities are also not very effective. As this area belongs from Marathwada Region, high illiteracy among the women, poor socio-economic conditions, lack of infrastructure, high level of BPL family are very prominent. One of the most important characteristics of the study area is there is a high level of impact of traditions and culture. For medical treatment, the people prefer to attend Sadhu, Bhagat, or village level Healer. Naturally, the problems become more severe, if they do not take appropriate treatment in time.

One of the most important aspects of social life is that for mental retardation, peoples are under impression that it is coerce of god or it is caused due to evil eye or it is the outcome of black magic. These cultural beliefs are creating the problems among the parents. Naturally the child is prevented from scientific treatment. In all these three blocks, the cases of mental retardation recorded at PHC level were selected. While selecting the villages, following criteria was used.

- i) The Village should not be far away from the PHC Centre.
- ii) Parents should be ready to provide the information.
- iii) Approachable by public transport
- iv) General cooperation from villagers or school teachers.

2.9 Research Design

Research Design is a plan of work prepared systematically, which provides direction for the research time to time. Three blocks and about 3 to 4 villages from each block were selected. However, the details are discussed in sampling design.

2.10 Sampling Design

Sampling may be defined as selection of some part of an aggregate or totality on the basis with judgment by adopting scientific method of selection. In this study, simple random sample method was used. The mentally retarded cases registered at PHC level were collected and from these cases, about 30-35 cases were selected by using lottery method from each block which may have spread over into 3-4 villages. However, for the convenience of the study, it was considered one block

2.11 Sample Size

Based on the records of the Primary Health Care Centre, the study population was selected as follows. Total of 101 cases were selected on random basis as follows:

At Ahmedpur recorded cases were 60 and selected cases 29.

At Latur, recorded cases were 95 and selected cases 37.

At Nilanga, recorded cases were 75 and selected cases 35.

2.12 Sources of Data

Two types of data were needed for this study. However, the secondary data was collected from PHC Centre and from the Zilla Parishad, Health Department, about total number of the cases. The details about each one of the case was collected from Primary Health Care Centre. And the primary data was collected from the respondents. As the primary source of data is the original source, from which researcher directly collects the data from the

close relative/parent or study person. Naturally it provides the first hand information in first attempt. Thus the primary data was collected from the parents of mentally retarded child.

2.13 Methods of Data Collection

The survey of all families was the primary task in selecting the respondents. After final selection as discussed in earlier part, interviews were conducted at the places as per their convenience. The researcher had visited their families, discussed with their parents, observed the situation, checked the records and interviews were held with the help of structured questionnaire.

2.14 Tools of Data Collection

Though there are several tools for survey method, all tools are not applicable to a certain conditions. Considering the nature of problem, it was very difficult to collect the data with the help of questionnaire only, because most of the parents were illiterate and were not able to provide the information as expected by the researcher. Considering this situation, interviews were conducted with the help of structured questionnaire, which was held to get systematic data from the parents and to probe the certain question as and when it was felt necessary. Data was collected by the researcher himself.

2.15 Data Analysis

After collecting data, extensive editing was undertaken. After clarifying the doubts, it was felt necessary to make second visit to the concerned respondents. Visit was made and necessary corrections were made in questionnaire. Soon after completing editing, coding was undertaken. Scientific method was used for coding and data was analyzed by using SPSS Software. Simple tables were prepared and graphs were designed and placed at appropriate places in respective chapters.

2.16 Presentation of the study

The entire study is presented in nine chapters as follows:

Chapter One Provides theoretical base, various theories, nature of the problem, extend of the problem, the efforts made by the government, the situation in the field, association of various variables, classification, various prevalent deficiencies, welfare services, integration of mental retardation with normal schools, various problems etc.

Chapter Two describes the research methodology. This includes, sampling design, tools of data collection, method of data collection, universe of study etc.

Chapter Three deals with socio-economic profile of study population, which includes Introduction, Age of Caretaker, Sex of Caretaker, Education, Occupational Pattern, Secondary Occupation, Income, Voter's List, Citizenship And Migration, Sex Distribution of Family Members, Age Distribution, Education, Occupation, Income, Types of Family, Addiction of Family Members, Type of Addiction and Use of Salt In Regular Diet

Chapter Four deals with Factors associated with delivery and its relation with mental retardation is discussed in detail. This includes Age of Mother At Marriage, Father's Age At Marriage, Illness During Pregnancy, Still Birth, History of Mental Retardation, Consanguineous Marriage, Relation Before Marriage, Abortion, X-Ray Exposure, Addiction of Mother and Expenditure On Mentally Retarded Children.

In Chapter Five, Health, Living Conditions and Behavioural problems of mentally retarded children is discussed. The various dimensions includes Condition during Delivery, Age of Mother at Delivery, Place of Delivery, Attendant of the Delivery, Advice from Medical Doctor, Vitamin Supplementation During Pregnancy, Birth Weight of Baby, Completion of All Trimester, Active Movement Soon After Birth, First Feeding After Birth, Duration of Breast Feeding, Information About MMR, General Immunization and Family Planning.

In Chapter Six, the daily activities, health problems, psychological status and family efforts to deal with mental retardation is discussed at a length. Various dimensions in this

regards are Age of Mentally Retarded Child, Sex of Mentally Retarded Child, Ordinal Position of Mentally Retarded Child, Diagnosis of Mental Retardation, Symptoms At the Time of Diagnosis, etc. have been discussed in this chapter.

Attitude of family members, community and lay men towards the mentally retarded child is explained in Chapter Seven. The various dimensions of this chapter are Attitude of the Community towards Family, Nature of Interaction with Neighbours, Reaction of Mentally Retarded Child to Negative Attitude of Neighbours, Perception about Responsibility of Mental Retardation in Child, Change in Behaviour of Parents Due to Mentally Retarded Child and Future of Mentally Retarded Child etc. have been discussed in this chapter.

In the Chapter Eight, perception of the parents about future of mentally retarded child is discussed, which includes Provision for Future, Parents' Effort for Education of Mentally Retarded Child, Information about the Schools of Mental Retardation, Efforts Made to Get Admission in School for Mentally Retarded Child, The Psychological Condition during Absence of Parents, Caretaker During Absent of Parents, Perception of Parents about the Safety of Child and Perception of Parents about Self-Reliance in Future.

In Ninth Chapter, Summary, Conclusion and Recommendations of the study are given.

In appendices, the questionnaire, map of the study area and Bibliography is given.

CHAPTER THREE

SOCIO-ECONOMIC PROFILE OF STUDY POPULATION

3.0 Introduction

Mental Retardation is complex social problem. There are various social factors operating on the mental retardation. Mental Retardation and Mental illness in the same individual presents unique challenge to mental health professionals both in terms of diagnosis and treatment. The mentally retarded comprises a complex group of persons whose needs are often poorly identified and who are often referred from agency to agency in the fruitless efforts to obtain help. These challenges are more severe which focussed on integrating mentally retarded children and adults into the mainstreams of the family and community life. As the more complex individuals with mental retardation are served in the community based programmes, mental health professionals have increasingly being confronted with the challenge of meeting their needs within the confluences of family and community life. Therefore, the main focus for dealing with the mental retardation is early diagnosis and sustainability in treatment of this population.

The diagnostic challenges are immense because of patient often cannot verbally express himself/herself and at the times the behavioural symptomatology is applied, it gets threats from the several angles. The treatment challenges are also plenty because of number of intrinsic and extrinsic factors such as nature and degree of mental retardation itself and society's response to person consider being a deviant. On this background, Diagnosis is important but treatment is more important. For the treatment, availability of the facilities, accessibility of the facilities and affordability of the individuals plays vital role in accepting, and sustaining the treatment. Thus, one finds that there is a synergistic interaction of various socio-economic, cultural and environmental factors. Individual's perception about mental retardation also plays a pivotal role in treatment and diagnosis of mental retardation. In this view, the age of the caretaker plays very vital role in caring the mentally retarded child.

The person who is going to take care of mentally retarded child should be mature enough, and one finds that the females are the main caretakers of the mentally retarded child. Considering the rural setting and educational level, most of the women are illiterate or their educational level is comparatively very low. This aspect is bound to happen when caring the child. The income and occupation are some other factors which have direct bearing on the affordability of the individuals. The persons, those who are economically poor are always moving from one place to another for want of employment. Due to rapid urbanization, the employment opportunities are more available in cities, or in urban areas rather than rural areas. Naturally, the traditional family system is converted into nuclear family system, where caring of mentally retarded child is more serious.

Family composition, family culture, their caste and social status, these aspects are also very vital in dealing with mentally retarded child. Details about the various factors that are operating on mental retardation are discussed in detail in following paragraphs:

3.1 Age of Caretaker:

Caring of mentally retarded child is highly skilled job that needs maturity and understanding of behaviour of child. Almost all mentally retarded children are facing several problems in their daily activities. Most of the children are not able to do their body services. Usually, parents are taking care of mentally retarded children. However, if it is not possible to the parents, their close relatives will take care of that child. Tolerance and patience, these are the two essential qualities needed for the caretaker. Therefore the caretaker must have adequate tolerance level to shoulder the responsibilities of mentally retarded children. Behavioural problems have multiplexer's dimensions. Though they observed to be normal, sometimes, their problems are quiet unusual. Physically they grow but mentally, they lag behind. Naturally, the behaviour of 16 years boy is just like behaviour of 5-6 years child.

Thus, to mould the behaviour and develop good habits in mentally retarded child, it is very essential to have proper and adequate understanding of human behaviour. It is assumed that, as age increases, the understanding and maturity also goes on increasing. Naturally, there is a close relationship between the age of caretaker with handling

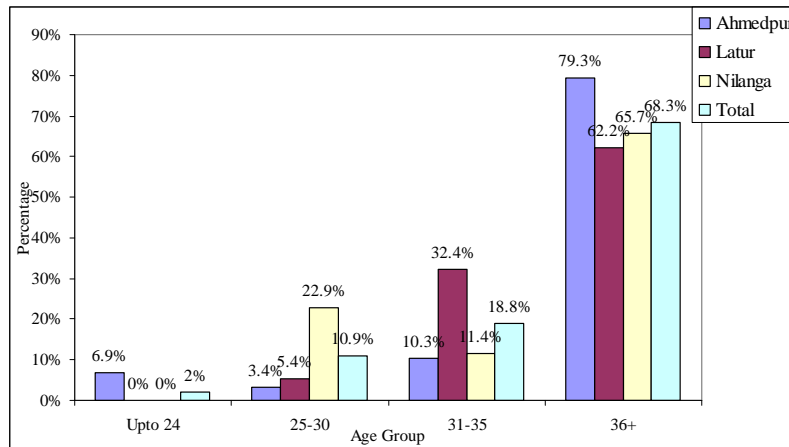
practices and understanding of child behaviour. Hence, age becomes more vital aspect of caretaking of the mentally retarded child.

TABLE NO. 3.1
DISTRIBUTION OF THE RESPONDENTS ACCORDING TO AGE

Village	AGE				Total
	Up to 24	25 - 30	31 - 35	36 +	
Ahmedpur	2	1	3	23	29
	6.9%	3.4%	10.3%	79.3%	100.0%
Latur	0	2	12	23	37
	0.0%	5.4%	32.4%	62.2%	100.0%
Nilanga	0	8	4	23	35
	0.0%	22.9%	11.4%	65.7%	100.0%
Total	2	11	19	69	101
	2.0%	10.9%	18.8%	68.3%	100.0%

Chart No. 3.1

Age group of the respondents



It is seen from the table that, very negligible number of respondents belongs from young age category, i.e. below 24 years. In Ahmedpur there are only 2, i.e. about 7%. In rest of the blocks there are not a single respondent of this category. In 25-30 years age group, about 23% respondents of Ahmedpur belong from this category, whereas in Ahmedpur

and Latur the proportion is very less ranging from 3-4%. In 31-35 years age group, the Latur has shown exceptionally high proportion, i.e. 32 percent whereas. Ahmedpur and Nilanga remain more or less same. The last category of the respondents is above 36 years age group. In Latur and Nilanga about 1/3 of the respondents belongs from this category, while in Ahmedpur about 80% of the respondents belongs from 36 and above age group. The overall picture shows that 68% respondents were above the age of 36 and 19% were up to 35 and 11% up to 30. This data clearly shows that there are matured care takers who are caring and rearing mentally retarded child in rural areas.

3.2 Sex of Caretaker:

It is assumed that females have more tolerance level than the males. Their understanding of the behaviour of children is always more as compared to the males. Growth and progress of the child mainly depends upon the socialization process and a woman is the best agent for proper socialization of a child. In a family, a woman is the person who takes care of the children in the family. Therefore the sex of the caretaker has vital significance to overcome the behavioural problem of the child. As regard to mental retardation, mother is the worse sufferer of the problem. The details about the behavioural pattern and the problem related to behaviour are properly understood by the mother every time.

TABLE NO. 3.2

**DISTRIBUTION OF THE RESPONDENTS
ACCORDING TO SEX**

Village	SEX		
	Male	Female	Total
Ahmedpur	0	29	29
	0.0%	100.0%	100.0%
Latur	3	34	37
	8.1%	91.9%	100.0%
Nilanga	1	34	35
	2.9%	97.1%	100.0%
Total	4	97	101
	4.0%	96.0%	100.0%

The above data indicates the prominence of females in care taking of the mentally retarded child. In Ahmedpur, all caretakers are female, whereas in Latur about 92% and in Nilanga about 97% caretakers are females. One can conclude from this data that females are the only caretakers at domestic level of mentally retarded child.

3.3 Education:

Education has more significant impact on the progress, growth and development of every individual. The educated person is expected to know much more details about everything than the non-educated persons. As regard to mental retardation, educated person is expected to understand the problem in more scientific manner and would respond in a systematic way. It always helps in widening the spectrum of understanding of various dimensions of human behaviour.

A mentally retarded child always has several problems and the complexities of these problems are also very serious. The complexities of behavioural problems may invite some other social problems too. Improving the quality of life of mentally retarded child, developing the healthy habits in mentally retarded child, developing his understanding in proper ways and developing him/her for self reliant, these are the main challenges in mental retardation. The educated person can easily cope with these problems and provides appropriate stage to the existing problem. Therefore, the education of the caretaker or the education of parents of mentally retarded child has vital significance to deal the problems of mental retardation in the society.

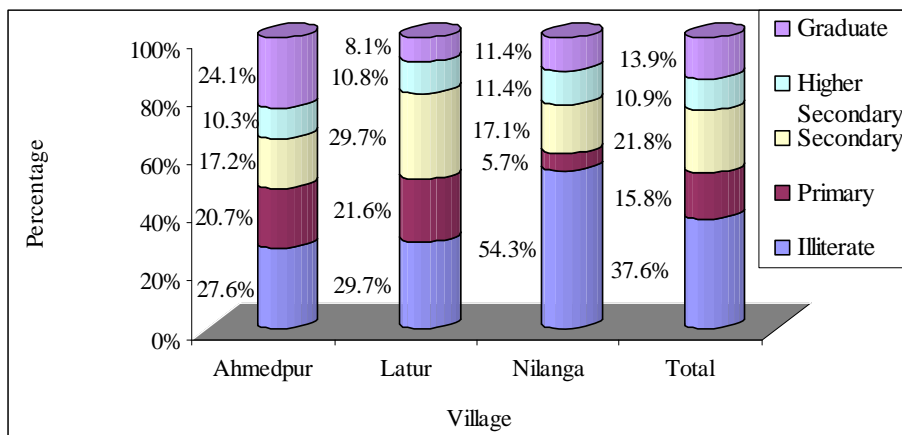
TABLE NO. 3.3 A

DISTRIBUTION OF THE RESPONDENTS ACCORDING TO EDUCATION

Village	EDUCATION					
	Illiterate	Primary	Secondary	Higher Secondary	Graduate	Total
Ahmedpur	8	6	5	3	7	29
	27.6%	20.7%	17.2%	10.3%	24.1%	100.0%
Latur	11	8	11	4	3	37
	29.7%	21.6%	29.7%	10.8%	8.1%	100.0%
Nilanga	19	2	6	4	4	35
	54.3%	5.7%	17.1%	11.4%	11.4%	100.0%
Total	38	16	22	11	14	101
	37.6%	15.8%	21.8%	10.9%	13.9%	100.0%

Chart No. 2

Educational Status of the respondents



It is seen from the table above that 38% of the respondents are illiterate followed by 16% have education up to Primary level and 22% secondary level. The proportion of higher secondary and graduates are comparatively very less in our sample size. There is a large

variation observed in the educational level in various blocks. In Ahmedpur and Latur, about 28% respondents are observed to be illiterate but in Nilanga, about 55% respondents are illiterate. In Ahmedpur and Latur more or less same trend have been observed in all categories of the education. One can conclude from the table above that the overall educational level is extremely low.

Table No. 3.3 B Distribution of Respondents According to Education vs. Main Occupation

Main Occ.	EDUCATION					Total
	Illiterate	Primary	Secondary	HSC	Graduation	
Service	0	2	5	5	8	20
	0.00	10.00	25.00	25.00	40.00	100.00
Agriculture	14	6	6	3	0	29
	48.28	20.69	20.69	10.34	0.00	100.00
Business	3	1	6	3	3	16
	18.75	6.25	37.50	18.75	18.75	100.00
Other	21	7	5	0	3	36
	58.33	19.44	13.89	0.00	8.33	100.00
Total	38	16	22	11	14	101
	37.624	15.842	21.782	10.891	13.861	100

The table above shows Education vs. Main Occupation. Those who are illiterate, mainly they are doing agriculture and other occupation, whereas those who are educated they are performing service as education increases, the number of persons doing service are also increases. Even in business, illiterate persons are more.

3.4 Occupational Pattern:

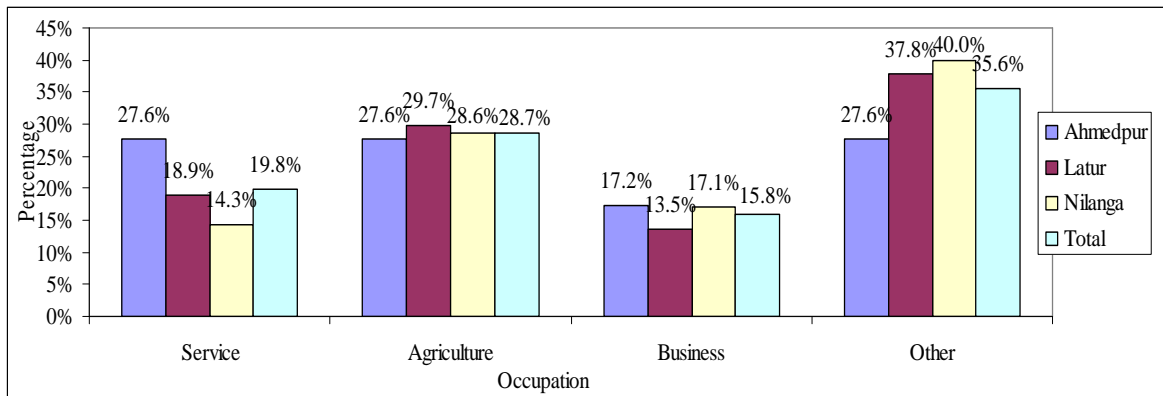
As regard to the mental retardation problem, the financial condition of the parents is very important. Mental Retardation has direct bearing on financial position exclusively depends upon occupational pattern. Therefore, occupation of parents is an integral part of the treatment of mentally retarded child. There are certain occupations which do not have

regular income. For example: agriculture, the person won't get fixed income even to predict the income of a farmer is a very difficult task. This affects the total affordability of the medical treatment. Usually in rural areas, we observe agriculture as a main occupation which does not have the fixed income or assured income. The occupation of the family is one of the most significant factors which make the significant influence on mental retardation. Parents' engagement in their own occupation makes the differences in treating their child in time, or providing health care in time, or it also dilutes the attention of parents' towards child.

TABLE NO. 3.4 A
DISTRIBUTION OF THE RESPONDENTS ACCORDING
TO MAIN OCCUPATION

Village	MAIN OCCUPATION				
	Service	Agriculture	Business	Other	Total
Ahmedpur	8	8	5	8	29
	27.6%	27.6%	17.2%	27.6%	100.0%
Latur	7	11	5	14	37
	18.9%	29.7%	13.5%	37.8%	100.0%
Nilanga	5	10	6	14	35
	14.3%	28.6%	17.1%	40.0%	100.0%
Total	20	29	16	36	101
	19.8%	28.7%	15.8%	35.6%	100.0%

Chart No. 3.4 Occupational status of the respondents



It is seen from the above table that about 20% of the respondents are following service as main occupation. The highest proportion is observed in Ahmedpur followed by Latur 19% and Nilanga 14%. The agriculture as a main occupation is followed by 29% of the respondents in all the blocks. No large variation has been observed between blocks. In Ahmedpur, Latur and Nilanga about 29% respondents are engaged in agriculture for their livelihood. Business is followed by 15% of the respondents. In this category also no large variation has been observed. And 1/3 of the total respondents of all the blocks are doing neither agriculture nor service. This indicates that substantial numbers of the respondents are engaged in opportunistic occupations. In brief it is to say that agriculture is the predominant main occupation followed by service, business and other variety of the occupations.

Table No. 3.4 B

Distribution of Respondents According to Main Occupation vs. Annual Income

		MAIN OCCUPATION				Total
		Service	Agriculture	Business	Other	
ANNUAL INCOME (in 1000)	Upto 10	1	8	0	5	14
		7.14	57.14	0.00	35.71	100.00
	11-20	0	8	3	17	28
		0.00	28.57	10.71	60.71	100.00
	21-30	5	10	8	11	34
		14.71	29.41	23.53	32.35	100.00
	31-40	7	3	2	2	14
		50.00	21.43	14.29	14.29	100.00
	40+	7	0	3	1	11
		63.64	0.00	27.27	9.09	100.00
Total		20	29	16	36	101
		19.80	28.71	15.84	35.64	100.00

In the above table, it shows that for the agriculture, the lowest income group is prominent, whereas in Service category, higher income is observed. It is also seen that in

business category, the level of income is comparatively higher than the agriculture, whereas in other category of the occupation, the proportion of respondents having income up to 20000 is prominently observed. One can conclude that in agriculture and other category of the business, the level of income is comparatively very low and those who are in regular employment, their income level is considerably high.

3.5 Secondary Occupation:

Generally, it is observed that people have secondary occupation to support his/her primary occupation. In rural areas, dairy, poultry, petty businesses, services etc. are some of the secondary occupation. If the income is not adequate or sufficient from main occupation which will help to support family, they are forced to undertake secondary occupation. Ultimately it always results in improving the affordability of the treatment to mentally retarded child. The occupational pattern is always associated with income of family. If there is not income from primary source, the secondary occupation always helps for the survival.

TABLE NO. 3.5
DISTRIBUTION OF THE RESPONDENTS ACCORDING TO SECONDARY
OCCUPATION

Village	SECONDARY OCCUPATION				
	Dairy	Agriculture	Business	Other	Total
Ahmedpur	15	1	5	8	29
	51.7%	3.4%	17.2%	27.6%	100.0%
Latur	17	1	5	14	37
	45.9%	2.7%	13.5%	37.8%	100.0%
Nilanga	14	1	6	14	35
	40.0%	2.9%	17.1%	40.0%	100.0%
Total	46	3	16	36	101
	45.5%	3.0%	15.8%	35.6%	100.0%

About half of the respondents are following dairy as a secondary occupation followed by business and other uncertain occupations. In the dairy business, in Ahmedpur

53% respondents, in Latur 46% and in Ahmedpur 40% have reported that dairy is their main secondary occupation. Those who are engaged in service as main occupation, hardly few of them are following agriculture as a secondary occupation, whereas in Ahmedpur and Nilanga 17% of the respondents are following business and rest of them are engaged in other businesses as an when they get the opportunity to undertake any other business. In brief it is to say that dairy is the main occupation in all blocks.

3.6 Income:

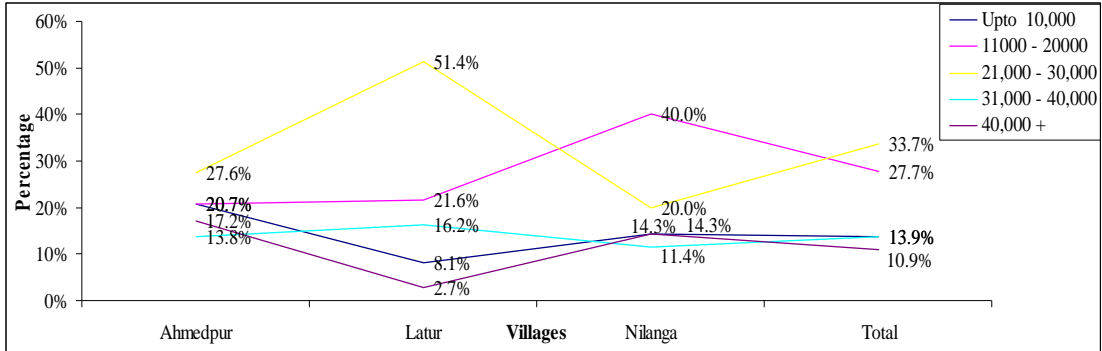
The services of livelihood are mainly depending upon the overall development of particular geographical area. In the industrial belt, one finds the income is comparatively high which ultimately results into the increase in purchasing power of the family and this situation ultimately results into the care system of mentally retarded child. In rural areas, more than 50 percent of the families are staying in Below Poverty Line. Such families do not have adequate financial support for medication. Perhaps their economic condition does not permit them to spend any amount on medical treatments. Poor the economic condition, poor the medical treatment, this simple equation applies everywhere irrespective of rural or tribal areas.

TABLE NO. 3.6

DISTRIBUTION OF THE RESPONDENTS ACCORDING TO ANNUAL INCOME

Village	ANNUAL INCOME					
	Upto 10,000	11000 - 20000	21,000 - 30,000	31,000 - 40,000	40,000 +	Total
Ahmedpur	6	6	8	4	5	29
	20.7%	20.7%	27.6%	13.8%	17.2%	100.0%
Latur	3	8	19	6	1	37
	8.1%	21.6%	51.4%	16.2%	2.7%	100.0%
Nilanga	5	14	7	4	5	35
	14.3%	40.0%	20.0%	11.4%	14.3%	100.0%
Total	14	28	34	14	11	101
	13.9%	27.7%	33.7%	13.9%	10.9%	100.0%

Chart No. 3.6
Annual income of the respondents



It is seen from the table above that, 60% of the respondents have their income ranging between 11000-30000. However, in smaller group of the income, proportion is 14% and in higher group of income, proportion is about 26%. Large variations have been observed between blocks in the income level of respondents. In smaller group, i.e. income up to 10,000 in Ahmedpur, about 21% respondents have hardly 10,000 in Nilanga, 14% and in Latur hardly 8%. The income of 11,000-20,000 also showed large variation between blocks. In Ahmedpur and Latur about 21% respondents and in Nilanga, 40% respondents have income up to 20,000. The same trend is observed in next group, i.e. income up to 30,000/ In Nilanga, 20% of respondents have income up to 30,000 followed by Ahmedpur, 28% and Latur, 52%. No large variation has been observed in the proportion of respondents whose income ranges in between 31,000-40,000 per annum. In Ahmedpur, about 14%, in Latur 16% and in Nilanga about 12 respondents have income up to 40,000. The higher income group, Ahmedpur and Nilanga have more or less same income ranging from 14% to 17% and in Latur it is only 3%. In brief it is to say that the smaller income group is observed to be a prominent in all the blocks.

3.7 Voter's list

Enrolment in Voter's list is a prime requirement to get the benefit of the government schemes. When there is a large scale migration, people do not stay at one place for longer period; naturally their names are not enlisted in Voter's list. Voter's list

is evidence for he is permanent member of the respective village and has full right to attend Gram Sabha and have full right vote for electing member of Gram Panchayat. Detail about the enrolment of family in voter's list is given in following table:

TABLE NO. 3.7
DISTRIBUTION OF THE RESPONDENTS
ACCORDING TO VOTER'S LIST

Village	VOTER'S LIST		
	Yes	No	Total
Ahmedpur	28	1	29
	96.6%	3.4%	100.0%
Latur	37	0	37
	100.0%	0.0%	100.0%
Nilanga	34	1	35
	97.1%	2.9%	100.0%
Total	99	2	101
	98.0%	2.0%	100.0%

If the person is enrolled in Voter's list, he/she is entitled to get all benefits that other villagers are getting. In all the blocks, there are hardly few respondents those who are not enrolled in the Voter's list. About 80% of the respondents are enrolled in Voter's list.

3.8 Citizenship and Migration:

Citizenship provides legal entity to get benefits provided by the government through various programmes. If the person is enlisted in voting list, he/she is entitled to get all the benefits that government has provided for development. It also provides an opportunity for selecting the public representative through voting. The migrant person is usually not enlisted in the voting list of a village or town.

As regard to the mental retardation, parents are observed to be moved from one place for avoiding so called social stigma. To have mentally retarded child, it is always considered as curse of god, and also there is a social stigma associated with this illness. Naturally to avoid this social reluctance, the family of mentally retarded child moves from one place to another place.

TABLE NO. 3.8
DISTRIBUTION OF THE RESPONDENTS
ACCORDING TO RESIDENCE

Village	RESIDENT		
	Yes	No	Total
Ahmedpur	20	9	29
	69.0%	31.0%	100.0%
Latur	32	5	37
	86.5%	13.5%	100.0%
Nilanga	31	4	35
	88.6%	11.4%	100.0%
Total	83	18	101
	82.2%	17.8%	100.0%

The data above shows that about 17% of the respondents are not the permanent resident of the village. In Ahmedpur, only 69% respondents are the residents whereas in Latur and Nilanga, about 88% of the respondents are the citizens of the village. Naturally, they are likely to get enrolled in Voter's list. Thus, they may get the benefit as others are getting.

3.14 Types of family:

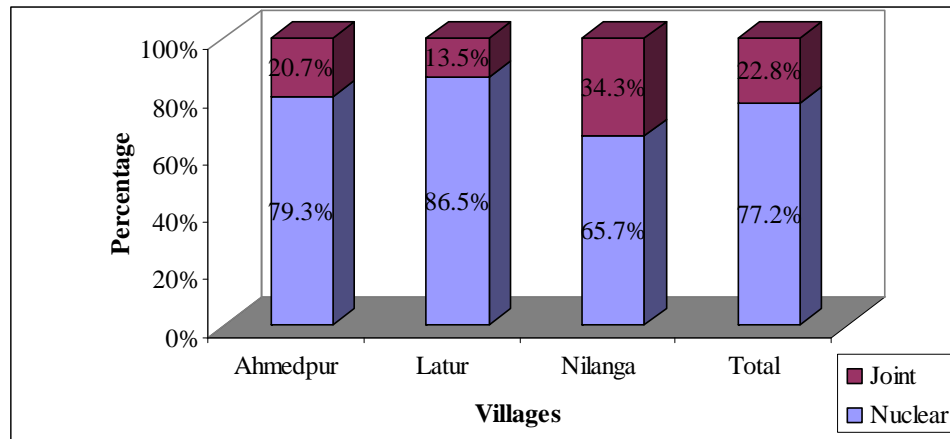
In Indian Society, Nuclear, Joint and Extended types of the families are prevalent. However, in recent years, single person family is prominently emerging. In the nuclear

type of family, husband, wife and their children stay together, whereas in Joint family, two married couple along with their parents and children are staying together. When there is a large number of the persons in the family, care of mentally retarded child becomes very easy. In joint family, everyone takes help of one another and develops himself/herself. Naturally, ageing, widows and orphans are cared by all family members. However, though there are positive points, there are some negative points too. As regard to the problems and difficulties of mentally retarded children, significance of types of family is very important.

TABLE NO. 3.14 A
DISTRIBUTION OF THE RESPONDENTS
ACCORDING TO FAMILY TYPE

Village	FAMILY TYPE		
	Nuclear	Joint	Total
Ahmedpur	23	6	29
	79.3%	20.7%	100.0%
Latur	32	5	37
	86.5%	13.5%	100.0%
Nilanga	23	12	35
	65.7%	34.3%	100.0%
Total	78	23	101
	77.2%	22.8%	100.0%

Chart No. 3.14
Type of family of the respondents



It is seen from the table above that, nuclear type of family is predominant in all blocks. However, it varied from village to village. In Latur, 87% followed by in Ahmedpur 80% and Nilanga 66% respondents have nuclear type of family. The proportion of joint type of families are predominant in Nilanga followed by 20% and Nilanga 13%. In brief it is to say that nuclear types of families are prominently observed in all blocks.

Table No. 3.14 B

Distribution of Respondents According to Main Occupation vs. Family Type

FAMILY TYPE		MAIN OCCUPATION				Total
		Service	Agriculture	Business	Other	
FAMILY TYPE	Nuclear	14	23	12	29	78
		17.95	29.49	15.38	37.18	100.00
	Joint	6	6	4	7	23
		26.09	26.09	17.39	30.43	100.00
Total		20	29	16	36	101
		19.80	28.71	15.84	35.64	100.00

The above table indicates in business category and other category constitutes more than half of the respondents having joint family, whereas in Service Category of occupation, the proportion of joint family is very low. This indicates the family occupation makes the difference in type of family.

3.15 Addiction of family members:

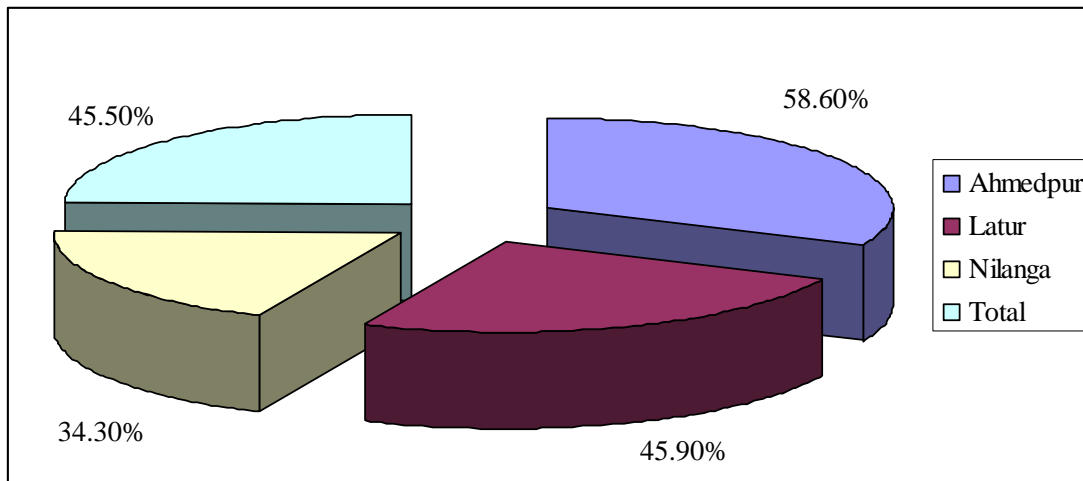
Addiction is one of the major social problems in India. If the mother is addicted, her addiction is bound to reflect on the health of child. Smoking, drinking and chewing tobacco are some of the forms of addiction. Women health grossly gets affected by addiction particularly during the time of pregnancy; addiction is very dangerous for her health as well as the foetus. The toxic effects of addictive substances are more serious during intra-uterine condition of the baby, indeed this is one of the major reason for disability.

In rural areas, chewing tobacco and use of mashery is a common phenomenon. The problems are the major hurdles in prevention of disability in early stage of life. To avoid disability, use of iodized salt is very essential. However, in rural area, parents are not aware about use of iodized salt. The intellectual abilities and several functions of the brains are closely associated with micro-nutrients; particularly intellectual abilities have close association with iodine. Therefore, it is very essential to use iodized salt or the vegetable rich in iodine. The information about the use of iodized salt is collected and discussed and discussed it in detail.

TABLE NO. 3.15
DISTRIBUTION OF THE RESPONDENTS
ACCORDING TO ADDICTION IN FAMILY

Village	ADDICTION IN FAMILY		
	Yes	No	Total
Ahmedpur	17	12	29
	58.6%	41.4%	100.0%
Latur	17	20	37
	45.9%	54.1%	100.0%
Nilanga	12	23	35
	34.3%	65.7%	100.0%
Total	46	55	101
	45.5%	54.5%	100.0%

Chart No.
Addiction in Family



It is seen from the table above that about half of the respondents' family do not have any addiction. In Ahmedpur, about 58% followed by Latur 46% and Nilanga 34% of the families have various types of the addiction. The type of addiction is discussed in following table.

3.16 Type of Addiction:

In rural areas, there are various types of addiction, mainly tobacco chewing, use of snuff, smoking bidis and cigars, consuming country liquor, these are the main types of addiction. These addictions are mainly depending upon their socio-economic condition and also whether that individual is able to afford the cost of addiction or not. At village level, chewing tobacco is the common addiction of rural population. Men chew the tobacco, whereas female use the tobacco in form of snuff. The details are discussed in following table:

TABLE NO. 3.16

DISTRIBUTION OF THE RESPONDENTS ACCORDING TO TYPE OF ADDICTION

Village	TYPE OF ADDICTION				
	Tobacco	Country liquor	Ganja/Bidi	Other	Total
Ahmedpur	29	0	0	0	29
	100.0%	0.0%	0.0%	0.0%	100.0%
Latur	35	2	0	0	37
	94.6%	5.4%	0.0%	0.0%	100.0%
Nilanga	33	0	1	1	35
	94.3%	0.0%	2.9%	2.9%	100.0%
Total	97	2	1	1	101
	96.0%	2.0%	1.0%	1.0%	100.0%

Very surprising results are observed from the above table. In earlier table, respondents have reported there are only 45% of the respondents those who are addicted but in the above table, it is seen that 96% of the respondents they are addicted for tobacco. There is no variation observed in this proportion. These figures may have multiple addictions such as tobacco, ganja etc. The respondents' perception about the addiction is not as serious as outsiders perceive. They feel that this is their habit and usual habit for addiction. The proportion of only country liquor, cigarette or bidi or the snuff is considerably negligible

in all blocks. The situation might be different in reality. In brief, it is to say that tobacco addiction is the prominent in all the blocks.

3.17 Use of Salt in Regular Diet

Micro-nutrients such as iodine, phosphorus, copper, zinc etc plays vital role in causing malnutrition and is closely associated with mental retardation. In rural areas, villagers are not aware about the role of these nutrients in their physical growth. In a natural diet, we get all these micro-nutrient from various sources. However, the deficiency of any other nutrients creates problem among the children particularly in young age. The detail regarding the use of type of salt is given in following table:

TABLE NO. 3.17
DISTRIBUTION OF THE RESPONDENTS ACCORDING TO USE OF SALT

Village	USE OF SALT			
	Iodized salt	Non-iodized salt	Unable to say	Total
Ahmedpur	2	5	22	29
	6.9%	17.2%	75.9%	100.0%
Latur	0	5	32	37
	0.0%	13.5%	86.5%	100.0%
Nilanga	1	8	26	35
	2.9%	22.9%	74.3%	100.0%
Total	3	18	80	101
	3.0%	17.8%	79.2%	100.0%

It is seen from the above table that there are hardly 3% respondents who are using iodized salt regularly. In all the blocks, this proportion is almost negligible. This indicates that there is hardly any awareness about the role of micro-nutrients in regular diet. About 18% of respondents have reported that they use general salt, which is available in the local market but they are also not aware about the type of salt they use. And about 80% of the respondents were not able to tell whether they use iodized salt or not.

Summary

In the socio-economic profile of study population, candidate has given the detail account of various social factors, economic factors and environmental factors. As mental retardation is a complex social problem, various factors are simultaneously operating on mental retardation to isolate the effects of each one of the factor is a complex task. However, the various factors that are operating on the problem is discussed in detail. This includes the age of respondents. It is found that more than 70% respondents were above 36 years age group followed by 18% 31-35, 11% 25-30 and 2% up to 24 years. Most of the caretakers are female; perhaps females are the appropriate people to take care of mentally retarded child. In all the villages, females are observed to be the main caretaker of the respondents. As regard to the education, it was found that about 40% of the respondents are illiterate and the level of education is comparatively low almost in all the villages. Large variations have been observed between various blocks. However, this variation doesn't constitute any significance with mental retardation.

Agriculture or agricultural labourer is the main occupation of most of the respondents. However, the service and business is observed to be very low. This indicates that their economic condition is also not very sound which are affecting the treatment and medical rehabilitation of mentally retarded child. To support main occupation, secondary occupation is dairy, agriculture, business etc. However, dairy and other petty businesses are observed to be prominent in all villages. As regard to the income, as most of the respondents have agriculture as a main business, there is an uncertainty of income. It was found that in rural areas, more than 50% population is living in Below Poverty Line. 62% of the respondents have their income ranging in between 11000-30000, 13% have income up to 40000 and hardly 10% of the respondents have income more than 40000. This indicates that the economic condition of the respondents is poor which is affecting on medication and treatment. Almost all the respondents are enrolled in Voter's list and 82% of the respondents are residents of the village.

As regard to the type of family it was found 77% of the respondents have nuclear type of family and hardly 23% have Joint type of family. The rate of addiction is observed to be very high in all villages. About 45% of the respondents' family have either this or that type of addiction and mainly tobacco is the prominent type of addiction. Use of iodized salt is an essential aspect for health, but 80% of the respondents were not able to tell the type of salt they are using. In brief it is to say that the overall socio-economic conditions are extremely poor in all villages.

CHAPTER FOUR:

FACTORS ASSOCIATED WITH DELIVERY AND ITS RELATION WITH MENTAL RETARDATION

In mental retardation, parental factors have pivotal position. Most of the factors are concerned with maternal care, maternal health, habits of mother, genetic constitution of the mother and father, chronic illness either from mother and father and the history of mental retardation of the parents. In other words, family relations and family history are the main causative factors, which are very difficult to control. If the mother has history of mental retardation in her family, chances of getting retardation in child is always more. Traumatic condition is always important during the conception process. If she gets exposure to radiation, the chances to have mentally retarded child are always more. Apart from the environmental condition, if a woman took excessive antibiotics, the functioning of brain gets affected grossly.

Delay in delivery, discharge of water during delivery, suffocation of baby during delivery, early birth or late birth and late age of delivery (after 42 years) have always risk to get mentally retarded child. These are the maternal factors closely associated to mental retardation.

Excessive strain, excessive stress, use of tranquilizers, mothers' health status during intra-uterine condition of the baby, use of forceps for delivery, these are also significant factors which may develop mental retardation in the child.

The details about mother's health and other maternal factors are discussed in following paragraphs.

4.1 Age of mother at marriage:

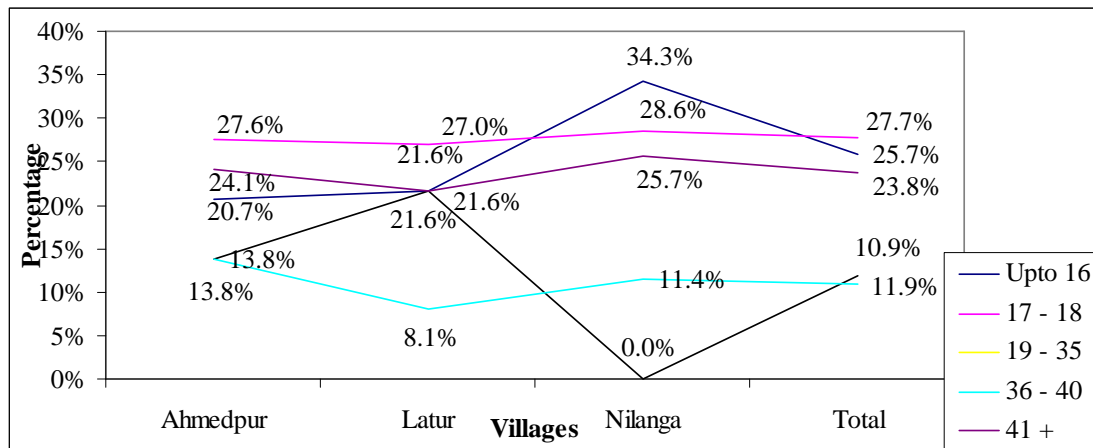
Either early age or late age of marriage grossly affects the health of the child. When the uterus of the mother is weak to bear and care the baby, gross malnutrition takes place even in intra-uterine condition. Below 18 years, the uterus of the mother is not fully

developed to bear the child or after 40 years uterus becomes so delicate and inactive; the foetus doesn't get adequate nutrients from mother. The absorption capacity of the foetus from the uterus of mother doesn't operates and anticipated way and hence if the foetus get inadequate supply of food substances through the capillaries from mother, chances of malfunctioning of brain takes place. Hence, there is always high risk to take a chance either below 18 years or after 40 years.

TABLE NO. 4.1 A
DISTRIBUTION OF THE RESPONDENTS ACCORDING TO
MOTHER'S AGE AT MARRIAGE

Village	MOTHERS AGE AT MARRIAGE					Total
	Upto 16	17 - 18	19 - 35	36 - 40	41 +	
Ahmedpur	6	8	4	4	7	29
	20.7%	27.6%	13.8%	13.8%	24.1%	100.0%
Latur	8	10	8	3	8	37
	21.6%	27.0%	21.6%	8.1%	21.6%	100.0%
Nilanga	12	10	0	4	9	35
	34.3%	28.6%	0.0%	11.4%	25.7%	100.0%
Total	26	28	12	11	24	101
	25.7%	27.7%	11.9%	10.9%	23.8%	100.0%

Chart No. 4.1 Mother's age at marriage



According to the above table, out of total respondents about 53% mother had already get married till the age of 18 and about 35% got married after 35 years, whereas only about 12% respondents got married in the proper age of marriage, i.e. 19-35 years. This data varies from one village to another. The proportion of all the blocks and Ahmedpur is approximately same, i.e. around 48% for upto 18 years, 38% for above 35 years and about 14% in the age on 19-35 years. The proportion for responses for all other remaining blocks is same for below 18 years and above 35 years. It is significant that the total respondents, who got married in between 19-35 years in Latur and Nilanga, it is 21.6% in Latur and 0% in Nilanga. There is a considerable correlation between age at marriage and the chance of getting mentally retarded child and the above data shows the positive correlation between the mental retardation and age at marriage. In brief, it is to say that substantial number of women, i.e. more than 50% got married before 18 years, when they have not developed their reproductive system and about 24% women got married after 41 years of age which is risky age to bear a child. In this age, uterus becomes very weak. Naturally, if child do not get adequate nutrients from mother, chances of mental retardation are observed at higher rate in this age group.

Table No. 4.1 B
Distribution of Respondents according to
Mother's Age at marriage vs. Birth Weight

		MOTHERS AGE AT MARRIAGE					Total
		Upto 16	17-18	19-35	36-40	41+	
BIRTH WEIGHT (in grams)	Below 1000	20	15	9	6	17	67
		29.85	22.39	13.43	8.96	25.37	100.00
	1000-1200	6	13	3	5	7	34
		17.65	38.24	8.82	14.71	20.59	100.00
Total		26	28	12	11	24	101
		25.74	27.72	11.88	10.89	23.76	100.00

About 30% of the respondents had below 1000gm weight of their new born babies, whose age was below 16 years. However, there are about 18% of the respondents whose weight was ranging between 1000-1200 gms.

Table No. 4.1 C
Distribution of Respondents According to
Fathers' Age at Marriage vs. Mothers' Age at Marriage

		FATHERS AGE AT MARRIAGE				Total
		17-18	19-35	36-40	41+	
MOTHERS AGE AT MARRIAGE	Upto 16	12	9	4	1	26
		46.15	34.62	15.38	3.85	100.00
	17-18	3	20	3	2	28
		10.71	71.43	10.71	7.14	100.00
	19-35	0	8	4	0	12
		0.00	66.67	33.33	0.00	100.00
	36-40	0	1	7	3	11
		0.00	9.09	63.64	27.27	100.00
	41+	0	7	1	16	24
		0.00	29.17	4.17	66.67	100.00
Total		15	45	19	22	101
		14.85	44.55	18.81	21.78	100.00

From the above table, it is observed that there is substantial gap between males and females as regard to the marriage. There is a considerable proportion of the women whose age is less than 16 years but their husband's age is more than 19 years, perhaps it is sometimes 36 or even 40 also.

4.2 Father's age at marriage:

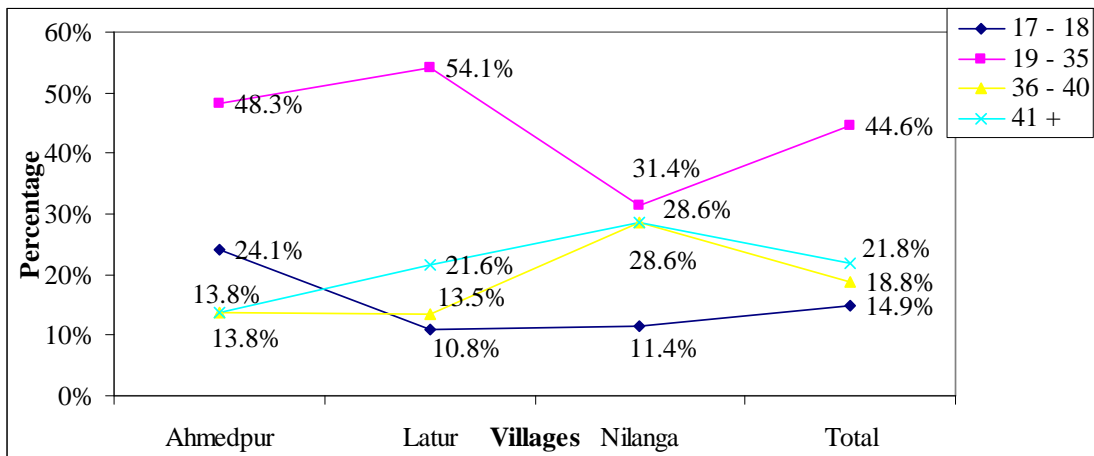
though there is no direct relevance of father's age to mental retardation of a child, it is the social condition that father's economic condition or earning capacity gets weakened after 40s. Particularly, if the father is not in regular job, he may face the

difficulties in providing appropriate medication to the child. Therefore, age of father at marriage is also significant in this regard. One point is to be noted here that, in rural areas there is a large gap of age between husband and wife and above table indicates that the old person is getting married with younger girl. The detail about the same is given in following table:

TABLE NO. 4.2
DISTRIBUTION OF THE RESPONDENTS ACCORDING TO
FATHER'S AGE AT MARRIAGE

Village	FATHERS AGE AT MARRIAGE				Total
	17 - 18	19 - 35	36 - 40	41 +	
Ahmedpur	7	14	4	4	29
	24.1%	48.3%	13.8%	13.8%	100.0%
Latur	4	20	5	8	37
	10.8%	54.1%	13.5%	21.6%	100.0%
Nilanga	4	11	10	10	35
	11.4%	31.4%	28.6%	28.6%	100.0%
Total	15	45	19	22	101
	14.9%	44.6%	18.8%	21.8%	100.0%

Chart No. 4.2
Father's age at Marriage



It is seen from the above table that, only 15% of the males are getting married between 17-18 years, whereas this proportion is more than 52% among women. About 45% of the males got married during 19-35 years of age, and 19% got married in 36-40 years of age. In all the three blocks, large variations have been observed as regard to the age of father's marriage. In brief it is to say that as compared to mother's age of marriage, father's age at marriage is considerably higher.

4.3 Illness during pregnancy:

If the mother gets major illness either of pathogenic infection or virus infection, she has to consume heavy antibiotics which may affect foetus. Indeed the infection grossly affects the growth of foetus in early stage. The viral infection has major consequences on the development of various body organs. Therefore, the illness of the mother during pregnancy is always considered to be of vital significance.

TABLE NO. 4.3 A
DISTRIBUTION OF THE RESPONDENTS ACCORDING TO
ILLNESS DURING PREGNANCY

Village	ILLNESS DURING PREGNANCY		
	Yes	No	Total
Ahmedpur	2	27	29
	6.9%	93.1%	100.0%
Latur	2	35	37
	5.4%	94.6%	100.0%
Nilanga	2	33	35
	5.7%	94.3%	100.0%
Total	6	95	101
	5.9%	94.1%	100.0%

It is seen from the above table that, hardly 6% of the women have reported that they were suffering by some illnesses during pregnancy. No large variation has been

observed between various blocks. However, one point is to be noted here that though women suffer from various illnesses, they do not consider this as illnesses. For example: Anaemic condition is not regarded as illness. Most of the women folk are of the opinion that they are lacking in blood, but in real sense blood formation is arrested mainly due to inadequate diet and their prevailing socio-economic conditions.

Table No. 4.3 B

Distribution of Respondents According to Illness during Pregnancy vs. Still Birth

		ILLNESS DURING PREGNANCY		Total
		Yes	No	
STILL BIRTH	Yes	0	3	3
		0.00	100.00	100.00
	No	6	92	98
		6.12	93.88	100.00
	Total	6	95	101
		5.94	94.06	100.00

Though there was no illness during pregnancy as reported by the respondents, one point is to be noted here that the level of perception is different among the women in rural areas about illness. A minor illness they consider, it is not the illness. No any consistent observation is recorded from the above table.

Table No. 4.3 C
Distribution of Respondents According to
Tablets during Pregnancy vs. Illness during Pregnancy

		TABLETS DURING DELIVERY		Total
		Yes	No	
ILLNESS DURING PREGNANCY	Yes	6	0	6
		100.00	0.00	100.00
	No	74	21	95
		77.89	22.11	100.00
Total		80	21	101
		79.21	20.79	100.00

It is prominently observed from the above table that who have taken the tablets as per the advice of doctor, do not experience any illnesses. This shows that during pregnancy, seeking advice of doctor is very important.

Table No. 4.3 D
Distribution of Respondents According to
Mothers' Age at Birth vs. Illness during Pregnancy

		MOTHERS AGE AT BIRTH			Total
		Below 18	19-20	21-30	
ILLNESS DURING PREGNANCY	Yes	3	2	1	6
		50.00	33.33	16.67	100.00
	No	40	21	34	95
		42.11	22.11	35.79	100.00
Total		43	23	35	101
		42.57	22.77	34.65	100.00

The illness during pregnancy is one of the prominent features in rural areas. Those who have experienced the illness during pregnancy, the considerable population of the women were below 18 years of age. This indicates that lesser the age at delivery, higher the chances of illness.

4.4 Still Birth:

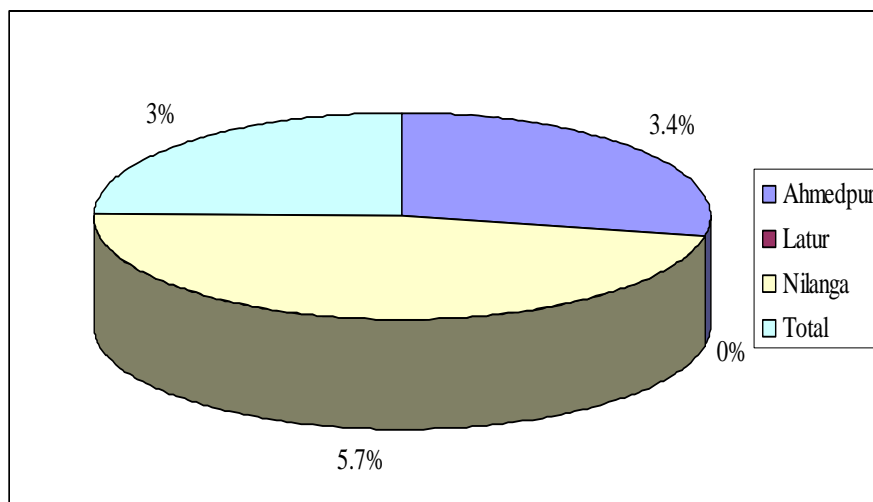
Still birth is an excellent indicator of poor health and nutritional status of mother, which is an outcome of poor economic condition, and the influence of the culture on daily life, congenital malformation invites several complexities if foetus and even in neonatal stage. Most of the women have the tendency of either abortion or still birth. To avoid this situation, adequate balanced diet is prime requirement. The health care practices in rural areas are so poor that women usually avoid paying adequate attention towards her health during pregnancy.

TABLE NO. 4.4 A

DISTRIBUTION OF THE RESPONDENTS ACCORDING TO STILL BIRTH

Village	STILL BIRTH		
	Yes	No	Total
Ahmedpur	1	28	29
	3.4%	96.6%	100.0%
Latur	0	37	37
	0.0%	100.0%	100.0%
Nilanga	2	33	35
	5.7%	94.3%	100.0%
Total	3	98	101
	3.0%	97.0%	100.0%

Chart No.
Still Birth History of Respondents



It is seen from the above table that very negligible proportion of respondents has reported that they had still birth history. Baring few cases in Ahmedpur and Nilanga, no more women have reported that they had any still birth experience in their reproductive age. In brief, it is to say that the incidence of still birth is observed to be very less. However, there are chances to hide this information by the mothers.

Table No. 4.4 B
Distribution of Respondents According to Addiction of Mother vs. Still birth

		ADDICTION OF MOTHER		Total
		Yes	No	
STILLBIRTH	Yes	2	1	3
		66.67	33.33	100.00
	No	95	3	98
		96.94	3.06	100.00
Total		97	4	101
		96.04	3.96	100.00

The above table indicates that those who are addicted among them chances of still birth are observed to be more. However, it has also shown some different situation in the field.

4.5 History of Mental Retardation:

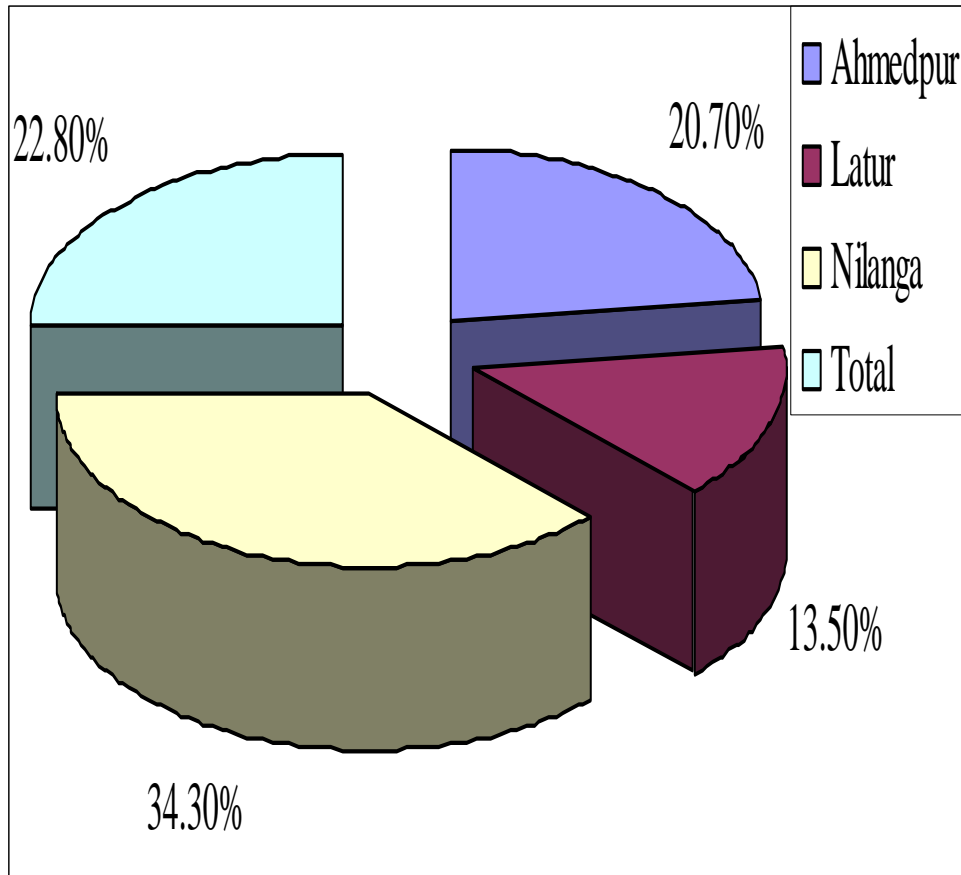
It is proved that mental retardation has the influence of heredity. If there is a history of mental retardation in the family, the chances of replication of the mental retardation is always more. Usually it is considered as either first child or the last child gets mental retardation. Therefore, the family history related to mental retardation is considered to be a vital significance.

The history consists of matrilineal and patrilineal heritage. In a family, if someone is mentally retarded, that has definite genetic history either in mother's family or father's family. The genetic constitution of a child has compounding effect of two families. If there is history in mother's family or in father's family, the child is likely to get mental retardation either during intra-uterine condition or during early neonatal stage. Such types of illnesses are usually transferred from one generation to another generation in alternative frequencies. Thus, if one generation has the mental retardation, that may reflect into second or third generation. The main impact of genetic transformation is an outcome of synergism of man and environment interaction.

TABLE NO. 4.5 A
DISTRIBUTION OF THE RESPONDENTS ACCORDING TO
HISTORY OF MENTAL RETARDATION

Village	HISTORY OF MENTAL RETARDATION		
	No	Yes	Total
Ahmedpur	23	6	29
	79.3%	20.7%	100.0%
Latur	32	5	37
	86.5%	13.5%	100.0%
Nilanga	23	12	35
	65.7%	34.3%	100.0%
Total	78	23	101
	77.2%	22.8%	100.0%

Chart No. 4.3
Mental Retardation in Mother's Family



It is seen from the above table that in 77% of the families, there is no history of mental retardation. In spite of this situation, there is incidence of mental retardation. In about 23% of the mother's families have history of mental retardation? This clearly indicates that mother's family's history have greater significance on new born baby and incidence of mental retardation at family level. There is a large variation in history ranging from 13-34%. In Latur 14% of mothers have mental retardation history followed by Latur 21% and highest in Nilanga, i.e. 34%.

Table No. 4.5 B
Distribution of Respondents According to
Mental Retardation in Mothers' Family vs. Fathers' Family

		M.R. MOTHERS FAMILY	Total
		No	
M.R. IN FATHERS FAMILY	Yes	1	1
		100.00	100.00
	No	100	100
		100.00	100.00
Total		101	101
		100.00	100.00

There is hardly history of mentally retarded child in one family from the mother's side. So, one cannot say that the history of mental retardation has close connection with history of mother's family.

The following table shows the history of mental retardation in father's family:

TABLE NO. 4.6
DISTRIBUTION OF THE RESPONDENTS ACCORDING TO
MENTAL RETARDATION IN MOTHER'S FAMILY

Village	MENTAL RETARDATION IN FATHERS FAMILY		
	Yes	No	Total
Ahmedpur	0	29	29
	0.0%	100.0%	100.0%
Latur	0	37	37
	0.0%	100.0%	100.0%
Nilanga	1	34	35
	2.9%	97.1%	100.0%

It is seen from the above table that, there is a history of mental retardation in father's family in 3% respondents. In only Nilanga, in one family, history has been reported, whereas in Ahmedpur and Latur, none of the single person has reported that there is history of mental retardation in their family.

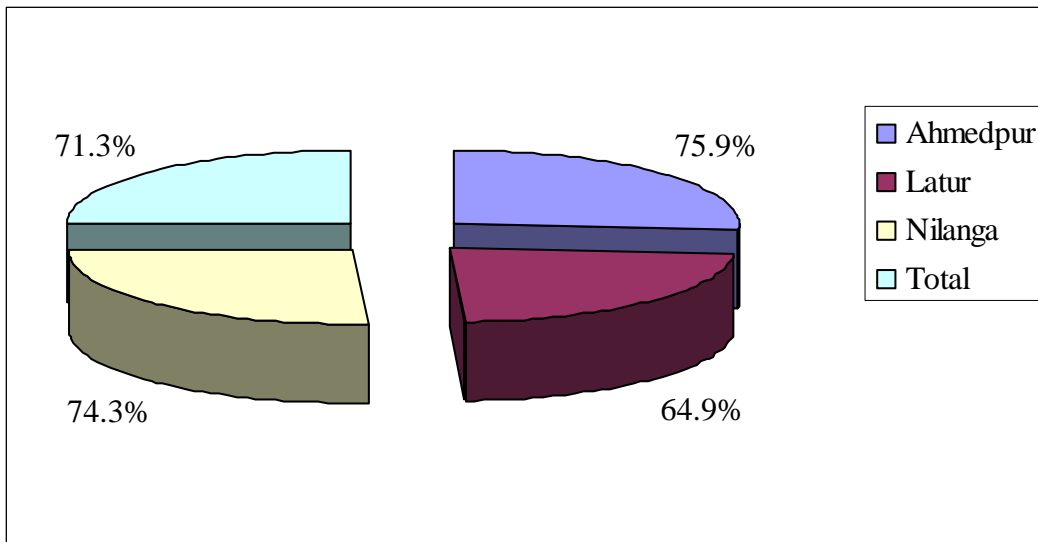
4.6 Consanguineous Marriage:

In Indian Society, marriage between cross-cousins has social sanction. A son or daughter of a woman can get marries with the son or daughter of her brother. Naturally, the same genes are transferred from one generation to another generation. Such cross-cousin marriages are taking place to that extent that probability to have the diseases of earlier generation is always more in next generation too. The chances of mental retardation are always at higher side in such type of relations.

TABLE NO. 4.7 A
DISTRIBUTION OF THE RESPONDENTS ACCORDING TO
CONSANGUENEIOUS MARRIAGE

Village	CONSANGUINEOUS MARRIAGE		
	Yes	No	Total
Ahmedpur	22	7	29
	75.9%	24.1%	100.0%
Latur	24	13	37
	64.9%	35.1%	100.0%
Nilanga	26	9	35
	74.3%	25.7%	100.0%
Total	72	29	101
	71.3%	28.7%	100.0%

Chart No. 4.4
Consanguineous Marriages



The above table shows one of the most significant observations in the field of mental retardation. In continuation of the earlier two points, this table indicates there are consanguineous marriages, where the incidences of mental retardation are more. As regard to the consanguineous marriages, the family background and marital history of parents shows that in Ahmedpur and Latur, about 75% of the parents have consanguineous marriages, whereas in Latur about 60% of the parents have consanguineous marriages. One can conclude from the above table that in consanguineous marriages, occurrence of mental retardation is very high. However, the relation between husband and wife before marriage makes much more difference on the incidence of mental retardation.

Table No. 4.7 B
Distribution of Respondents According to
Consanguineous Marriage vs. Relation before Marriage

	CONSINGUINEOUS MARRIAGE		Total	
		Yes		No
RELATION BEFORE MARRIAGE	Cross Cousin	38	15	53
		71.70	28.30	100.00
	Son of Maternal Aunt	33	14	47
		70.21	29.79	100.00
	Maternal Uncle	1	0	1
		100.00	0.00	100.00
Total		72	29	101
		71.29	28.71	100.00

The above table indicates that more than 70% of the consanguineous marriages have taken place between cross cousins or son or daughter of maternal aunt. This clearly indicates that the consanguineous marriages have strong association with mental retardation as deform genes are transferred from one generation to another and it has continued in next generation.

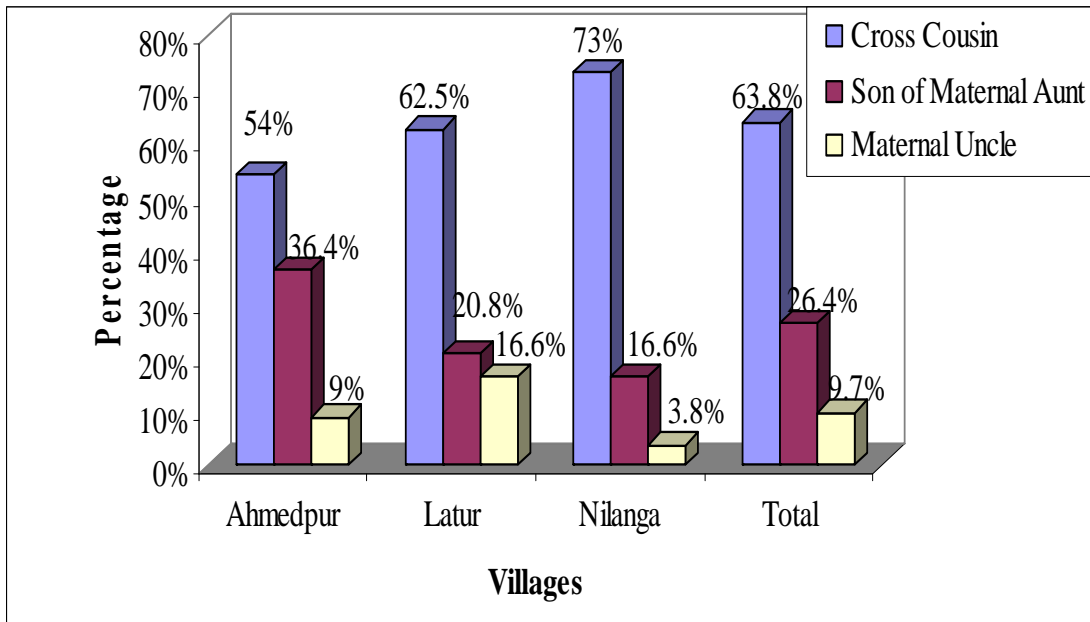
4.7 Relation before marriage:

In Indian culture, cross cousin marriages are widely accepted. However, the rural population is not aware that the cross-cousin marriages may invite serious problems in their families. However, as this is the traditional practice in most of the families even today, it is performed in almost all blocks. The detail regarding the relation between husband and wife prior to marriage in following table:

TABLE NO. 4.8
DISTRIBUTION OF THE RESPONDENTS ACCORDING TO
RELATION BEFORE MARRIAGE

Village	RELATION BEFORE MARRIAGE			
	Cross Cousin	Son of Maternal Aunt	Maternal Uncle	Total
Ahmedpur	12	8	2	22
	54%	36.4%	9%	100.0%
Latur	15	5	4	24
	62.5%	20.8%	16.6%	100.0%
Nilanga	19	6	1	26
	73%	16.6%	3.8%	100.0%
Total	46	19	7	72
	63.8%	26.4%	9.7%	100.0%

Chart No. 4.5
Relation before Marriage



4.8 Abortion:

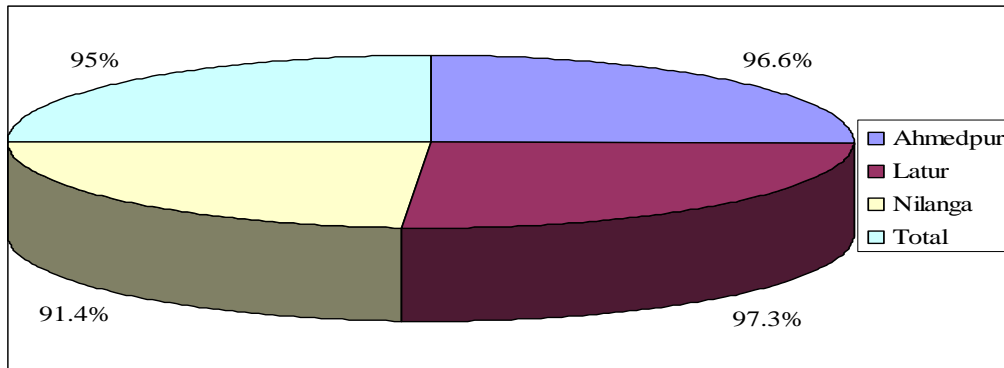
Mother's health status is closely associated with growth and development of the foetus. Poor nutritional condition and poor health status always gives complications during pregnancy. These complications ultimately results into abortion. The recent trend shows that there are two types of abortion, once induced abortion and two is Natural Abortion. In induced abortion, sex determination of the foetus is one of the main reasons. Considering the cultural set up of Indian Society, the chances of induced abortion are always more. As regard to the mental retardation, if the mother has tendency of frequent abortion, chances of development of disability in foetus are more. Therefore, the association of abortion with mental retardation are observed to be prominent. Working conditions, hard work long hours of work, these are the various factors causing abortion in women. Considering the working condition of agricultural women labourer, they have to bear hardship in their day to day activities. Drudgery is daily routine is also one of the most important aspect of abortion.

TABLE NO. 4.9 A

DISTRIBUTION OF THE RESPONDENTS ACCORDING TO ABORTION HISTORY

Village	ABORTION HISTORY		
	No	Yes	Total
Ahmedpur	1	28	29
	3.4%	96.6%	100.0%
Latur	1	36	37
	2.7%	97.3%	100.0%
Nilanga	3	32	35
	8.6%	91.4%	100.0%
Total	5	96	101
	5.0%	95.0%	100.0%

Chart No. 4.6
Abortion History



It is seen from the above table that there is a strong history of abortion in almost all families. Only 8% of the family do not have any history of abortion. This clearly indicates that delay in child birth, complications during pregnancy, poor health during pregnancy, chronic illnesses etc. are prevailing in the families of most of the respondents. Abortions or still births are two factors closely associated with mother's health, which ultimately is the responsibility of entire family for adequate and appropriate care in time as per the need and demand from the mother. In brief it is to say that mother's poor health conditions are responsible for mental retardation.

Table No. 4.9 B
Distribution of Respondents According to Illness during Pregnancy vs. Abortion

		ILLNESS DURING PREGNANCY		Total
		Yes	No	
ABORTION	Yes	0	5	5
		0.00	100.00	100.00
	No	6	90	96
		6.25	93.75	100.00
Total		6	95	101
		5.94	94.06	100.00

The above table indicates, there is a history of abortion in only 6% of women those who were ill during pregnancy. This is one of the most important observations as regard to the disability.

Table No. 4.9 C

Distribution of Respondents According to Addiction of Mother vs. Abortion

		ADDICTION OF MOTHER		Total
		Yes	No	
ABORTION	Yes	4	1	5
		80.00	20.00	100.00
	No	93	3	96
		96.88	3.13	100.00
Total		97	4	101
		96.04	3.96	100.00

Those who are addicted, among them chances of abortion are always high. There are four cases those who are addicted have the tendency of abortion.

Table No. 4.9 D Distribution of Respondents According to Mothers' Age at Birth vs. Abortion

		MOTHERS AGE AT BIRTH			Total
		Below 18	19-20	21-30	
ABORTION	Yes	2	1	2	5
		40.00	20.00	40.00	100.00
	No	41	22	33	96
		42.71	22.92	34.38	100.00
Total		43	23	35	101
		42.57	22.77	34.65	100.00

Above table shows that, lesser the age, higher the chances of abortion.

4.9 X-ray Exposure:

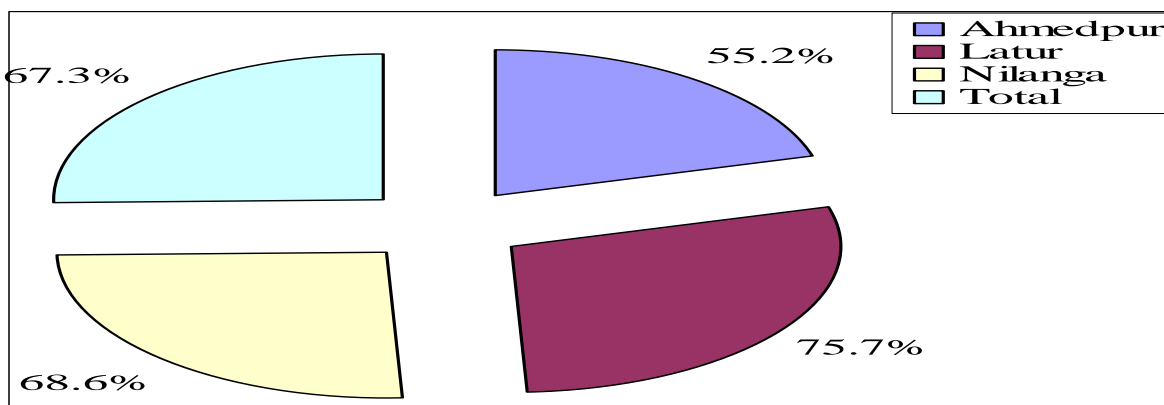
Scientifically it has been proved that exposure of variation leads disability. There are several occasions where the women are there to exposure of radiation. During her work, if she gets bone fracture, exposure to radiation is inevitable. Therefore in rural areas, these aspects have considerable significance about mental retardation.

TABLE NO. 4.10

DISTRIBUTION OF THE RESPONDENTS ACCORDING TO X-RAY EXPOSURE

Village	X -RAY EXPOSURE		
	Yes	No	Total
Ahmedpur	16	13	29
	55.2%	44.8%	100.0%
Latur	28	9	37
	75.7%	24.3%	100.0%
Nilanga	24	11	35
	68.6%	31.4%	100.0%
Total	68	33	101
	67.3%	32.7%	100.0%

Chart No. 4.7 X-ray Exposure during Pregnancy



It is seen from the above table that, about 67% of the mothers have come across with the exposure of X-ray machine. In Ahmedpur about 55% and in Latur more than

75% and in Nilanga about 69% of the mothers have exposure of X-ray during their pregnancy. These figures seem to be over estimated, because in general situation doctors are aware about not to expose pregnant women to X-ray machine, but it has been reported by the respondents. In brief it is to say that, considerable number of the women have got exposure to the X-ray. Naturally, mental retardation is bound to be occurring in new-born baby.

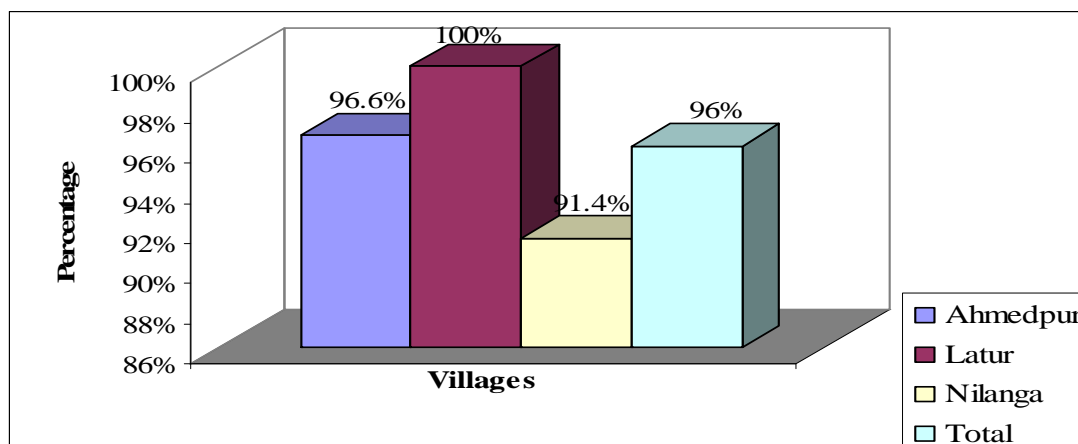
4.10 Addiction of mother:

In Indian Society, drinking and smoking are not socially accepted in rural areas, it is almost absent. Smoking of bidi/cigar and drinking of iluciat liquor are also very rare in rural areas. In tribal communities, drinking is very common phenomenon and that has social sanction also. One of the most important observations is that chewing tobacco or using masher (made up of tobacco) is very common phenomenon. Use of masher helps to explicit blood circulation. Hence, user feels fresh for some time, but the users are not aware that masher or tobacco has toxic effect. These toxins affect the function of brain. Ultimately, it results into mental retardation. If the mother is lactating, that grossly affects the growth of the child. Either tobacco or masher have multidimensional destructive characteristics of cognitive abilities of an individual. This correlation between addiction and mental retardation has shown the several evidences in various categories of working women.

TABLE NO. 4.11 A
DISTRIBUTION OF THE RESPONDENTS ACCORDING TO
ADDICTION OF MOTHER

Village	ADDICTION OF MOTHER		
	Yes	No	Total
Ahmedpur	28	1	29
	96.6%	3.4%	100.0%
Latur	37	0	37
	100.0%	0.0%	100.0%
Nilanga	32	3	35
	91.4%	8.6%	100.0%
Total	97	4	101
	96.0%	4.0%	100.0%

Chart No. 4.8
Addiction of Mother



It is seen from the table that almost all mothers have various types of the addiction. Among these addictions, uses of tobacco, snuff or masherri are common. As this data is from the Marathwada region, use of masherri or chewing the tobacco is common practice in all the blocks. Therefore, the chances of getting mental retarded child are observed to be more among these women. No large variation has been observed in case of addiction. However, the following table provides various types of addiction:

Table No. 4.11 B
Distribution of Respondents According to Education vs. Addiction of Mother

		EDUCATION					Total
		Illiterate	Primary	Secondary	HSC	Graduation	
ADDICTION OF MOTHER	Yes	34	16	22	11	14	97
		35.05	16.49	22.68	11.34	14.43	100.00
	No	4	0	0	0	0	4
		100.00	0.00	0.00	0.00	0.00	100.00
Total		38	16	22	11	14	101
		37.62	15.84	21.78	10.89	13.86	100.00

Among the illiterate women, the proportion of addiction is more and those who are educated, there is very less proportion. One can conclude from this table, the educated women do not have any addiction.

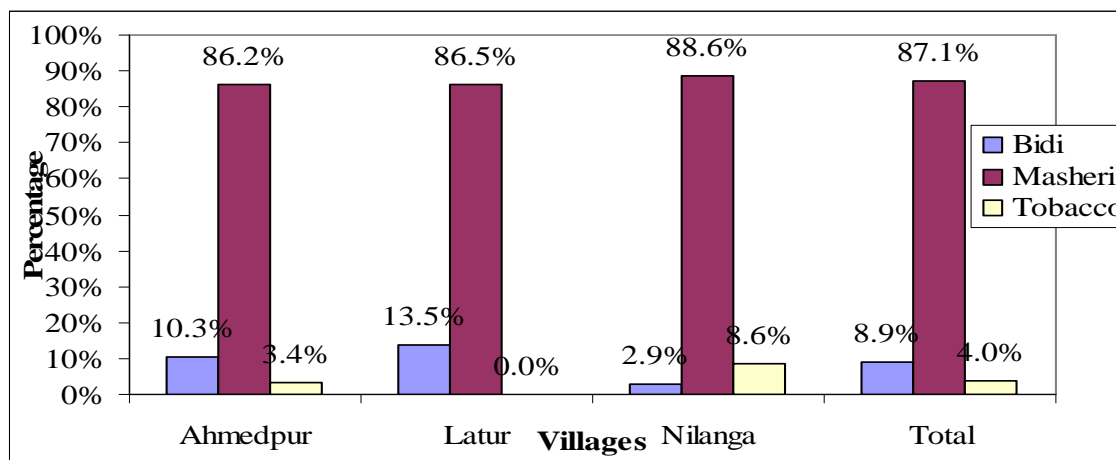
TABLE NO. 4.12

DISTRIBUTION OF THE RESPONDENTS ACCORDING TO TYPE OF ADDICTION

Village	TYPE OF ADDICTION				
	Nil	Bidi	Masheri	Tobacco	Total
Ahmedpur	1	3	25	1	29
	3.4%	10.3%	86.2%	3.4%	100.0%
Latur	0	5	32	0	37
	0.0%	13.5%	86.5%	0.0%	100.0%
Nilanga	3	1	31	3	35
	8.6%	2.9%	88.6%	8.6%	100.0%
Total	4	9	88	4	101
	4.0%	8.9%	87.1%	4.0%	100.0%

Chart No. 4.9

Type of Addiction



It is seen from the above table that more than 87% of the women are using Masher. Masher is a type of tobacco which is to be used for cleaning the teeth. During the cleaning, it gets absorbed in the blood through saliva and for some period, there is a speedy blood circulation and the individual feels fresh. In real sense, there is hardly any impact on their efficiency but this is the psychological feeling that prevails in almost all women. Bidi is used by 9% of respondents. Among them in Latur, about 14% of the women are using bidi regularly. In Ahmedpur and Nilanga the proportion ranges between 10-12% of the mothers are using bidi for addiction. Tobacco chewing is also observed in 4% of the mothers. In rural areas, tobacco is used by males for chewing. Even in most of the families, it is not considered as addiction, but is considered as essential commodity. In brief, it is to say that almost all mothers of the mentally retarded child have addiction either this or that type and hence the chances of retardation are not new in anyway. In brief, it is to say addictions have been observed to a prominent reason responsible for mental retardation in rural areas.

4.11 Expenditure on mentally retarded children:

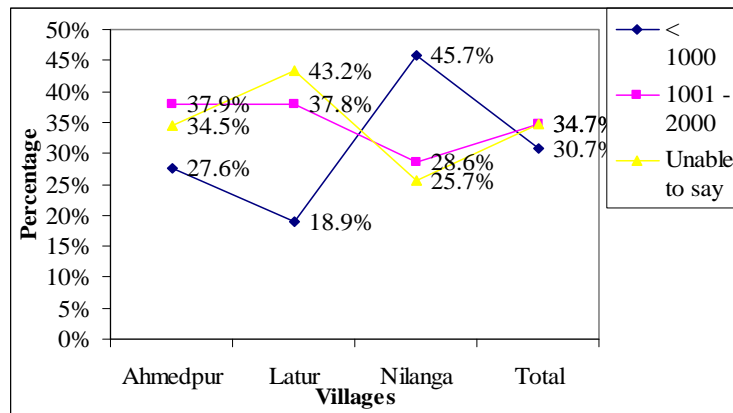
The economic condition of the family is grossly affected by the expenses on medical treatment. The expenses vary from place to place and situation to situation. Availability of the service and affordability of the treatments are two significant factors closely inter-linked with each other. The size of family, sources of income and the expenses of the family have very complex phenomenon. Treatment of mental retardation is always costly and expensive. In most of the cases, the economic condition doesn't permit to spent large amount on medical treatment, when the resources are very limited. If they do not get adequate treatment in time, the problems may result in some other complexities. Considering economic condition of the rural population, it is very difficult to spend any amount from their regular income for medication. Generally, we observed that, due to poverty, they can't afford medical treatment and if they can't afford medical treatment, the problem further gets aggravated.

TABLE NO. 4.13
DISTRIBUTION OF THE RESPONDENTS ACCORDING TO
MONTHLY EXPENSES

Village	MONTHLY EXPENSES			
	< 1000	1001 - 2000	Unable to say	Total
Ahmedpur	8	11	10	29
	27.6%	37.9%	34.5%	100.0%
Latur	7	14	16	37
	18.9%	37.8%	43.2%	100.0%
Nilanga	16	10	9	35
	45.7%	28.6%	25.7%	100.0%
Total	31	35	35	101
	30.7%	34.7%	34.7%	100.0%

Chart No. 4.10

Monthly Expenditure on Mentally Retarded Child



It is seen from the above table that, about 30% of the families are spending less than 1000 rupees on medication. In Ahmedpur and Latur, more or less same trend have been observed as per the medical expenses but in Nilanga, considerably large number of the families are spending up to Rs. 1000 per month on medication of their child. About 35% of the respondents are spending One-two thousands of rupees on medication. In this category also, no any variation between blocks have been observed in study population, but there is a large variation have been observed in last category, i.e. unable to say. In all

population, about 35% of the respondents are not able to mention specific amount they spend on medication of a child. In brief it is to say that there is a considerably large amount that the villagers are affording for proper treatment of a child.

Summary

In this chapter, the detail about various factors associated with mental retardation is discussed in detail. It is known fact that mentally retarded individuals are at risk for the development of wide variety of emotional and behavioural disorders. The magnitude and importance of this problem have been emphasized by two relatively recent trends, i.e. de-institutionalization and mainstreaming of the retarded person and second one the development of separate service delivery system for disabled and mentally ill person. In this view, various factors have been discussed in detail. Particularly, the factors associated with the delivery of a child and its relation with mental retardation. This includes age of mother at marriage, father's age at marriage, illness during pregnancy, still birth, history of mental retardation, Consanguineous marriages, relation before marriage between mother and father, abortion, X-ray Exposure etc.

As regard to the age at marriage of the mother, it was found that about 53% of the mothers got married before they attain the age of eighteen years. About 25% of mothers were below 16 years. Whereas, in case of the age of father, it was observed that about 15% have got married up to 18 years old, 45% were 19-35 years, 18% were 36-40 years and 22% were more than 40 years. This indicates that among males late marriages are prominently observed whereas in females, early marriages were prominently observed. It was found that during pregnancy, there was hardly any problem. Only 6% of the respondents have reported that they had some problems during pregnancy. Only 3% of the respondents have the history of still birth in earlier delivery while the history of mental retardation either from mother's side or father's side is observed to be considerably high. 23% of the respondents have history of mental retardation. Among them, 3% have the history of mental retardation in father's family. This indicates that these individuals have genetic deformities. Very prominent observation is observed as regard to consanguineous marriages, which is about 72% high in all the cases. This

indicates that 72% of the couples have earlier relations between them. These relations are either cross-cousin (63%), Son of maternal aunt (26%) and 10% maternal uncle.

Abortion is observed to be the prominent in all the cases. About 95% of the respondents have reported they have the history of abortion and very significant number of the respondents has reported that they had exposure of X-ray. Addiction is observed to be prominent among the mothers and the mishery, which is made up of tobacco is the main type of addiction. The expenses varies from, families to families on the treatment of mentally retarded child. However these expenses are exclusively based on the economic condition of the family. In brief, this chapter provides the brief assessment of various factors related to mental retardation.

CHAPTER FIVE

HEALTH, LIVING CONDITIONS AND BEHAVIOURAL PROBLEMS OF MENTALLY RETARDED CHILDREN

After fulfilling nine months of progress in the womb of mother, now the child is ready to come out to the world. During the time of delivery, the mother gets labour pain, which is the significant indication that the child is now prepared to come out. Sometimes, the child might get delay in delivery, due to certain circumstances such as unskilled birth attendants or even lack of birth attendants, the instrument they use, the age of mother, mother's health status, nutritional status, family's socio-economic status, environmental condition etc. For delivery, much trained Birth attendant is needed either Traditional Birth Attendant or Medically trained attendant. If they are unavailable during delivery, then there are more chances of delay in delivery. This causes to suffocation to the child in the womb. Child can't get enough oxygen to the brain, so that mental retardation is bound to occur.

Similarly, the position of child in the womb also leads to delay in delivery. If child is in normal position, there is less chance to stick in the cervix during delivery, but if it is opposite then, the shoulders of the child make problem to come out. As child does not get enough oxygen in the brain, some sort of malfunction in the brain is bound to occur. /use of forceps during delivery can also leads to various mental retardation including Dawn's Syndrome, Cerebral Palsy etc.

f the mother has got pregnancy in early age, then the cervix is not matured and from the narrow way, the child get problem in delivery. In this case, either the vulnerability to death or vulnerability to get any type of mental of physical deformities is very high.

The superstitious beliefs may also lead to the vulnerability to mother and child. Socio-economic condition of the family and type of nutritious food, she got during pregnancy also determines the health status of the child and complexities during delivery.

5.1 Condition during delivery:

The condition of the child, during pregnancy matters a lot, what type of delivery the child will be having. If child is in normal position, there might be less vulnerability during delivery. But, if the position of the child is other way around, and legs come first than head, then the shoulders of the child creates problem to come out totally from womb. Child needs external oxygen soon after child is excluded from placenta, and in normal position, it takes time to get external oxygen. The brain can't get enough oxygen, which definitely leads to any sort of disability. Most of the women in developing countries deliver child in own home, so they can't get proper and timely treatment of any delivery complications.

TABLE NO. 5.1
DISTRIBUTION OF THE RESPONDENTS ACCORDING TO
CONDITION DURING DELIVERY

Village	CONDITION DURING DELIVERY			
	General	Complicated	Illness	Total
Ahmedpur	19	9	1	29
	65.5%	31.0%	3.4%	100.0%
Latur	32	5	0	37
	86.5%	13.5%	0.0%	100.0%
Nilanga	28	6	1	35
	80.0%	17.1%	2.9%	100.0%
Total	79	20	2	101
	78.2%	19.8%	2.0%	100.0%

It is observed from the above table that 78% of the deliveries of the respondents are normal, whereas complications have been occurred among 20% of the deliveries and

2% of the mother were ill during pregnancy. Large variations have been observed ranging from 13-31% of the respondents. In Ahmedpur, 31% respondents were reported they had complications during delivery followed by 17% in Nilanga and about 14% in Ahmedpur. The illness is not observed in most of the cases. Only two respondents have reported that they were ill during delivery. Therefore, one can conclude that considerable number of complications has been occurred during delivery. It is quite obvious that in rural areas most of the deliveries are conducted at home. Naturally, the complications are bound to happen.

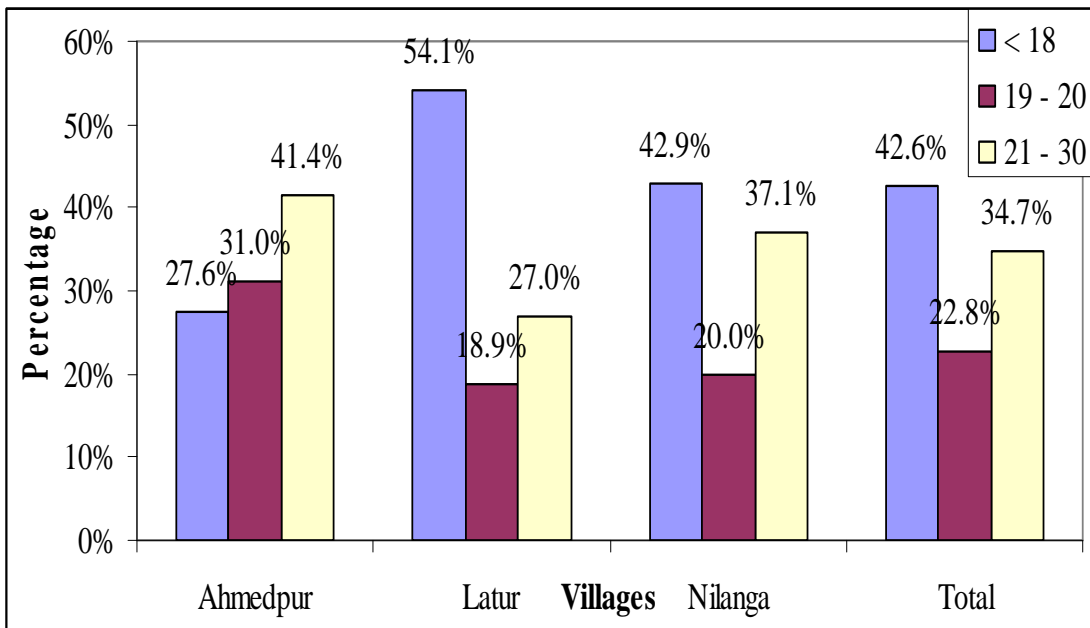
5.2 Age of mother at delivery

The age of mother during pregnancy and delivery is the significant factor, which may cause to mental retardation of the child. Generally, the fertility period of any woman starts at 15 and ends at 49 years. But it is not that, one can give birth in 15 years or in 49 years. One should get mature reproductive organ before giving birth and also the reproductive organs get deteriorated in late fertility period after 40 years. So, it is not appropriate to give birth to the child in this period as well. If it is not, then the foetus gets problem in growth and development in the womb. In addition, due to narrow cervix, the child gets problem in delivery as well. Her organs are not so developed that she can tolerate the extreme labour pain. The complication is added more due to narrow cervix. The delivery can be delayed, child is unable to get adequate oxygen which leads to brain dysfunction and mental retardation in child or child sticks in cervix and the Birth Attendant is forced to apply external force to take out the child. Pulling out by forceps or hands gives more pressure to the head of the child, which may also lead to mental retardation in the child.

TABLE NO. 5.2 A
DISTRIBUTION OF THE RESPONDENTS ACCORDING TO
MOTHER'S AGE AT DELIVERY

Village	MOTHERS AGE AT DELIVERY			
	< 18	19 - 20	21 - 30	Total
Ahmedpur	8	9	12	29
	27.6%	31.0%	41.4%	100.0%
Latur	20	7	10	37
	54.1%	18.9%	27.0%	100.0%
Nilanga	15	7	13	35
	42.9%	20.0%	37.1%	100.0%
Total	43	23	35	101
	42.6%	22.8%	34.7%	100.0%

Chart No.
Mother's Age at Delivery



The overall picture shows that about 43% of the mothers' age at first delivery was below 18 years and about 23% of the mothers' age was ranging between 19-20. One point is to be noted here that, in early age, if the complications have been developed during delivery, chances of getting mental retardation to the baby are always more. In Ahmedpur, the proportion of younger age in delivery is considerably low as compared to other two blocks, i.e. Latur and Nilanga. The more than half of the women deliver their first child, when they were below 18 years of age. As regard to the age group of 19-20, Latur and Nilanga have shown the same trend, whereas in Ahmedpur about 31% of the mothers had 19-20 years age in their first delivery. In brief it is to say that about 2/3 of the respondents had given birth to the child when they are not totally fit for delivery. From this table one can draw the conclusion that early age of delivery is one of the most important factors which have direct bearing on the incidence of retardation in rural areas.

Table No. 5.2 B
Distribution of Respondents According to
Mothers' Age at Birth vs. Condition during Delivery

		MOTHERS AGE AT BIRTH			Total
		Below 18	19-20	21-30	
CONDITION DURING DELIVERY	General	31	17	31	79
		39.24	21.52	39.24	100.00
	Complicated	10	6	4	20
		50.00	30.00	20.00	100.00
	Illness	2	0	0	2
		100.00	0.00	0.00	100.00
Total		43	23	35	101
		42.57	22.77	34.65	100.00

It is found that lesser the age of women at the delivery, chances of complication in delivery are more and the above table clearly indicates about this situation.

Table No. 5.2 C

Distribution of Respondents According to Mothers' Age at Birth vs. Abortion

		MOTHERS AGE AT BIRTH			Total
		Below 18	19-20	21-30	
ABORTION	Yes	2	1	2	5
		40.00	20.00	40.00	100.00
	No	41	22	33	96
		42.71	22.92	34.38	100.00
Total		43	23	35	101
		42.57	22.77	34.65	100.00

Very significant observation is observed that in early age, the abortions are more. This may be due to that reproductive organs might not be physically mature to deliver a child. From this table, one can conclude that lesser the age of delivery, more the chances of complications.

Table No. 5.2 D

Distribution of Respondents According to Mothers' Age at Birth vs. Condition during Pregnancy

		MOTHERS AGE AT BIRTH			Total
		Below 18	19-20	21-30	
CONDITION DURING DELIVERY	General	31	17	31	79
		39.24	21.52	39.24	100.00
	Complicated	10	6	4	20
		50.00	30.00	20.00	100.00
	Illness	2	0	0	2
		100.00	0.00	0.00	100.00
Total		43	23	35	101
		42.57	22.77	34.65	100.00

It is seen from the above table that 50% of the mothers those who are below 18 years have complication during pregnancy. This is one of the most important observations as regard to mental retardation.

The details about the place of delivery are shown in next table.

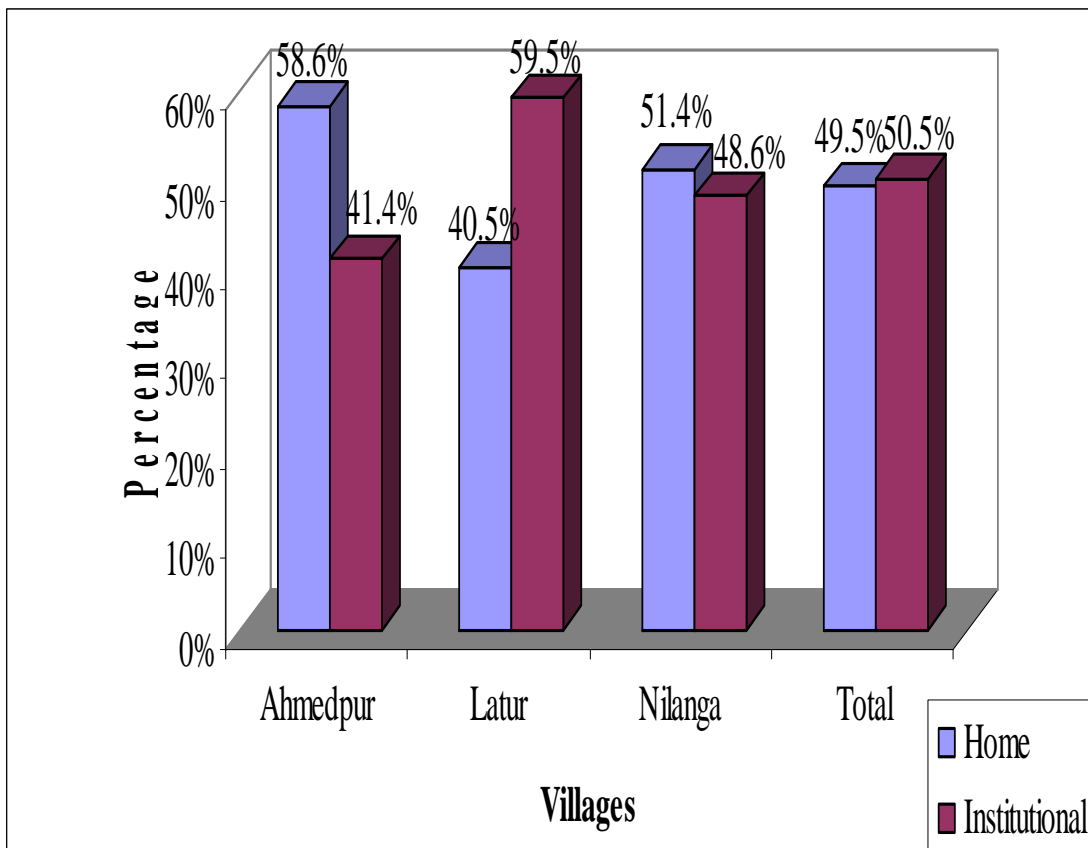
5.3 Place of delivery:

Place of delivery determines the health condition of the child. In developing countries, more than 90 percent deliveries are done in home only or even in the cowshed in some of the tribal and ethnic groups. In case of home delivery, there are no proper instruments or facilities available to prevent or cure the complication. If child gets delay in delivery, the tradition birth attendant couldn't take any action due to lack of skills and confidence. In those circumstances, taking the woman to Health Post of hospital also takes time after getting complication. It can make delivery more delayed and the more delay may lead to more vulnerability to mental retardation.

TABLE NO. 5.3
DISTRIBUTION OF THE RESPONDENTS ACCORDING TO PLACE OF
DELIVERY

Village	PLACE OF DELIVERY		
	Home	Institutional	Total
Ahmedpur	17	12	29
	58.6%	41.4%	100.0%
Latur	15	22	37
	40.5%	59.5%	100.0%
Nilanga	18	17	35
	51.4%	48.6%	100.0%
Total	50	51	101
	49.5%	50.5%	100.0%

Chart No. 5.1
Place of Delivery



It is seen from the above table that, about 50% of the deliveries are taking place at home and 50% at hospitals and clinics. In Latur, institutional deliveries are more, whereas in Ahmedpur, home deliveries considerably large in number. The place of delivery has direct bearing on mental retardation, because at home based deliveries, the chances of developing complications are more. In brief it is to say that even today, though the government is providing the facilities for safe deliveries, there are considerable number of deliveries being conducted at home. From this table, one can conclude that there is hardly any impact of medical facilities on the deliveries or the women even today prefer to conduct their deliveries at home only. The detail about the person conducted delivery is discussed in next table.

Table No.
Distribution of Respondents According to
Place of Delivery vs. Condition during Delivery

		PLACE OF DELIVERY		Total
		Home	Institution	
CONDITION DURING DELIVERY	General	44	35	79
		55.70	44.30	100.00
	Complicated	4	16	20
		20.00	80.00	100.00
	Illness	2	0	2
		100.00	0.00	100.00
Total		50	51	101
		49.50	50.50	100.00

The above table indicates that considerable numbers of the deliveries that have been taken place at home without any complications. This might be the perception of the mothers. However, the controversial observation is observed, complications are more in institutionalized deliveries. Perhaps there are the chances that, if there is a possibility of the complications as suggested by the doctors, deliveries may be conducted in institutions. Hence, the complications are more in the institutionalized deliveries.

5.4 Attendant of the delivery:

Attending the delivery is not a simple task. They need proper training and quick decision skills. In home delivery, the traditional birth attendant is only available in most of the cases. These TBAs are generally traditional and are not trained. They might have superstitious and traditional ways of delivering a baby. The position of mother to give delivery is also very important and the knowledge should be there with the attendant.

When child gets any complication in delivery, the TBA doesn't have any knowledge what should be done and what should not be done. They pressurize mother to deliver

baby or try to use external forces to pull out the child. In this case, the fragile child is forced to get pain. This process may lead to any brain dysfunction in the child.

TABLE NO. 5.4
DISTRIBUTION OF THE RESPONDENTS ACCORDING TO
ATTENDANT IN DELIVERY

Village	ATTENDANT IN DELIVERY						
	Dai	Mother	Mother-in-Law	Trained Dai	Traditional Birth Attendant	Doctor	Total
Ahmedpur	5	10	2	0	3	9	29
	17.2%	34.5%	6.9%	0.0%	10.3%	31.0%	100.0%
Latur	7	7	0	1	6	16	37
	18.9%	18.9%	0.0%	2.7%	16.2%	43.2%	100.0%
Nilanga	0	15	2	1	3	14	35
	0.0%	42.9%	5.7%	2.9%	8.6%	40.0%	100.0%
Total	12	32	4	2	12	39	101
	11.9%	31.7%	4.0%	2.0%	11.9%	38.6%	100.0%

It is seen from the table above that, the deliveries which have been taken place either in hospital or in maternity homes have been attended by either doctor or trained person, but at home there is hardly any trained person. In Ahmedpur and Latur about 18% deliveries have been conducted by trained Dais, whereas 43% deliveries in Nilanga, 35% in Ahmedpur and 19% in Latur have been conducted by the mother. It is to be noted here that, the first delivery is usually conducted at native house, there are only 4% respondents who have responded that their mother in law have conducted their deliveries. Very surprising observation is observed that only 2% deliveries have been conducted by trained dais and 12% have been conducted by Traditional Birth Attendant. The deliveries that have been taken place in the clinics and hospitals have been attended by doctors.

5.5 Advice from medical doctor:

Prenatal care is very important during pregnancy for both mother and baby. It is appropriate to visit the doctor at least for four times, so that mother is able to know the real condition of mother and child. She can also get advice and information about vitamin supplementation, immunization, what should be done and what should not be done etc. The proper counselling of doctor can make mother able to plan for the child.

TABLE NO. 5.5
DISTRIBUTION OF THE RESPONDENTS ACCORDING TO
ADVICE OF DOCTOR DURING PREGNANCY

Village	ADVICE OF DOCTOR IN PREGNANCY		
	Yes	No	Total
Ahmedpur	22	7	29
	75.9%	24.1%	100.0%
Latur	31	6	37
	83.8%	16.2%	100.0%
Nilanga	23	12	35
	65.7%	34.3%	100.0%
Total	76	25	101
	75.2%	24.8%	100.0%

During pregnancy, it is expected that a woman should take the advice of medical doctor to avoid complications of the delivery. The above table shows, in Ahmedpur 75% women have sought advice from doctor, whereas in Latur, 84% of the women have sought advice from doctor. As compared to Ahmedpur and Latur, in Nilanga only 65% respondents have sought advice from doctor. None of single respondents have given any specific reason for not getting the advice, but the general trend is observed that medical facilities are not easily accessible or if the doctor provide any medicine they may not be able to purchase these medicines due to poor economic condition. In Nilanga, larger proportion of the women have, they have not sought advice followed by Ahmedpur 24% and Latur

16%. The detail about the advice and the recommended medicine are discussed in following table. However, in brief one can say that due to non-accessibility of health services, villagers are not seeking advice from trained doctor.

5.6 Vitamin Supplementation during pregnancy:

During pregnancy, the mother increases weight till 11 kilograms. She needs nutrition for both child and herself. The foetus in the womb extracts each and everything whatever needed from mother's body and doesn't care of mother's body. In this process, the mother may get malnutrition. To cover up all those lacks, the mother needs extra vitamin supplementation which includes iron, calcium, folic acid, vitamin 'B' Complex etc. Iron prevents anaemia, calcium for physical development and folic acid for increment in blood circulation. The Vitamin 'B' Complex is needed for total development of mother and child. If all the supplementations are not provided to mother during pregnancy, the total development of child is affected, and developing brain and other organs leads to mental retardation or physical deformity.

TABLE NO. 5.6 A
DISTRIBUTION OF THE RESPONDENTS ACCORDING TO
TABLETS DURING DELIVERY

Village	TABLETS DURING DELIVERY		
	Yes	No	Total
Ahmedpur	23	6	29
	79.3%	20.7%	100.0%
Latur	32	5	37
	86.5%	13.5%	100.0%
Nilanga	25	10	35
	71.4%	28.6%	100.0%
Total	80	21	101
	79.2%	20.8%	100.0%

In continuation of the earlier discussion, about 80% of the women have been taken the tablets of vitamin mainly calcium, iron and folic acids. Perhaps, these are the basic requirements for safe delivery. The women who sought the advice during pregnancy have got the medicine from the doctor, but those who couldn't contact to the doctor have failed to take the medicine. Naturally the chances of developing complications during pregnancy are more among such women. Therefore it is very essential not only to seek the advice but to follow the medication as prescribed by doctor is very essential the further complication during child birth and to avoid the disability.

Table No. 5.6 B

Distribution of Respondents According to Tablets during Pregnancy vs. Abortion

		TABLETS DURING DELIVERY		Total
		Yes	No	
ABORTION	Yes	4	1	5
		80.00	20.00	100.00
	No	76	20	96
		79.17	20.83	100.00
Total		80	21	101
		79.21	20.79	100.00

Those who have not followed the advice of doctor or not had tablets as suggested by doctor, the incidences of abortions are always more. In brief, during pregnancy, one has to follow the advice of doctor to have tablets.

5.7 Birth weight of baby:

The weight of the baby during birth is the proof that what type of growth the baby got during pregnancy. If the mother gets nutritious food, then the foetus also gets nutrition in equal ratio to grow physically and mentally. If the child is underweight, the total development of child is not full. Malnutrition during the period of Cephalocaudal and Proximo-distal growth leads to physical or mental deformity.

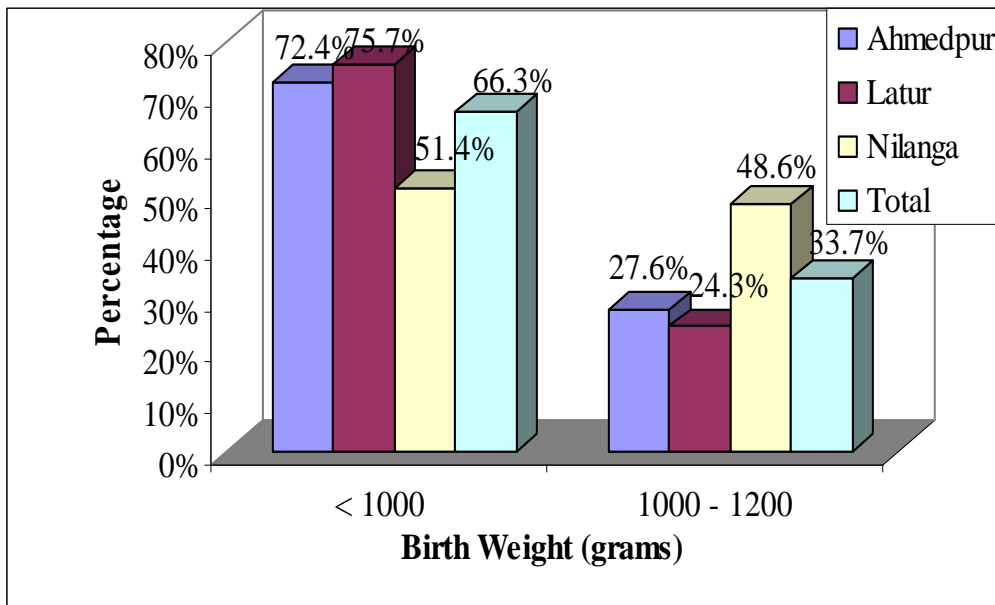
TABLE NO. 5.7

DISTRIBUTION OF THE RESPONDENTS ACCORDING TO BIRTH WEIGHT

Village	BIRTH WEIGHT		
	< 1000	1000 - 1200	Total
Ahmedpur	21	8	29
	72.4%	27.6%	100.0%
Latur	28	9	37
	75.7%	24.3%	100.0%
Nilanga	18	17	35
	51.4%	48.6%	100.0%
Total	67	34	101
	66.3%	33.7%	100.0%

Chart No. 5.2

Birth Weight of Mentally Retarded Child



One of the most significant observation is observed from the above table is that, about 1/3 of the respondents have reported that the weight of the baby at birth was below 1000gms. In Ahmedpur and Latur, about 75% of the respondents have reported that their weight of birth was less than 1000gms, whereas half of the respondents from Nilanga have reported the weight less than 1000gms. As regard to the birth rate, the proportion of the respondents, whose baby's birth weight was ranging from 1000-1200gms is considerably high in Nilanga. In brief it is to say that significant number of the babies took birth below the standards of birth weight as suggested by WHO.

5.8 Completion of all trimester:

The growth and development of foetus during first trimester leads to cephalocaudal and proximo-distal direction. It is also period of rapid growth, where each and every organ of human body is developed. In the second trimester, the developed organ starts to function gradually and in third trimester, the organs get maturity. In this sense, each trimester has own significance in developing human body. If any problem occurs during any of these trimesters in mother, it has significant effect on development of foetus, which may be mental or physical. The child may get any type of disability.

In another case, if the child takes birth before the completion of all trimester, the child is premature birth and premature babies have premature organs, including brain, which can also affect on mental disorder and mental retardation. These children have very low immunity power and have more chance to get any of the childhood disease and infection.

TABLE NO. 5.8 A
DISTRIBUTION OF THE RESPONDENTS ACCORDING TO
COMPLETION OF TRIMESTER

Village	COMPLETION OF TRIMESTER		
	Yes	No	Total
Ahmedpur	14	15	29
	48.3%	51.7%	100.0%
Latur	16	21	37
	43.2%	56.8%	100.0%
Nilanga	11	24	35
	31.4%	68.6%	100.0%
Total	41	60	101
	40.6%	59.4%	100.0%

It is seen from the above table that only 40% of the women have completed their all trimesters and 60% could not. In Ahmedpur, about half of the mothers have completed their all trimester followed by 43% in Latur and only 31% in Nilanga. One of the most important observation is that as age of mother at delivery is very low, they may not be competent to complete their all the trimesters. Delivery before time always creates the problem and therefore chances of getting disability are always higher. One of the most critical conditions during premature delivery is use of forceps for delivery. In this condition, chances to get sufficient oxygen to the new born are always less. Hence, mental retardation is bound to happen. In brief it is to say that premature deliveries are considerably high among the women whose age at delivery is very less.

**Table No. 5.8 B Distribution of Respondents According to
Completion of Trimester vs. Birth Weight**

		COMPLETION OF TRIMESTER		Total
		Yes	No	
BIRTH WEIGHT (in grams)	Below 1000	30	37	67
		44.78	55.22	100.00
	1000-1200	11	23	34
		32.35	67.65	100.00
Total		41	60	101
		40.59	59.41	100.00

Very significant observation is observed from the above table that 60% of the women have not completed their trimester. Among them, more than half of the women had delivered extremely low birth weight babies. Whereas, about 68% of the women who could not complete their all trimester had birth weight ranging between 1000-1200 gms. This indicates that there is a close relationship between completion of trimester and birth weight of the baby.

**Table No. 5.8 C Distribution of Respondents According to
Completion of Trimester vs. Mothers' Age at Birth**

		COMPLETION OF TRIMESTER		Total
		Yes	No	
MOTHERS AGE AT BIRTH	Below 18	19	24	43
		44.19	55.81	100.00
	19-20	10	13	23
		43.48	56.52	100.00
	21-30	12	23	35
		34.29	65.71	100.00
Total		41	60	101
		40.59	59.41	100.00

The women who have not completed their all the trimesters are mainly below 18 years of age. This clearly shows that physical maturity is important to bear the child.

5.9 Active movement soon after birth:

The child should cry soon after birth and should move the limbs. If the child is not doing so, then it is understood that there must be some problem with child. If the delivery is done in hospital, then the doctor tries best to make child conscious or make child cry, and this prevents some vulnerability. But in case of home delivery, the TBAs don't have proper knowledge and skill as the doctors. This may lead to vulnerability to mental retardation.

TABLE NO. 5.9
DISTRIBUTION OF THE RESPONDENTS ACCORDING TO
CRYING SOON AFTER BIRTH

Village	CRYING SOON AFTER BIRTH		
	Yes	No	Total
Ahmedpur	25	4	29
	86.2%	13.8%	100.0%
Latur	35	2	37
	94.6%	5.4%	100.0%
Nilanga	26	9	35
	74.3%	25.7%	100.0%
Total	86	15	101
	85.1%	14.9%	100.0%

Crying is one of the symptom of baby is alright. There are no any complications. Usually, child cries immediately after the birth. From the above table, 85% of the mentally retarded children cried immediately after birth. However, there is large variation between various blocks. In Ahmedpur, 86% children cried soon after birth followed by 74% in Nilanga and highest proportion, i.e. 95% in Latur. It seems that, there are no any other complications, which has been taken place during intra-uterine condition. It may

take some time to recognize mental retardation by the family members. In brief it is to say that after delivery; most of the children have given appropriate body response.

5.10 First feeding after birth:

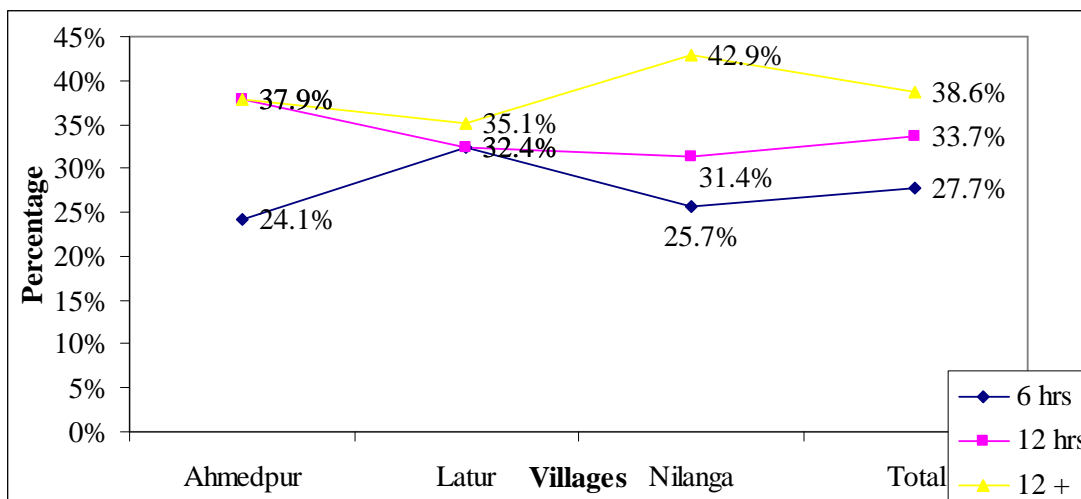
In some of the tribal group and in rural areas, the mothers are not supposed to feed the first milk to the child, so they don't feed. In fact, the first milk is fully nourished for child to develop immune system from the very beginning. So, it is the foundation of development of immune system. Those children, who don't get first milk are prone to diseases in one hand and in other hand and also could not develop their brain properly and can get various mental and physical retardation on the other hand.

In some of the tribal groups, it is also prevalent that the mothers are not supposed to feed the child some days due to superstitious reasons. In many of the cases, due to malnutrition, the mother doesn't get milk to feed the child in the beginning of the days after birth.

TABLE NO. 5.10 A
DISTRIBUTION OF THE RESPONDENTS ACCORDING TO TIME OF FIRST FEEDING

Village	TIME OF FIRST FEEDING			
	6 hrs	12 hrs	12 +	Total
Ahmedpur	7	11	11	29
	24.1%	37.9%	37.9%	100.0%
Latur	12	12	13	37
	32.4%	32.4%	35.1%	100.0%
Nilanga	9	11	15	35
	25.7%	31.4%	42.9%	100.0%
Total	28	34	39	101
	27.7%	33.7%	38.6%	100.0%

Chart No. 5.3
Time of First Feeding



The table above, it is seen that there is large variation of the first feeding of the new born baby. It is expected that the child should get first feed immediately after birth, but in rural areas, there are several misconceptions about first feeding. As the colostrums is thick in the beginning, there is wrong belief that it becomes very difficult for digestion of thick colostrums and hence the baby may get problem in his latter life. It is seen from the table that in Ahmedpur only 24% respondents have given first feed within 6 hours. In Latur, 32% have given first feed within 6 hours whereas in Nilanga, only 1/4 of the total mothers have given first feed within 6 hours. There is a large variation observed in the first feed. When the probing question was asked why the first feed within 1-2 hours, they got responses as the condition of mother was bad, hence she could not give feeding to the baby. There are 34% of the total respondents, who have reported that they have given feeding after 12 hours. The Nilanga and Latur have shown more or less same trend, whereas in Nilanga, it was comparatively larger proportion. The feed after 12 hours is always harmful, because the baby needs energy within 3-4 hours only. The extortive movement of the baby requires high demand for energy. In all the blocks, about 38% of the women have given first feed after 12 hours. No large variation has been observed between blocks. However, in Ahmedpur about 38%, in Latur 35% and in Nilanga 43% of the respondents have given first feed after 12 hours.

Table No. 5.10 B
Distribution of Respondents According to
Birth Weight vs. Time of First Feeding

		BIRTH WEIGHT (grams)		Total
		< 1000	1000-1200	
TIME OF FIRST FEEDING	6 hrs	19	9	28
		67.86	32.14	100.00
	12 hrs	24	10	34
		70.59	29.41	100.00
	> 12 hrs	24	15	39
		61.54	38.46	100.00
Total		67	34	101
		66.34	33.66	100.00

It was found that, whose weight was less than 1000 gms at birth, mother has given the first feed after 6 hours and there are about 70% of mothers in this category had given within 12 hours and the equal proportion of mothers had given after 12 hours.

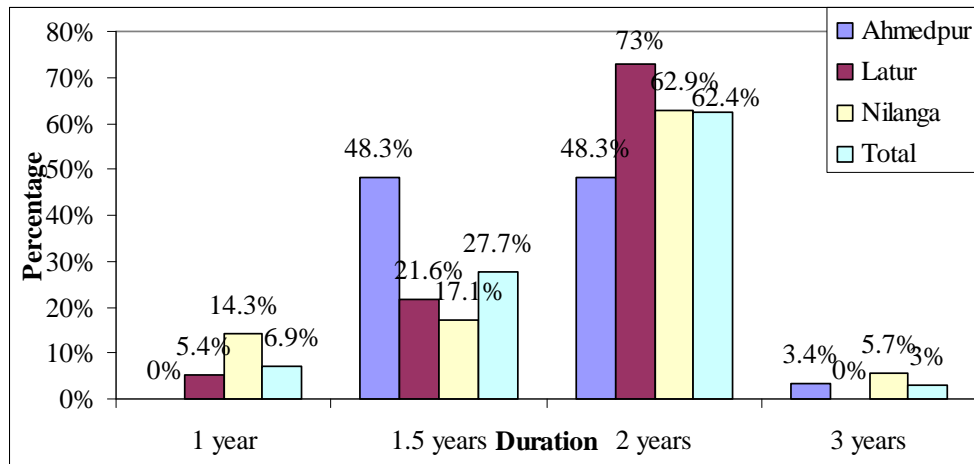
5.11 Duration of Breast Feeding:

Breast feeding is the most important nutritious element for the human body in the early life. It not only feed the child, but also develops proper immune system in the human body. For six months after birth, the child is solely dependent on mother’s milk. Then, the child starts to have some liquid and semi liquid food. The child who doesn’t get proper lactation from mother, they are prone to various diseases and also, their mental growth doesn’t go properly, which can lead to any mental deformity.

TABLE NO. 5.11
DISTRIBUTION OF THE RESPONDENTS ACCORDING TO
DURATION OF BREAST FEEDING

Village	DURATION OF BREAST FEEDING (YEARS)				
	1	1.5.	2	3	Total
Ahmedpur	0	14	14	1	29
	0.0%	48.3%	48.3%	3.4%	100.0%
Latur	2	8	27	0	37
	5.4%	21.6%	73.0%	0.0%	100.0%
Nilanga	5	6	22	2	35
	14.3%	17.1%	62.9%	5.7%	100.0%
Total	7	28	63	3	101
	6.9%	27.7%	62.4%	3.0%	100.0%

Chart No. 5.4
Duration of Breast Feeding



It is seen from the table that about 1/3 of the respondents have fed their child for more than 2 years. About 28% were breast fed for 1.5 years and hardly 7% have fed for 1 year. Large variations have been observed between blocks. In Latur, about 5% and in Nilanga about 14% mothers have given breast fed for one year to their child.

Considerably high proportion was observed for the duration of 1.5 years. About half of the respondents of Ahmedpur have given breast fed for more than 1.5 years followed by 21% in Latur and 17% in Nilanga. However, highest proportion of all the respondents have given breast fed for more than 2 years in all blocks. About 50% of the respondents for Ahmedpur, 73% respondents from Latur and 63% respondents from Nilanga have given breast fed to a child. From this table one can conclude that as an average the breast feeding period ranges between 18-24 months in all the blocks. The above observations are more serious because after one month, child increases his energy requirement and mother's milk cannot meet his requirement. Naturally, in very early age, the child enters into the state of malnutrition and it continues in latter life. In brief, it is to say that child nutrition is extremely poor in all the blocks.

5.12 Information about MMR

Rubella is German measles, and it is the most dangerous disease for foetus during first trimester. First trimester is important for the development of all the organs of human body in the foetus. The direction of development in this period is Cephalocaudal and Proximo-distal. If the mother gets Rubella Infection during the first trimester of pregnancy, then body organ development becomes incomplete and the brain is also not properly developed. If the mother gets TT (Tetanus Toxin) and MMR (Measles, Mumps and Rubella) Vaccination during or before pregnancy, then there is less chance to get Rubella Infection. Rubella doesn't affect in mother but the total consequences are seen in the new born child.

TABLE NO. 5.12
DISTRIBUTION OF THE RESPONDENTS ACCORDING TO
INFORMATION ABOUT MMR

Village	INFORMATION ABOUT MMR		
	Yes	No	Total
Ahmedpur	2	27	29
	6.9%	93.1%	100.0%
Latur	3	34	37
	8.1%	91.9%	100.0%
Nilanga	6	29	35
	17.1%	82.9%	100.0%
Total	11	90	101
	10.9%	89.1%	100.0%

The above table indicates the information about MMR. Hardly, 7% respondents in Ahmedpur, 8% in Latur and 17% in Nilanga have information about MMR immunization. Mumps, Measles and Rubella immunization is to be taken by mother during her pregnancy to avoid the complications and infection of these diseases of her new born babies. However, 90% of the women from all the blocks are not aware about this immunization. However, chances of immunization are very less.

A probing question was asked about whether they are immunized for MMR during pregnancy. The details are given in following table:

TABLE NO. 5.13 A
DISTRIBUTION OF THE RESPONDENTS ACCORDING TO
IMMUNIZATION OF MMR

Village	IMMUNIZATION OF MMR		
	Yes	No	Total
Ahmedpur	0	29	29
	0.0%	100.0%	100.0%
Latur	2	35	37
	5.4%	94.6%	100.0%
Nilanga	3	32	35
	8.6%	91.4%	100.0%
Total	5	96	101
	5.0%	95.0%	100.0%

In continuation of the earlier table about 95% of the women have not taken MMR immunization during their pregnancy. Very few mothers, i.e. 5% in Latur and 9% in Ahmedpur have taken MMR during their pregnancy period. While collecting data, it was observed that as high illiteracy is prevalent among the women, it was not possible to learn or to get information about MMR. The second reason put forward by most of the reason is that it is not available either in village or in nearby area. Hence, they have not taken it. This situation may create the problem among the babies in their later life. Indeed, it is one of the most important reasons for mental retardation in children.

Table No. 5.13 B
Distribution of Respondents According to
Information about MMR vs. Immunization of MMR

		INFORMATION ABOUT MMR		Total
		Yes	No	
IMMUNIZATION OF MMR	Yes	5	0	5
		100.00	0.00	100.00
	No	6	90	96
		6.25	93.75	100.00
Total		11	90	101
		10.89	89.11	100.00

About 94% of women are not aware about MMR immunization hence they have not immunized their children.

5.13 General Immunization:

Soon after birth till 9 months, the child should be provided with different types of immunization to build immunity power to fight with diseases. The vaccination includes BCG, DPT, Measles, Polio, Hepatitis etc. If the right immunization is not provided to the child, child gets more vulnerable to several diseases. The post-effect of any disease during childhood leads to various physical and mental disability. Most of the children who get measles during childhood have post effect as Visual Impairment, chill and fever has post effect as hearing impairment etc. There are so many diseases which lead to mental retardation as well. So, the immunization to develop immune system and capacity to fight with any disease in the child is very important.

TABLE NO. 5.14 A
DISTRIBUTION OF THE RESPONDENTS ACCORDING TO
GENERAL IMMUNIZATION

Village	IMMUNIZATION OF BABY IN TIME		
	Yes	No	Total
Ahmedpur	25	4	29
	86.2%	13.8%	100.0%
Latur	35	2	37
	94.6%	5.4%	100.0%
Nilanga	28	7	35
	80.0%	20.0%	100.0%
Total	88	13	101
	87.1%	12.9%	100.0%

The above table shows that the status of general immunization in study population. It is observed that the situation about general immunization is considerably better; perhaps it is a good status. In Ahmedpur, about 86% respondents have taken general immunization, which consists of Polio, Tetanus, Diphtheria, Pertusis, and Tuberculosis etc. In Latur, about 95% children have been covered under general immunization and in Nilanga, more than 80% have been covered under general immunization, the overall trend shows that about 90% of the children in study population have been covered under general immunization program. This might be due to the impact of Pulse Polio Program, which is being implemented since 1993.

Table No. 5.14 B
Distribution of Respondents According to
Education vs. Immunization of baby in time

		EDUCATION					Total
		Illiterate	Primary	Secondary	HSC	Graduation	
IMMUNIZATION OF BABY IN TIME	Yes	32	12	21	10	13	88
		36.36	13.64	23.86	11.36	14.77	100.00
	No	6	4	1	1	1	13
		46.15	30.77	7.69	7.69	7.69	100.00
Total		38	16	22	11	14	101
		37.62	15.84	21.78	10.89	13.86	100.00

From the above table, it is seen that, illiteracy is the main cause for not immunizing their children. In the above table, about 76% of the women are either illiterate or had the education up to Primary level. This is quite obvious that the educated women always prefer her children to be immunized to protect from the diseases.

5.14 Family Planning:

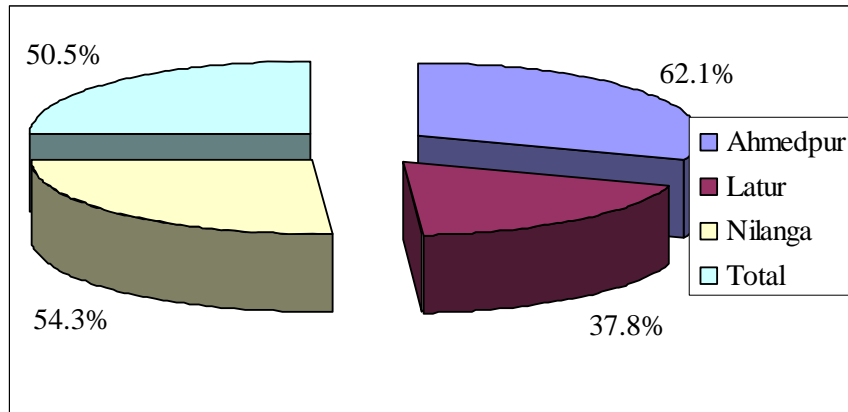
Mother's mental status during pregnancy is also considered a significant factor. If mother is not mentally prepared to bear a child, then the negative feeling towards child may effect on development of child. Many times the birth spacing between two children also caused to mental retardation. Neither it should be short or so long. Side by side the side-effects of the various contraceptives also lead to problems during pregnancy.

TABLE NO. 5.15 A

DISTRIBUTION OF THE RESPONDENTS ACCORDING TO FAMILY PLANNING

Village	FAMILY PLANNING		
	Yes	No	Total
Ahmedpur	18	11	29
	62.1%	37.9%	100.0%
Latur	14	23	37
	37.8%	62.2%	100.0%
Nilanga	19	16	35
	54.3%	45.7%	100.0%
Total	51	50	101
	50.5%	49.5%	100.0%

Chart No. 5.5
Family Planning



It is seen from the above table that about half of the respondents are following various methods of family planning and half of them are not following any type of family planning methods to control the birth. In Latur, hardly 37% of the respondents are following family planning methods followed by in Nilanga about 55% and in Latur about 62%. Large variations have been observed in this regard. However, the Latur have shown

very poor performance about the family planning practices among all the villagers. A probing question was asked what the reason for not practicing family planning is. It was reported by most of the women that when they have mentally retarded child, they want to take more chance for another male child and they are more interested in male child.

Table No. 5.15 B

Distribution of Respondents According to Education vs. Family Planning

		EDUCATION					Total
		Illiterate	Primary	Secondary	HSC	Graduation	
FAMILY PLANNING	Yes	18	8	13	5	7	51
		35.29	15.69	25.49	9.80	13.73	100.00
	No	20	8	9	6	7	50
		40.00	16.00	18.00	12.00	14.00	100.00
Total		38	16	22	11	14	101
		37.62	15.84	21.78	10.89	13.86	100.00

If the relationship between family planning and education is observed very surprising results are found. Among the illiterate women, response for not planning the birth control is observed to be very high. This indicates, there is a strong relationship between education and family planning.

Table No. 5.15 C

Distribution of Respondents According to Mothers' Age at Marriage vs. Family Planning

		MOTHERS AGE AT MARRIAGE					Total
		<16 year	17-18	19-20	21-35	35+	
FAMILY PLANNING	Yes	16	11	6	7	11	51
		31.37	21.57	11.76	13.73	21.57	100.00
	No	10	17	6	4	13	50
		20.00	34.00	12.00	8.00	26.00	100.00
Total		26	28	12	11	24	101
		25.74	27.72	11.88	10.89	23.76	100.00

There are hardly any women those who have adopted family planning practices in early age. This indicates that even today, in rural areas, family planning is not very popular.

Summary

In this chapter, the researcher has made and attempts to explain the situation of health and hygiene, living conditions and the behavioural problems of mentally retarded child. When the child is young, it doesn't have any problem. The handling of child is very easy task, but as it grows, it become very difficult to manage the child. Hot temperament, uncontrolled behaviour, unexpected behaviour, adjustment problems, obesity, unhealthy relations with siblings, these are the common observable problems which creates the anxiety and guilty feeling among the parents. The condition during delivery, age of mother at the time of delivery, the place of delivery, attendant, health check up, medical treatment, Vitamin Deficiency, Birth Weight, Movement soon after birth, the feeding practices, information about MMR Immunization, Immunization, Family Planning etc. have been discussed in detail in the chapter.

As regard to the condition of the health condition of mother during delivery, it was found that about 22% of the women had complications of various types. These complications might be one of the causes for mental retardation. When the mother is physically not fit to deliver a baby, complication are bound to occur. Naturally, it was found that among 22% of the women have complicated delivery. The age of mother at the time of delivery is observed to be considerably low. Naturally, during pregnancy, she may not be able to nurture the foetus properly. It was found that 42% of the women delivered their child, when they are below 18 years age. Among these mothers, chances of complications leading to mental retardation are bound to be there. It was found that 50% of the deliveries have been taken place at home and only 50% were conducted in hospital. When the delivery is conducted at home, the chances of untrained attendant are always more. It was found that only 2% trained dais were available to conduct delivery. And rest of them were conducted either by mother in law or some close relatives. If the mother is performing daily activities during pregnancy, it is not consider that she is ill,

but if she fails to perform daily routine, then only she is considered as ill. Naturally, seeking the advice from doctor for the health doesn't arise. It was found that about 25% of the women have never visited doctor for advice during pregnancy. And 75% those who have sought advice from doctor have failed to continue the medicine as prescribed by the doctor. Naturally low birth weight is prominently observed in all villages. When the child is not as per the expected weight in natural course, its movement are very less but it was observed that about 15% babies have not shown any sign any movement for a long time even after the delivery.

Feeding Practices have tremendous wrong beliefs and most of the children the sufferer of the children. The rural women do not give first feeding, soon after the birth. On the ground that the baby is not competent to digest colostrums, duration of breast feeding varies from one year to three year. About 2/3 respondents have reported that they give breast feeding for more than 2 years. This indicates that the baby is grossly lacking in oral food. Perhaps this is one of the main reasons for early childhood malnutrition. About 90% respondents were not aware about MMR and 95% of them have not immunized their child for MMR. But for general immunization, more than 87% of the respondents have immunized for Polio, Tetanus, BCG, DPT etc. 50% of the respondents have reported that they have undergone the family planning and some of them have reported they are using contraceptives. In brief it is to say that, in this chapter, various factors associated with mental retardation is discussed in detail.

CHAPTER SIX:
DETAIL ABOUT MENTALLY RETARDED CHILD-
DAILY ACTIVITY, HEALTH PROBLEM,
PSYCHOLOGICAL STATUS AND FAMILY EFFORTS

The future of our country depends on the mental health and strength of our young people. However, many children have mental health problems that interfere with normal development and functioning. In the India 1 in 10 children and adolescents suffer from mental illness severe enough to cause some level of impairment. However, in any given year, it is estimated that these children receives needed treatment. (NIPCCID2008)

Recent evidence compiled by the World Health Organization (WHO 2008) indicates that by the year 2020, childhood neuropsychiatric disorders will rise proportionately by over 50 percent, internationally, to become one of the five most common causes of morbidity, mortality, and disability among children. The mental health problems affecting children and adolescents include the following:

A. Depression

Large-scale research studies have reported that up to 3 percent of children and up to 8 percent of adolescents suffer from depression, a serious mental disorder that adversely affects mood, energy, interest, sleep, appetite, and overall functioning. In contrast to normal emotional experiences of sadness or passing mood states, the symptoms of depression are extreme and persistent and can interfere significantly with the ability to function at home or at school.

There is evidence that depression emerging early in life often recurs and continues into adulthood, and that early onset depression may predict more severe illness in adult life. Diagnosing and treating children and adolescents with depression is critical in preventing impairment in academic, social, emotional, and behavioral functioning and to allow children to live up to their full

potential. Depression in children and adolescents is associated with an increased risk of suicidal behaviors. Since 1964, the suicide rate among adolescents and young adults has doubled. In 1996, the most recent year for which statistics are available, suicide was the 3rd leading cause of death in 15 to 24 year olds and the 4th leading cause among 10 to 14 year olds. (Crime Bureau 2005)

Antidepressant medications are prescribed to treat children and adolescents with depression. Recent studies indicate that certain selective serotonin reuptake inhibitors (SSRIs) are safe and efficacious treatments for depression in young people. However, care must be used in prescribing and monitoring all medication.

Special forms of psychotherapy, such as cognitive-behavioral therapy, have proved effective for adolescents with depression, and current studies are evaluating the effectiveness of individual, family, and group therapies for young people. A current multi-site study of adolescents who are depressed is evaluating the comparative effectiveness of medication, psychosocial, or combined treatments.

B. Anxiety Disorders

Anxiety disorders are the most common mental health problems that occur in children and adolescents. According to one large-scale study of 9 to 17 year olds, entitled Methods for the Epidemiology of Child and Adolescent Mental Disorders (MECA), as many as 13 percent of young people had an anxiety disorder in a year.

a. Generalized Anxiety Disorder: symptoms include exaggerated worry and tension over everyday events.

b. Obsessive Compulsive Disorder (OCD): characterized by intrusive, unwanted, repetitive thoughts and rituals performed out of a feeling of urgent need; at least one-third of adult cases begins in childhood.

c. Panic Disorder: characterized by feelings of extreme fear and dread that strike unexpectedly and repeatedly for no apparent reason, often accompanied

by intense physical symptoms, such as chest pain, pounding heart, shortness of breath, dizziness, or abdominal distress.

d. Post Traumatic Stress Disorder (PTSD): a condition that can occur after exposure to a terrifying event, most often characterized by the repeated re-experience of the ordeal in the form of frightening, intrusive memories, and brings on hypervigilance and deadening of normal emotions.

e. Phobias: social phobia, extreme fear of embarrassment or being scrutinized; specific phobia, excessive fear of an object or situation, such as dogs, heights, loud sounds, flying, costumed characters, enclosed spaces, etc.

f. Other disorders: separation anxiety, excessive anxiety concerning separation from the home or from those to whom the person is most attached; and selective mutism, persistent failure to speak in specific social situations.

Various forms of psychotherapy, including cognitive-behavioral therapy and family therapy, as well as certain medications, particularly selective serotonin reuptake inhibitors (SSRIs), are used to treat anxiety disorders in children and adolescents. Research on the safety and efficacy of these treatments is ongoing.

C. Separation Anxiety Disorder

Although separation anxieties are normal among infants and toddlers, they are not appropriate for older children or adolescents and may represent symptoms of separation anxiety disorder. To reach the diagnostic threshold for this disorder, the anxiety or fear must cause distress or affect social, academic, or job functioning and must last at least 1 month (DSM-IV).

Children with separation anxiety may cling to their parent and have difficulty falling asleep by themselves at night. When separated, they may fear that their parent to be involved in an accident or taken ill, or in some other way be "lost" to the child forever. Their need to stay close to their parent or home may make it difficult for them to attend school or camp, stay at friends' houses, or be in a room by themselves. Fear of separation can lead to dizziness, nausea, or palpitations (DSM-IV).

Separation anxiety is often associated with symptoms of depression, such as sadness, withdrawal, apathy, or difficulty in concentrating, and such children often fear that they or a family member might die. Young children experience nightmares or fears at bedtime.

About 4 percent of children and young adolescents suffer from separation anxiety disorder (DSM-IV). Among those who seek treatment, separation anxiety disorder is equally distributed between boys and girls. In survey samples, the disorder is more common in girls (DSM-IV). The disorder may be overdiagnosed in children and teenagers who live in dangerous neighborhoods and have reasonable fears of leaving home.

The remission rate with separation anxiety disorder is high. However, there are periods where the illness is more severe and other times when it remits. Sometimes the condition lasts many years or is a precursor to panic disorder with agoraphobia. Older individuals with separation anxiety disorder may have difficulty moving or getting married and may, in turn, worry about separation from their own children and partner.

The cause of separation anxiety disorder is not known, although some risk factors have been identified. Affected children tend to come from families that are very close-knit. The disorder might develop after a stress such as death or illness in the family or a move. Trauma, especially physical or sexual assault, might bring on the disorder. The disorder sometimes runs in families, but the precise role of genetic and environmental factors has not been established.

D. Generalized Anxiety Disorder

Children with generalized anxiety disorder worry excessively about all manner of upcoming events and occurrences. They worry unduly about their academic performance or sporting activities, about being on time, or even about natural disasters such as earthquakes. The worry persists even when the child is not being judged and has always performed well in the past. Because of their anxiety, children may be overly conforming, perfectionist, or unsure of themselves. They tend to redo tasks if

there are any imperfections. They tend to seek approval and need constant reassurance about their performance and their anxieties (DSM-IV). The 1-year prevalence rate for all generalized anxiety disorder sufferers of all ages is approximately 3 percent. The lifetime prevalence rate is about 5 percent (DSM-IV).

About half of all adults seeking treatment for this disorder report that it began in childhood or adolescence, but the proportion of children with this disorder who retain the problem into adulthood is unknown. The remission rate is not thought to be as high as that of separation anxiety disorder.

E. Social Phobia

Children with social phobia have a persistent fear of being embarrassed in social situations, during a performance, or if they have to speak in class or in public, get into conversation with others, or eat, drink, or write in public.

Feelings of anxiety in these situations produce physical reactions: palpitations, tremors, sweating, diarrhea, blushing, muscle tension, etc. Sometimes a full-blown panic attack ensues; sometimes the reaction is much more mild.

Adolescents and adults are able to recognize that their fear is unreasonable or excessive, although this recognition does not prevent the fear. Children, however, might not recognize that their reaction is excessive, although they may be afraid that others will notice their anxiety and consider them odd or babyish.

Young children do not articulate their fears, but may cry, have tantrums, freeze, cling, appear extremely timid in strange social settings, shrink from contact with others, stay on the side during social events, and try to stay close to familiar adults. They may fall behind in school, avoid school completely, or avoid social activities among children their age. The avoidance of the fearful situations or worry preceding the feared event may last for weeks and interferes with the individual's daily routine, social life, job, or school. They may find it impossible to speak in social situations or in the presence of unfamiliar people.

Social phobia is common, the lifetime prevalence ranging from 3 to 13 percent, depending on how great the fear is and on how many different situations induce the anxiety. In survey studies, the majority of those with the disorder were found to be female (DSM-IV). Often the illness is lifelong, although it may become less severe or completely remit. Life events may reassure the individual or exacerbate the anxiety and disorder.

Although anxiety disorders are the most common disorder of youth, there is relatively little research on the efficacy of psychotherapy. For childhood phobias, contingency management¹⁰ was the only intervention deemed to be well-established, according to an evaluation by Qllendick and King, which applied the American Psychological Association Task Force criteria.

Several psychotherapies are probably efficacious for treating phobias: systematic desensitization¹¹; modeling, based on research by Bandura and colleagues, which capitalizes on an observational learning technique; and several cognitive-behavioral therapy (CBT) approaches. CBT, as pioneered by Kendall and colleagues, is deemed by the American Psychological Association Task Force as probably efficacious. It has four major components: recognizing anxious feelings, clarifying cognitions in anxiety-provoking situations,¹² developing a plan for coping, and evaluating the success of coping strategies.

A more recent study in Australia added a parent component to CBT, which enhanced reduction in post-treatment anxiety disorder significantly compared with CBT alone. However, none of the interventions identified above as well-established or probably efficacious has, for the most part, been tested in real-world settings.

Psychodynamic treatment to address underlying fears and worries can be helpful, and behavior therapy may reduce the child's fear of separation or of going to school; however, the experimental support for these approaches is limited. Preliminary research suggests that selective serotonin reuptake inhibitors may provide effective treatment of separation anxiety disorder and other anxiety disorders of childhood and adolescence. Two large-scale randomized controlled trials are currently being

undertaken. Neither tricyclic antidepressants nor benzodiazepines have been shown to be more effective than placebo in children.

F. Obsessive-Compulsive Disorder

Obsessive-compulsive disorder (OCD), which is classified in DSM-IV as an anxiety disorder, is characterized by recurrent, time-consuming obsessive or compulsive behaviors that cause distress and/or impairment. The obsessions may be repetitive intrusive images, thoughts, or impulses. Often the compulsive behaviors, such as hand-washing or cleaning rituals, are an attempt to displace the obsessive thoughts (DSM-IV). Estimates of prevalence range from 0.2 to 0.8 percent in children, and up to 2% of adolescents.

There is a strong familial component to OCD, and there is evidence from twin studies of both genetic susceptibility and environmental influences. If one twin has OCD, the other twin is more likely to have OCD if the children are identical twins rather than fraternal twin pairs. OCD is increased among first-degree relatives of children with OCD, particularly among fathers.

It does not appear that the child is simply imitating the relative's behavior, because children who develop OCD tend to have symptoms different from those of relatives with the disease. Many adults with either childhood- or adolescent-onset of OCD show evidence of abnormalities in a neural network known as the orbitofrontalstriatal area.

Some children with OCD develop the condition after experiencing one type of streptococcal infection. This condition is referred to by the acronym PANDAS, which stands for Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal infections. Its hallmark is a sudden and abrupt exacerbation of OCD symptoms after a strep infection.

This form of OCD occurs when the immune system generates antibodies to the streptococcal bacteria, and the antibodies cross-react with the basal ganglia of a susceptible child, provoking OCD. In other words, "the cause of this form of OCD

appears to be antibodies directed against the infection mistakenly attacking a region of the brain and setting off an inflammatory reaction.

The selective serotonin reuptake inhibitors appear effective in ameliorating the symptoms of OCD in children, although more clinical trials have been done with adults than with children. Several randomized, controlled trials revealed SSRIs to be effective in treating children and adolescents with OCD.

The appropriate duration of treatment is still being studied. Side effects are not inconsequential: dry mouth, somnolence, dizziness, fatigue, tremors, and constipation occur at fairly high rates. Cognitive- behavioral treatments also have been used to treat OCD, but the evidence is not yet conclusive.

G. Autism

Autism, the most common of the pervasive developmental disorders, is characterized by severely compromised ability to engage in, and by a lack of interest in, social interactions. It has roots in both structural brain abnormalities and genetic predispositions, according to family studies and studies of brain anatomy. The search for genes that predispose to autism is considered an extremely high research priority for the National Institute of Mental Health.

Although the reported association between autism and obstetrical hazard may be due to genetic factors, there is evidence that several different causes of toxic or infectious damage to the central nervous system during early development also may contribute to autism. Autism has been reported in children with fetal alcohol syndrome, in children who were infected with rubella during pregnancy, and in children whose mothers took a variety of medications that are known to damage the fetus.

Cognitive deficits in social perception likely result from abnormalities in neural circuitry. Children with autism have been studied with several imaging techniques, but no strongly consistent findings have emerged, although abnormalities in the cerebellum and limbic system and larger brains have been reported. In one small study, evidence of delayed maturation of the frontal cortex was found. The evidence for

genetic influences include a much greater concordance in identical than in fraternal twins.

Because autism is a severe, chronic developmental disorder, which results in significant lifelong disability, the goal of treatment is to promote the child's social and language development and minimize behaviors that interfere with the child's functioning and learning.

Intensive, sustained special education programs and behavior therapy early in life can increase the ability of the child with autism to acquire language and ability to learn. Special education programs in highly structured environments appear to help the child acquire self-care, social, and job skills. Only in the past decade have studies shown positive outcomes for very young children with autism. Given the severity of the impairment high intensity of service needs, and costs , there has been an ongoing search for effective treatment.

Thirty years of research demonstrated the efficacy of applied behavioral methods in reducing inappropriate behavior and in increasing communication, learning, and appropriate social behavior. A well-designed study of a psychosocial intervention was carried out by Lovaas and colleagues.

Nineteen children with autism were treated intensively with behavior therapy for 2 years and compared with two control groups. Followup of the experimental group in first grade, in late childhood, and in adolescence found that nearly half the experimental group but almost none of the children in the matched control group were able to participate in regular schooling. Up to this point, a number of other research groups have provided at least a partial replication of the Lovaas model. - Several uncontrolled studies of comprehensive center-based programs have been conducted, focusing on language development and other developmental skills. A comprehensive model. Treatment and Education of Autistic and Related Communication Handicapped Children (TEACCH), demonstrated short-term gains for preschoolers with autism who received daily TEACCH home-teaching sessions, compared with a matched control group. A review of other comprehensive, center-based programs has been conducted,

focusing on elements considered critical to school-based programs, including minimum hours of service and necessary curricular components.

The antipsychotic drug, haloperidol, has been shown to be superior to placebo in the treatment of autism, although a significant number of children develop dyskinesias as a side effect. Two of the SSRIs, clomipramine and fluoxetine, have been tested, with positive results, except in young autistic children, in whom clomipramine was not found to be therapeutic, and who experienced untoward side effects.

H. ADHD

Attention deficit hyperactivity disorder (ADHD) is the most commonly diagnosed psychiatric disorder of childhood, estimated to affect 3 to 5 percent of school-aged children. Research shows that ADHD tends to run in families. Its core symptoms include developmentally inappropriate levels of attention, concentration, activity, distractibility, and impulsivity.

Children with ADHD usually have impaired functioning in peer relationships and multiple settings including home and school. ADHD has also been shown to have long-term adverse effects on academic performance, vocational success, and social-emotional development.

Psychostimulant medications, including methyl-phenidate (Ritalin), amphetamine (Dexedrine and Adderall), and pemoline (Cylert), are by far the most widely researched and commonly prescribed treatments for ADHD.

Numerous short-term studies have established the safety and efficacy of stimulants and psychosocial treatments for alleviating the symptoms of ADHD. A multisite study of children with ADHD recently concluded that the two most effective treatment modalities for elementary school children with ADHD are a closely monitored medication treatment and a treatment that combines medication with intensive behavioral interventions. Another study, jointly funded by the NIMH and the National Institute on Drug Abuse, has shown that boys with ADHD who are treated with stimulants

are significantly less likely to abuse drugs and alcohol when they get older. In previous studies, these same researchers found that nearly twice as many adults with ADHD also abused drugs and/or alcohol at some point in their lives, compared to adults without ADHD.

I. Eating Disorders

Eating disorders are most common among adolescent and young women. In addition to causing various physical health problems, eating disorders are associated with illnesses such as depression, substance abuse, and anxiety disorders.

Among adolescent and young adult women in the U.S., it is estimated that between 0.5 and 1.0 percent suffer from anorexia nervosa, 1 to 3 percent have bulimia nervosa, and 0.7 to 4 percent experience binge-eating disorder. There are limited data concerning the prevalence in males.

Similar to other mental disorders, such as obsessive-compulsive disorder and depression, patients with eating disorders have little control over their symptoms, and suffer from often serious and sometimes life-threatening illnesses that require medical and psychiatric attention.

Because of their complexity, eating disorders call for a comprehensive treatment plan involving medical care and monitoring, psychotherapy, nutritional counseling, and medication management. Studies are investigating the causes of eating disorders and effectiveness of treatments.

J. Manic Depressive Illness

Manic-depressive illness causes extreme shifts in mood, energy, and functioning. Overly energized, disruptive, and reckless periods alternate with periods of sadness, withdrawal, hopelessness, and other depressive symptoms. Unlike normal mood states of happiness and sadness, symptoms of manic-depressive illness can interfere with school performance, family relationships, peer interactions, and other everyday activities.

Although manic-depressive illness typically emerges in late adolescence or early adulthood, there is increasing evidence that the disorder also can begin in childhood. According to one study, one percent of adolescents ages 14-18 were found to have met criteria for manic-depressive illness or cyclothymia, a milder form of the illness, in their lifetime.

NIMH research efforts are attempting to clarify the diagnosis, course, and treatment of manic-depressive illness in youth. Evidence suggests that manic-depressive illness beginning in childhood or early adolescence may be a different possibly more severe form of the disorder than older adolescent and adult-onset manic-depressive illness. When the illness begins before or soon after puberty, it is often characterized by a continuous, rapid-cycling, and mixed symptom state that may co-occur with ADHD or other behavioral disorders, or may have features of these disorders as initial symptoms.

In contrast, later onset manic-depressive illness appears to begin suddenly, often with a manic episode, and to have a more episodic pattern with relatively stable periods between episodes. Various treatments known to be effective in adults with manic-depressive illness-also may help relieve the symptoms in young people. The essential treatment for this disorder is the use of appropriate doses of mood stabilizing medications.

The most typical is lithium, known to be very effective in adults for controlling mania and preventing recurrences of manic and depressive episodes. Research on the effectiveness of this and other medications in children and adolescents with manic-depressive illness is ongoing. In addition, studies are investigating various forms of psychotherapy to complement medication treatment for this illness in young people.

K. Schizophrenia

Schizophrenia is a chronic, severe, and disabling brain disorder that affects about 1 percent of the population during their lifetime. Symptoms include hallucinations, delusions, disordered thinking, and social withdrawal. Research studies are revealing

that various cognitive and social impairments may be evident early in children who later develop schizophrenia. These and other findings may lead to the development of preventive interventions for children.

In the emerging picture, genetic factors, which confer susceptibility to schizophrenia, appear to combine with other factors early in life to interfere with normal brain development. These developmental disturbances eventually appear as symptoms of schizophrenia many years later, typically during adolescence or young adulthood. A number of new, effective medications for schizophrenia have been introduced during the past ' decade.

L. Tourette's Syndrome

Tourette's Syndrome (TS) is characterized by repeated, involuntary movements and uncontrollable vocal sounds, known as tics. Affecting approximately 100,000 Americans in its full-blown form, TS generally emerges during childhood or early adolescence. Although the basic cause of TS ,is unknown, current research suggests there is a genetic abnormality affecting certain neurotransmitters in the brain, and that varying environmental factors, possibly including infections, modifies the clinical expression of the disorder.

Symptoms of TS are seen in association with some other neurological disorders, particularly OCD. Researchers are investigating the neurological similarities between OCD and TS to determine whether a genetic relationship exists. In most cases, Tourette's Syndrome is not disabling, symptoms don't impair patients, development proceeds normally, and there is no need for treatment. However, some effective medications are available in the rare instances when symptoms interfere with functioning.

Children with TS can generally function well at home and in the regular classroom. If they have an accompanying learning disability or other disorder, such as ADHD or OCD, they may require tutoring, special classes, psychotherapy, or medication.

M. Bipolar disorder

Research findings, clinical experience, and family accounts provide substantial evidence that bipolar disorder, also called manic-depressive illness, can occur in children and adolescents. Bipolar disorder is difficult to recognize and diagnose in youth, however, because it does not fit precisely the symptom criteria established for adults, and because its symptoms can resemble or co-occur with those of other common childhood-onset mental disorders. In addition, symptoms of bipolar disorder may be initially mistaken for normal emotions and behaviors of children and adolescents.

But unlike normal mood changes, bipolar disorder significantly impairs functioning in school, with peers, and at home with family. Better understanding of the diagnosis and treatment of bipolar disorder in youth is urgently needed. In pursuit of this goal, the US National Institute of Mental Health (NIMH) is conducting and supporting research on child and adolescent bipolar disorder.

Effective treatment depends on appropriate diagnosis of bipolar disorder in children and adolescents. There is some evidence that using antidepressant medication to treat depression in a person who has bipolar disorder may induce manic symptoms if it is taken without a mood stabilizer.

In addition, using stimulant medications to treat attention deficit hyperactivity disorder (ADHD) or ADHD-like symptoms in a child with bipolar disorder may worsen manic symptoms. While it can be hard to determine which young patients will become manic, there is a greater likelihood among children and adolescents who have a family history of bipolar disorder. If manic symptoms develop or markedly worsen during antidepressant or stimulant use, a physician should be consulted immediately, and diagnosis and treatment for bipolar disorder should be considered.

Bipolar disorder is a serious mental illness characterized by recurrent episodes of depression, mania, and/or mixed symptom states. These episodes cause unusual

and extreme shifts in mood, energy, and behavior that interfere significantly with normal, healthy functioning. Manic symptoms include:

- Severe changes in mood—either extremely irritable or overly silly and elated
- Overly-inflated self-esteem; grandiosity
- Increased energy
- Decreased need for sleep—ability to go with very little or no sleep for days without tiring
- Increased talking—talks too much, too fast; changes topics too quickly; cannot be interrupted
- Distractibility—attention moves constantly from one thing to the next
- Hypersexuality—increased sexual thoughts, feelings, or behaviors; use of explicit sexual language
- Increased goal-directed activity or "hysical agitation
- Disregard of risk—excessive involvement in risky behaviors or activities

Depressive symptoms include:

- persistent sad or irritable mood
- Loss of interest in activities once enjoyed
- Significant change in appetite or body weight
- Difficulty sleeping or oversleeping
- Physical agitation or slowing
- Loss of energy
- Feelings of worthlessness or inappropriate guilt
- Difficulty concentrating
- Recurrent thoughts of death or suicide

Symptoms of mania and depression in children and adolescents may manifest themselves through a variety of different behaviors 1,2. When manic, children and adolescents, in contrast to adults, are more likely to be irritable and prone to destructive outbursts than to be elated or euphoric.

When depressed, there may be many physical complaints such as headaches, muscle aches, stomachaches or tiredness, frequent absences from school or poor performance in school, talk of or efforts to run away from home, irritability, complaining, unexplained crying, social isolation, poor communication, and extreme sensitivity to rejection or failure.

Other manifestations of manic and depressive states may include alcohol or substance abuse and difficulty with relationships.

Existing evidence indicates that bipolar disorder beginning in childhood or early adolescence may be a different, possibly more severe form of the illness than older adolescent- and adult-onset bipolar disorder 1,2. When the illness begins before or soon after puberty, it is often characterized by a continuous, rapid-cycling, irritable, and mixed symptom state that may co-occur with disruptive behavior disorders, particularly attention deficit hyperactivity disorder (ADHD) or conduct disorder (CD), or may have features of these disorders as initial symptoms.

In contrast, later adolescent- or adult-onset bipolar disorder tends to begin suddenly, often with a classic manic episode, and to have a more episodic pattern with relatively stable periods between episodes. There is also less co-occurring ADHD or CD among those with later onset illness.

A child or adolescent who appears to be depressed and exhibits ADHD-like symptoms that are very severe, with excessive temper outbursts and mood changes, should be evaluated by a psychiatrist or psychologist with experience in bipolar disorder, particularly if there is a family history of the illness.

This evaluation is especially important since psychostimulant medications, often prescribed for ADHD, may worsen manic symptoms. There is also limited evidence suggesting that some of the symptoms of ADHD may be a forerunner of full-blown mania.

Findings from an NIMH-supported study suggest that the illness may be at least as common among youth as among adults. In this study, one percent of adolescents ages 14 to 18 were found to have met criteria for bipolar disorder or cyclothymia, a similar but milder illness, in their lifetime 3.

In addition, close to six percent of adolescents in the study had experienced a distinct period of abnormally and persistently elevated, expansive, or irritable mood even though they never met full criteria for bipolar disorder or cyclothymia. Compared to adolescents with a history of major depressive disorder and to a never-mentally-ill group, both the teens with bipolar disorder and those with subclinical symptoms had greater functional impairment and higher rates of co-occurring illnesses, suicide attempts, and mental health services utilization.

The study highlights the need for improved recognition, treatment, and prevention of even the milder and subclinical cases of bipolar disorder in adolescence.

Once the diagnosis of bipolar disorder is made, the treatment of children and adolescents is based mainly on experience with adults, since as yet there is very limited data on the efficacy and safety of mood stabilizing medications in youth 4. The essential treatment for this disorder in adults involves the use of appropriate doses of mood stabilizers, most typically lithium and/or valproate, which are often very effective for controlling mania and preventing recurrences of manic and depressive episodes.

Research on the effectiveness of these and other medications in children and adolescents with bipolar disorder is ongoing. In addition, studies are investigating various forms of psychotherapy, including cognitive-behavioral therapy, to complement medication treatment for this-illness in young people.

According to studies conducted in Finland in patients with epilepsy, valproate may increase testosterone levels in teenage girls *and* produce polycystic ovary syndrome in women who began taking the medication before age 20 5. Increased testosterone can lead to polycystic ovary syndrome with irregular or absent menses, obesity, and abnormal growth of hair. Therefore, young female patients taking valproate should be monitored carefully by a physician. Very young children are being prescribed psychotropic medications. The studies to date are incomplete, and much more needs to be learned about young children who are treated with medications for all kinds of illnesses. In the field of mental health, new studies

are needed to tell us what the best treatments are for children with emotional and behavioral disturbances.

Children are in a state of rapid change and growth during their developmental years. Diagnosis and treatment of mental disorders must be viewed with these changes in mind. While some problems are short-lived and don't need treatment, others are persistent and very serious, and parents should seek professional help for their children. Not long ago, it was thought that many brain disorders such as anxiety disorders, depression, and bipolar disorder began only after childhood. We now know they can begin in early childhood.

An estimated 1 in 10 children and adolescents in the United States suffers from mental illness severe enough to cause some level of impairment. Fewer than 1 in 5 of these ill children receives treatment. Perhaps the most studied, diagnosed, and treated childhood-onset mental disorder is attention deficit hyperactivity disorder (ADHD), but even with this disorder there is a need for further research in very young children.

The behavioural problem of mentally retarded child mainly depends upon the complexities involved in his/her diseases. In mental retardation, the behavioural problems are more complex. Their biological age increases, but the mental age does not increase along with it. Thus, there is a large gap between biological and mental age. This problem further gets aggravated by the sex of child. For male child, it is not so complex, but the chances of sexual exploitation is very high among the girls.

Age of mother at delivery have close association with mental retardation. It birth takes place in early age of mother (below 18 years) and late age (After 40 years), the chances of occurring new born baby are always higher. It is generally observed that either first child or last child gets mental retardation. If the baby is first child, then there is hearty welcome from the family members. Naturally, due to their happiness, family members do not able to diagnose mental retardation in early age. This situation also further creates more complexities. This happens mainly due to most of the parents are not able to correlate the natural expectations with actual expectation in each its progress.

Mother, father or the caretakers of the baby should be able to identify 'lacuna' in its behaviour. However, once it is recognized, the general tendency in rural areas is to follow the religious or traditional treatment to overcome this problem. In this situation only, it continues to grow and when the problem become intolerable, they seek help from local doctor instead of specialized doctor. By this time, the dependency of a child gets increased and there is considerable lag in its behaviour performance. In real sense, parents should provide adequate scientific training to baby for performing his/her daily activities. These activities mainly include toilet training, awareness about toilet practice, bedding, dressing, eating etc.

Directory practices are more important in mental retardation. They do not understand how much food they have to eat. When the movements are related, they need very less quantity of food, but in reality they eat more. Hence, one finds that the obesity is the general problem among mental retardation. Spoiling the food is their usual practice. Most of the mentally retarded children are not eating their food properly or they do not take tea/milk neatly. Such type of behavioural problem is continuous attention of the care taker which brings the restriction on them.

The other siblings also start to hate mentally retarded child. There is always negligence from the parents. Perhaps, sometimes parents also feel guilty due to his/her behavioural problem and difficulty in movement. Parents are not able to taking for various programmes and public functions. Another important aspect is general attitude of the community towards mental retardation is not so positive that these children cannot be accommodate in that society. Social stigma is still prevalent in Indian Society and it is strong in rural areas.

6.1 Age of mentally retarded child:

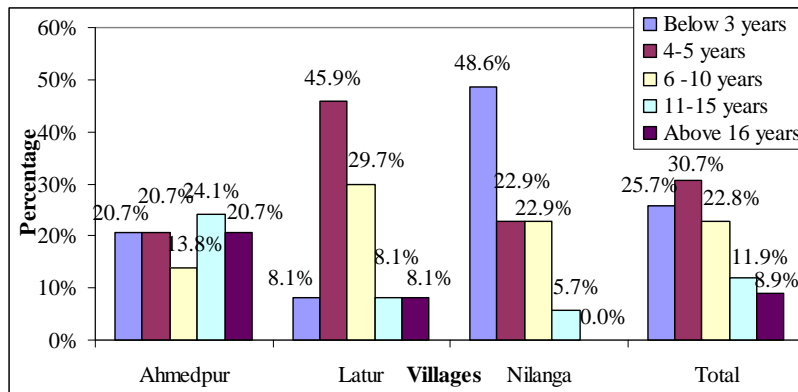
It is very hard to define when the mental retardation occurs in the child. Sometimes the cases could be congenital due to genetic factors, but the parents are unable to identify mental retardation in their children. And in some of the cases, the child get

mental retardation after some type of diseases such as fever, measles, small pox etc as after effect of these diseases. In congenital cases, the parents are able to identify the mental retardation in their children when the child does not shows the behaviour he/she has to show in particular age. The general tendency to identify the mentally retarded child is identifying 'lacuna' in the child.

TABLE NO. 6.1
DISTRIBUTION OF THE RESPONDENTS ACCORDING TO
AGE OF MENTALLY RETARDED CHILD

Village	AGE OF MENTALLY RETARDED CHILD (YEARS)					Total
	< 3	4 to 5	6 to 10	11 to 15	16 +	
Ahmedpur	6	6	4	7	6	29
	20.7%	20.7%	13.8%	24.1%	20.7%	100.0%
Latur	3	17	11	3	3	37
	8.1%	45.9%	29.7%	8.1%	8.1%	100.0%
Nilanga	17	8	8	2	0	35
	48.6%	22.9%	22.9%	5.7%	0.0%	100.0%
Total	26	31	23	12	9	101
	25.7%	30.7%	22.8%	11.9%	8.9%	100.0%

Chart No: 6.1
Age of Mentally Retarded Child



It is seen from the table that in all the samples, 26% respondents are less than 3 years old. 31% are in 4-5 years age group followed by 23% of 6-10 years, 12% 11-15

years and 9% above 16 years. The large variation ranging from 8 % to 48% have been observed in younger age i.e. below 3 years. As compared to all other age group, this age group have large variation. However, about other age group, this proportion does not differ from village to village. In Ahmedpur, there is a hardly 21% mentally retarded children of 4-5 years whereas in Latur about 46 and in Nilanga this proportion is 23%. As regard to the 6-10 years age group, highest proportion has been observed in Latur, i.e. 30% followed by Nilanga 23% and in Ahmedpur 14%. 11-15 years age group is considerably the group which comes under adolescence age group. The proportion of this age group is comparatively less as compared to other younger age groups. There were about 20% respondents whose age is ranging between 11 onwards. One point is to be noted here during adolescence age group, it becomes very difficult to manage the child. Physically they are stronger, but they do not behave as expected level of their age. There are more or less same proportions in all blocks in these two age groups. In brief it is to say that 4-10 years age group is comparatively highest age group in mentally retarded children.

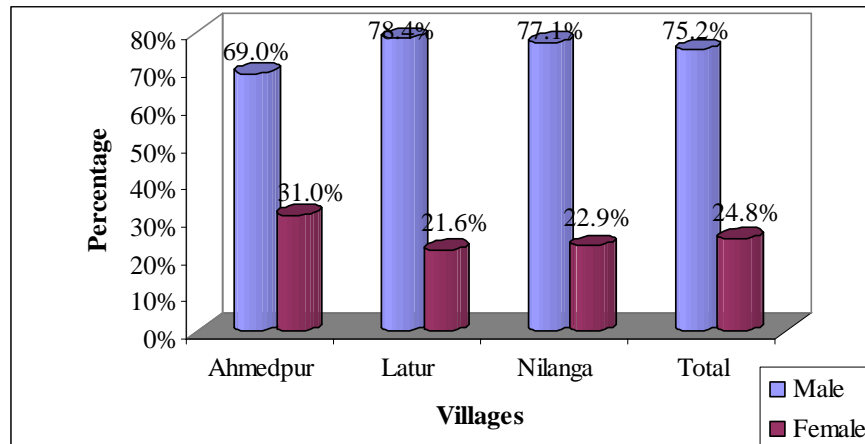
6.2 Sex of mentally retarded child:

In most of the consanguineous cases, the child having mentally retardation is especially male child. As the Indian Society is matrilineal society, many of the genetic diseases are seen in the upcoming generation in male children. In this way mental retardation is more prominent in male children than in female.

TABLE NO. 6.2
DISTRIBUTION OF THE RESPONDENTS ACCORDING TO
SEX OF MENTALLY RETARDED CHILD

Village	SEX OF MENTALLY RETARDED CHILD		
	Male	Female	Total
Ahmedpur	20	9	29
	69.0%	31.0%	100.0%
Latur	29	8	37
	78.4%	21.6%	100.0%
Nilanga	27	8	35
	77.1%	22.9%	100.0%
Total	76	25	101
	75.2%	24.8%	100.0%

Chart No. 6.2
Sex of the mentally retarded Child



It is seen from the above table that, in overall population, 75% of the mentally retarded children are males and 25% are females. As regard to the sex composition of mentally retarded child, Latur and Nilanga have observed more or less same trend in the proportion of males and female whereas in Ahmedpur males are comparatively lesser than the females. From the above table one can conclude that mental retardation is more among the males. There might be several reasons for higher incidence. Mainly, son

preference deliveries are being conducted and till they get the son (at any age), they will take the chance. But the villagers are not aware that late age delivery, frequent deliveries, illness during pregnancy, all these are the various factors that are operating on mental retardation in rural areas. In brief it is to say that male dominance is more in all the blocks. The next table provides the information about the ordinal position of mentally retarded child in the family.

6.3 Ordinal position of mentally retarded child:

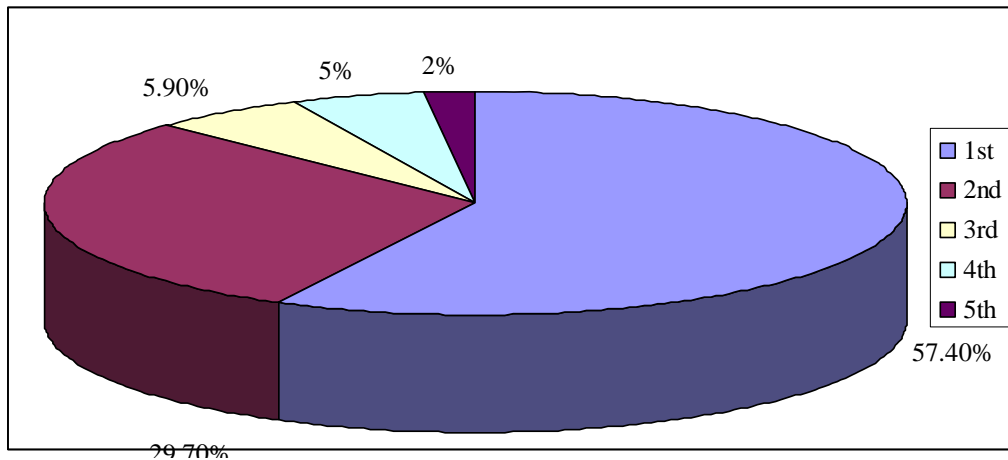
The ordinal position in the family within siblings is also very important thing to consider as there is also vulnerability of mental retardation. Generally, the first child of the family or the last child has more chance to get mental retardation. If the mother is pregnant in early age, then her reproductive organs are not so developed to bear a child, and it may be the reason of deformity in the first child. Similarly, when the age goes up, the functioning of the reproductive organs get deteriorated, so that it is not appropriate to give birth to a child. But if it is done, then the child couldn't get the proper environment in the womb as it needs, thus creates some sort of mental deformity.

TABLE NO. 6.3 A
DISTRIBUTION OF THE RESPONDENTS ACCORDING TO
ORDINAL POSITION OF CHILD

Village	ORDINAL POSITION OF THE CHILD					
	1 st	2 nd	3 rd	4 th	5 th	Total
Ahmedpur	14	9	3	1	2	29
	48.3%	31.0%	10.3%	3.4%	6.9%	100.0%
Latur	23	13	0	1	0	37
	62.2%	35.1%	0.0%	2.7%	0.0%	100.0%
Nilanga	21	8	3	3	0	35
	60.0%	22.9%	8.6%	8.6%	0.0%	100.0%
Total	58	30	6	5	2	101
	57.4%	29.7%	5.9%	5.0%	2.0%	100.0%

Chart No. 6.3

Ordinal Position of the child



It was observed that the proportion of mentally retarded children goes on decreasing as ordinal position increases. It is seen from the table that highest proportion of mentally retarded child has first position among their siblings, followed by second, third and fourth position. In Ahmedpur, about 50% of the mentally retarded children have first position. In Latur and Nilanga, about 61% of respondents have the first ordinal position. No large variation has been observed among the villagers. About 30% of the respondents have second ordinal position among their siblings. In the second position, the Ahmedpur and Latur have shown the same trend whereas in Nilanga, it is comparatively less. As regard to the third position, there are 10 % children in Ahmedpur and 9% in Nilanga, whereas in Latur, there is not a single respondent whose ordinal position is third. In fourth and fifth ordinal position, there are hardly one or two respondents from each village. This shows that, as the ordinal position goes on increasing, the numbers of respondents are decreasing. One can conclude from the data that there is a perfect correlation between ordinal position and mental retardation.

Table No. 6.3 B
Distribution of Respondents according to
Ordinal Position of the Child vs. Mother's Age at Birth

		ORDINAL POSITION OF THE CHILD					Total
		1 st	2 nd	3 rd	4 th	5 th	
MOTHERS AGE AT BIRTH	Below 18	25	12	2	3	1	43
		58.14	27.91	4.65	6.98	2.33	100.00
	19-20	11	8	2	1	1	23
		47.83	34.78	8.70	4.35	4.35	100.00
	21-30	22	10	2	1	0	35
		62.86	28.57	5.71	2.86	0.00	100.00
Total		58	30	6	5	2	101
		57.43	29.70	5.94	4.95	1.98	100.00

It is seen from the above table that the women who delivers the child below 18 years have chances of retardation. Usually it is observed that in all the ages, the first child is mentally retarded.

Table No. 6.3 C
Distribution of Respondents According to
Ordinal Position of the Child vs. Birth Weight

		ORDINAL POSITION OF THE CHILD					Total
		1 st	2 nd	3 rd	4 th	5 th	
BIRTH WEIGHT	< 1000	38	19	5	3	2	67
		56.72	28.36	7.46	4.48	2.99	100.00
	1000-1200	20	11	1	2	0	34
		58.82	32.35	2.94	5.88	0.00	100.00
Total		58	30	6	5	2	101
		57.43	29.70	5.94	4.95	1.98	100.00

The first child has lesser birth weight as compared to the second onwards. More than half of the children whose ordinal position is first had low birth weight.

Table No. 6.3 D
Distribution of Respondents According to
Ordinal Position of the Child vs. Need for Special Care

		ORDINAL POSITION OF THE CHILD					Total
		1 st	2 nd	3 rd	4 th	5 th	
NEEDS FOR SPECIAL CARE	Movement	15	5	2	0	0	22
		68.18	22.73	9.09	0.00	0.00	100.00
	Behaviour	16	6	2	2	1	27
		59.26	22.22	7.41	7.41	3.70	100.00
	Body Services	26	18	2	3	1	50
		52.00	36.00	4.00	6.00	2.00	100.00
	All	1	1	0	0	0	2
	50.00	50.00	0.00	0.00	0.00	100.00	
Total		58	30	6	5	2	101
		57.43	29.70	5.94	4.95	1.98	100.00

Substantial number of the mentally retarded children is observed to have the problem of movement and body services. Usually, the first child has this problem more prominently.

Table No. 6.3 E: Distribution of Respondents according to
Ordinal Position of the child vs. Sex of Mentally Retarded Child

		ORDINAL POSITION OF THE CHILD					Total
		1 st	2 nd	3 rd	4 th	5 th	
SEX OF MR CHILD	Male	46	22	3	4	1	76
		60.53	28.95	3.95	5.26	1.32	100.00
	Female	12	8	3	1	1	25
		48.00	32.00	12.00	4.00	4.00	100.00
Total		58	30	6	5	2	101
		57.43	29.70	5.94	4.95	1.98	100.00

No consistent observation has been observed from the above table as regard to the ordinal position and sex of the child.

6.4 Diagnosis of mental retardation:

Mental retardation diagnosis is very tough task. During the early months of life, the children cannot respond to the parents as they can't understand. But later on, the children are expected to respond to the activities and also learn many new things along with the age such as giggling, laughing, smiling, grasping, responding to sound, imitating sound etc. When they are not able to perform as expected, then the family members, especially who are very close to the child identify child and his/her lacuna. The proper diagnosis is done only by the medical practitioner after some tests.

TABLE NO. 6.4 A
DISTRIBUTION OF THE RESPONDENTS ACCORDING TO
RECOGNITION OF MENTAL RETARDATION

Village	RECOGNATION OF MENTAL RETARDATION					
	by Birth	Within 6 months	Within 1 yr	Within 2 yrs	2 yr +	Total
Ahmedpur	2	25	0	2	0	29
	6.9%	86.2%	0.0%	6.9%	0.0%	100.0%
Latur	2	32	2	1	0	37
	5.4%	86.5%	5.4%	2.7%	0.0%	100.0%
Nilanga	2	23	4	4	2	35
	5.7%	65.7%	11.4%	11.4%	5.7%	100.0%
Total	6	80	6	7	2	101
	5.9%	79.2%	5.9%	6.9%	2.0%	100.0%

It is observed from the table above that, the diagnosis was done immediately after the birth. There are hardly 6-7% of the respondents reported that they diagnosed mental retardation immediately after the birth of the child whereas, about 80% of the respondents have reported that they came to know that their child is mentally retarded within six

month after the birth. This is highest proportion among all the categories. For other categories the proportion ranges between 5-7% and also there is no large variation between various blocks. In brief one can say from the table that, either soon after the birth or within first six months period, the retardation was diagnosed. One point is to be noted here that considering the level of education of the mothers and the place of delivery to identify the symptoms of mental retardation is always correlated with each other.

Table No. 6.4 B
Distribution of Respondents According to
Recognition of Mental Retardation vs. Type of Medical Treatment

		RECOGNATION OF MENTAL RETARDATION					Total
		By birth	Within 6 months	1 year	2 years	More than 2 years	
TYPE OF THE MEDICAL TREATMENT	Ayurvedic	1	1	0	1	0	3
		33.33	33.33	0.00	33.33	0.00	100.00
	Psychiatric	1	12	1	3	1	18
		5.56	66.67	5.56	16.67	5.56	100.00
	General Practitioner	4	67	5	3	1	80
		5.00	83.75	6.25	3.75	1.25	100.00
Total		6	80	6	7	2	101
		5.94	79.21	5.94	6.93	1.98	100.00

It is observed from the above table that among the 80% of the respondents that those who have followed the treatment from medical practitioner have taken the treatment within 6 months. This may be due to that parents were not able to identify, the problem of mental retardation in early stage.

6.5 Symptoms at the time of diagnosis

There are two types of age, proximal and mental. Normally, people have both these ages as equal goes along with each other. But in case of mental retardation, the children are unable to grow themselves mentally as equal to physically. They couldn't do

anything as they are expected to do in particular age. This is one symptom. Apart from this, the facial structure of the child also helps to identify the mental retardation. Generally, they have very big eyes, which are uncommon; they seem to be slow etc., because almost all the mentally retarded children have same type of facial structure.

TABLE NO. 6.5
DISTRIBUTION OF THE RESPONDENTS ACCORDING TO
SYMPTOMS OF MENTAL RETARDATION

Village	SYMPTOMS OF MENTAL RETARDATION				Total
	No movement	No response	No movement of eyes	Standing hair	
Ahmedpur	1	3	25	1	29
	3.4%	10.3%	86.2%	3.4%	100.0%
Latur	0	5	32	0	37
	0.0%	13.5%	86.5%	0.0%	100.0%
Nilanga	3	1	31	3	35
	8.6%	2.9%	88.6%	8.6%	100.0%
Total	4	9	88	4	101
	4.0%	8.9%	87.1%	4.0%	100.0%

It is seen from the table above that 96% of the children's movement have not been observed by the caretaker, might be the mother or any other close relatives. In Ahmedpur, 100% respondents have reported that they have not seen any natural movement of a small baby even after two months of their age. Then, they find child is not responding for their actions, when there is no reaction from child's size they have taken the advice from their doctors. No response is reported by only 2% of the respondents. No response means wherever the baby has kept, the baby has not changed its position for hours together and only 2% of the respondents have reported other symptoms. In brief it is to say that from the experience of the senior persons in the family, they identified the symptoms of mental retardation. However the concerned person who recognized that the baby have some problem is given in following table.

6.6 The person who diagnosed mental retardation:

To identify anything, there should be closeness with the matter. Similarly, to identify a mentally retarded child, somebody should be very close to the child, who knows each and every developmental step of that child, or say who takes care of the child. Close members could be mother, father, siblings or some close relatives. But it is already stated that the definite diagnosis is only done by the specialized medical practitioner.

TABLE NO. 6.6
DISTRIBUTION OF THE RESPONDENTS ACCORDING TO
PERSON WHO RECOGNIZED MENTAL RETARDATION

Village	PERSON WHO RECOGNISED MENTAL RETARDATION				
	Self	Relative	Grandmother	Dai	Total
Ahmedpur	25	2	2	0	29
	86.2%	6.9%	6.9%	0.0%	100.0%
Latur	35	2	0	0	37
	94.6%	5.4%	0.0%	0.0%	100.0%
Nilanga	28	2	2	3	35
	80.0%	5.7%	5.7%	8.6%	100.0%
Total	88	6	4	3	101
	87.1%	5.9%	4.0%	3.0%	100.0%

It is seen from the above table that about 87% of the respondents have identified themselves the symptoms discussed in earlier table. Only 6% of the respondents have reported that their relatives have identified mental retardation. In brief it is to say that the person who is taking the care of baby, is always have the proximate observation on the behaviour of child.

6.7 First reaction of parents about mental retardation:

It is universally true that every parents want perfect off-spring. But it is not applicable in every case due to certain circumstances. Sometimes the circumstances could be themselves, i.e. due to consanguineous marriage. It is not less than a shock for the parents when they first know about the child. Their first reaction could be denial; they are not ready to accept the mental retardation in their child. Some parents may not accept the child and just show the rejection towards child. The parents develop fear to expose their child in the neighbours, community as mentally retarded child. And after coming back to normal condition, they accept child in the same condition with mental retardation, they build courage to accept the challenge.

TABLE NO. 6.7
DISTRIBUTION OF THE RESPONDENTS ACCORDING TO
FIRST REACTION

Village	FIRST REACTION					
	Referred to Doctor	Waited for some days	Religious Treatment	Worship of God	Nil	Total
Ahmedpur	5	23	0	1	0	29
	17.2%	79.3%	0.0%	3.4%	0.0%	100.0%
Latur	9	26	1	1	0	37
	24.3%	70.3%	2.7%	2.7%	0.0%	100.0%
Nilanga	12	21	0	1	1	35
	34.3%	60.0%	0.0%	2.9%	2.9%	100.0%
Total	26	70	1	3	1	101
	25.7%	69.3%	1.0%	3.0%	1.0%	100.0%

25% of the respondents have reported when they come to know that their child have problem immediately they referred to doctor and consulted about their health. Large variations have been observed between blocks. 34% in Nilanga, 24% in Latur and 17% in Ahmedpur have reported immediately to the doctor. It is the general tendency that in

spite of the recognition of the symptoms, the villagers do not take cognitions of these symptoms. About 80% of the respondents waited for some days expecting in a natural condition, they will overcome the problem. In Latur, 70% respondents and in Nilanga 60% respondents have reported that they waited for some period to confirm the illness. Naturally, this period is very critical period. Actually, they should not practice such type of delay in retardation. That might have aggravated the problem further. There are a negligible proportion of the respondents who have taken the religious treatment and worshipped god for its cure. In brief it is to say that the villagers are not so prompt to refer the cases to the medical doctor.

6.8 Doctor's advice for mental retardation:

One, after having mental retardation there is no cure at all. The treatment cost is so costly in one side and in another side it is not treatment to cure totally. The only option left is rehabilitation. Community-based Rehabilitation (CBR) is one of the best examples of rehabilitation of mentally retarded child in the community.

TABLE NO. 6.8
DISTRIBUTION OF THE RESPONDENTS ACCORDING TO
FOLLOWING DOCTOR'S ADVICE

Village	WHETHER DOCTOR'S ADVICE WAS SOUGHT		
	Yes	No	Total
Ahmedpur	28	1	29
	96.6%	3.4%	100.0%
Latur	35	2	37
	94.6%	5.4%	100.0%
Nilanga	33	2	35
	94.3%	5.7%	100.0%
Total	96	5	101
	95.0%	5.0%	100.0%

In continuation of the earlier table, once they come to know that there is a problem, they have consulted the doctors about 95% of the respondents of all the blocks have consulted doctor for medical treatment and only 5% of the respondents have reported that due to non-availability of the experts they have not referred to the doctor and sought the advice for specialized treatment.

6.9 Type of treatment

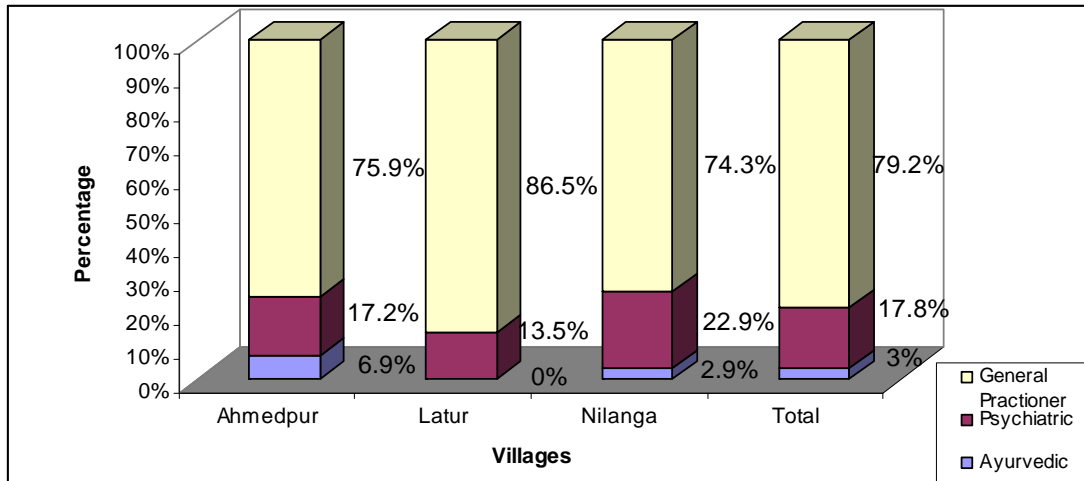
Usually, when mental retardation is diagnosed, parents are not interested to take allopathic medicines. For they try for domestic medicines followed by religious treatment. It is known fact that religious treatment is not solution to any disease. In spite of this, parents prefer to take religious treatment first. When they know that religious treatment is not effective or it is not making any impact, they turn towards Ayurvedic medicines. And if ayurvedic medicine fails to show any improvement, they take advice from the doctor. The treatment of mental retardation is very prolonged and also very expensive. Economic condition of the parents should permit to take the expensive treatment. In other words, affordability of the parents makes much more differences in the treatment of the mental retardation.

Along with the medical treatment, psychological treatment is also very effective for mental retardation. Indeed, psycho-medical treatment, i.e. combination of psychological and medical is one of the best solutions for this treatment.

TABLE NO. 6.9
DISTRIBUTION OF THE RESPONDENTS ACCORDING TO
TYPE OF MEDICAL TREATMENT

Village	TYPE OF MEDICAL TREATMENT			
	Ayurvedic	Psychiatric	General Practitioner	Total
Ahmedpur	2	5	22	29
	6.9%	17.2%	75.9%	100.0%
Latur	0	5	32	37
	0.0%	13.5%	86.5%	100.0%
Nilanga	1	8	26	35
	2.9%	22.9%	74.3%	100.0%
Total	3	18	80	101
	3.0%	17.8%	79.2%	100.0%

Chart No. 6.3
Type of Treatment



It is seen from the above table that about 80% of the respondents have reported that they have taken the medical treatment from general practitioners. 185 of the respondents have reported that they have taken the treatment from psychiatrist whereas in 3% of the respondents they sought advice from Ayurvedic doctor. In brief it is to say that

allopathic medicines are preferred more followed by psychiatric treatment and Ayurvedic treatment.

6.10 Doctor's reaction:

In view of the condition of the patient, doctor gives advice to the parents about the effectiveness of the treatment and also educates the parents about the plan of treatment. The plan of treatment and course of action are two aspects which are very critical in mental retardation for two main reasons- one it is complex phenomenon and patient needs to take prolonged treatment. Thus the expected progress is very slow and another reason is stigmatization of the illness. Parents usually do not accept this illness, and there is wrong impression that mental retardation is exclusively genetic disease, which is outcome of the curse of god. Therefore, doctor's reaction in this regards (treatment and rehabilitation) is very important.

TABLE NO. 6.10
DISTRIBUTION OF THE RESPONDENTS ACCORDING TO
DOCTOR'S ADVICE

Village	DOCTOR'S ADVICE			
	Treatment	Special Schools	Nil	Total
Ahmedpur	3	26	0	29
	10.3%	89.7%	0.0%	100.0%
Latur	25	11	1	37
	67.6%	29.7%	2.7%	100.0%
Nilanga	15	20	0	35
	42.9%	57.1%	0.0%	100.0%
Total	43	57	1	101
	42.6%	56.4%	1.0%	100.0%

The immediate reaction of the doctor is given in the above table. Large variations have been observed between blocks about the treatment they received from various doctors. In Latur, about 68% of the respondents have followed the treatment as per doctor's advice and rest of them doctor suggested to send that child into the school for special training. In Ahmedpur, about 90% of the doctors advised to send these children to school and only 10% have given the treatment to a child. In Nilanga, 57% respondents have reported that doctor has suggested sending him in a normal school and about 43% have got treatment from the doctor.

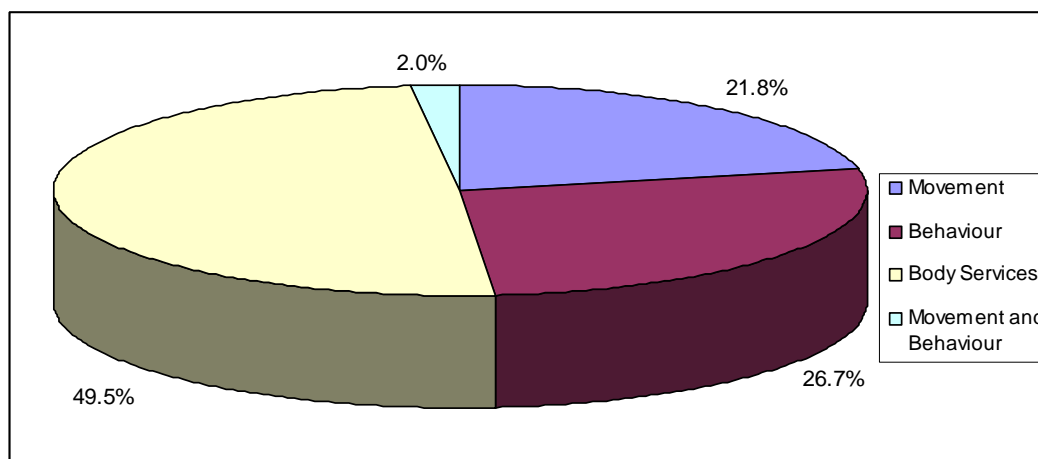
6.11 Special care of mentally retarded child:

As mentally retarded children are considered special children according to their special needs, they should be provided with special care. The special care includes exclusive attention on food, latrine, clothing and even in their timely activities. As their proximal age and mental age are different, they are unable to identify what should be done and what should not be done. For that also, the special care should be given so that they can learn socialization slowly. The education system also should be different for them. The teachers should get special training to make the children learn.

TABLE NO. 6.11
DISTRIBUTION OF THE RESPONDENTS ACCORDING TO
NEEDS FOR SPECIAL CARE

Village	NEEDS FOR SPECIAL CARE				
	Movement	Behaviour	Body Services	Movement and Behaviour	Total
Ahmedpur	6	4	17	2	29
	20.7%	13.8%	58.6%	6.9%	100.0%
Latur	7	9	21	0	37
	18.9%	24.3%	56.8%	0.0%	100.0%
Nilanga	9	14	12	0	35
	25.7%	40.0%	34.3%	0.0%	100.0%
Total	22	27	50	2	101
	21.8%	26.7%	49.5%	2.0%	100.0%

Chart No. 6.4
Needs for Special Care



About 22% of the respondents have reported that they have to take care of movements of the child mainly due to that child do not understand about his movements. To provide continuous attention on his behaviour is an important aspect of care taking. In all the blocks about 27% of the respondents have reported that they have to take special care of his behaviour. Large variations have been observed in this regard. 43% of the respondents from Nilanga, 24% from Latur and 14% from Ahmedpur have reported they have to take special care of the behaviour of the child. Very significant observation have been observed from this table is that about 50% of the respondents have reported that they have to take care of their body services. In Ahmedpur and Latur, equal proportion of the respondents have reported body services needs special attention whereas in Nilanga, hardly 34% respondents have to take care of his body services. In brief it is to say that need for special care is centred on with his body services rather than general behaviour and the movement.

6.12 Dependency of Child:

It is known to everyone that, mentally retarded children need some special care than other children. In this sense, they are dependent to their parents even in late

childhood and sometime even in early adulthood. So, they are more dependent to the parents and parents also should consider those children and should pay extra attention.

TABLE NO. 6.12 DISTRIBUTION OF THE RESPONDENTS ACCORDING TO INDEPENDENT MOBILITY

Village	INDEPENDENT MOBILITY		
	Yes	No	Total
Ahmedpur	3	26	29
	10.3%	89.7%	100.0%
Latur	2	35	37
	5.4%	94.6%	100.0%
Nilanga	10	25	35
	28.6%	71.4%	100.0%
Total	15	86	101
	14.9%	85.1%	100.0%

About 80% of the respondents have reported that the child is not able to go outside the home independently. In Ahmedpur, only 10%, in Nilanga the proportion is 29% whereas in Latur, this proportion is hardly 5%. That means only 15% of the mentally retarded children are able to move independently and 85% are not able to move independently.

6.13 Recall memory while going out and coming back:

The mentally retarded children have very short term memory. They can recall things for very short period, as there is no proper coordination between the body organs and brain in mentally retarded child. May be they can only recall very primary things such as recall the mother, father, family or something much important for them. It often depends upon severity of the mental retardation. Some mentally retarded children can respond, talk and approach to others, whereas some could not. They don't have any type of consciousness regarding anything.

TABLE NO. 6.13
DISTRIBUTION OF THE RESPONDENTS ACCORDING TO
RECALLING THE WAY OF GOING

Village	RECALLING THE WAY OF GOING		
	Yes	No	Total
Ahmedpur	12	17	29
	41.4%	58.6%	100.0%
Latur	5	32	37
	13.5%	86.5%	100.0%
Nilanga	10	25	35
	28.6%	71.4%	100.0%
Total	27	74	101
	26.7%	73.3%	100.0%

If a child moves nearby the house, child is not able to come back from the way that he/she went out. This means the child is not able to recall from which road that he/she came. Only 41% respondents of Ahmedpur, 29% from Nilanga and only 14% from Latur have reported that the child is not able to come back from the road, where he/she went out.

6.14 Ability to recognize relatives:

Generally, all mentally retarded children can identify their close relatives such as mother, father and family members. They can often identify some frequent visitors of the family. But it depends upon the severity of the mental retardation. It is again very difficult to identify the relatives for the children who have severe mental retardation.

TABLE NO. 6.14
DISTRIBUTION OF THE RESPONDENTS ACCORDING TO
MEMORISING INDIVIDUALS

Village	MEMORISING THE INDIVIDUALS		
	Yes	No	Total
Ahmedpur	12	17	29
	41.4%	58.6%	100.0%
Latur	18	19	37
	48.6%	51.4%	100.0%
Nilanga	19	16	35
	54.3%	45.7%	100.0%
Total	49	52	101
	48.5%	51.5%	100.0%

About half of the respondents have reported that the mentally retarded child is not able to recognize his relatives. In all the blocks more or less same trend have been observed. This clearly indicates that the child is not able to recognize not only the relatives but even the family members also. These children need special attention.

6.15 Most favourite items:

In mental retardation, there is a physical growth but the mental growth doesn't take place in a speed as anticipated by the medical stages. Naturally, if he is 15 years old, he may not behave the person like 15 years. There are some milestones of the development either physical or mental. Accordingly, there is a development of likings of particular item. The detail about the same is given in following table:

TABLE NO. 6.15
DISTRIBUTION OF THE RESPONDENTS ACCORDING TO
MOST FAVOURITE ITEMS

Village	MOST FAVOURITE ITEMS			
	Clothing	Food	Pets	Total
Ahmedpur	3	12	14	29
	10.3%	41.4%	48.3%	100.0%
Latur	9	13	15	37
	24.3%	35.1%	40.5%	100.0%
Nilanga	0	11	24	35
	0.0%	31.4%	68.6%	100.0%
Total	12	36	53	101
	11.9%	35.6%	52.5%	100.0%

It is seen from the above table that about 53% of the respondents have reported that the mentally retarded children like pets such as dog, cat etc, whereas 36% have reported he likes various food items of different tastes and 12% have reported he likes clothes of various colours. Large variations have been observed between blocks. In one village, particular liking is more whereas in another village, some different liking is observed.

6.16 Prolonged illness during childhood:

Naturally children are immature and have very weak or developing immune system. In this period, they are very prone to diseases such as cold and cough, fever, chills, measles, tetanus, polio, small pox etc. If those diseases are prolonged, then they effect on development of brain. Thus the brain becomes malfunctioned. In this case, they get underdeveloped brain and are prevail to get mental retardation.

When children get cold and cough and is not treated properly, the cold make nasal inflammation, which makes difficulty in respiration. Accordingly, if they are not able to

do respiration, the brain will not get adequate oxygen as needed, which can hamper brain to work and it can develop mental retardation in the child.

TABLE NO. 6.16 A
DISTRIBUTION OF THE RESPONDENTS ACCORDING TO
CHRONIC ILLNESSES

Village	CHRONIC ILLNESSES		
	Yes	No	Total
Ahmedpur	2	27	29
	6.9%	93.1%	100.0%
Latur	2	35	37
	5.4%	94.6%	100.0%
Nilanga	13	22	35
	37.1%	62.9%	100.0%
Total	17	84	101
	16.8%	83.2%	100.0%

It is seen from the above table that, 17% of the respondents have reported that the mentally retarded children have chronic illness and even in Ahmedpur, Latur about 7% respondents have reported the children have problem of chronic illness. In Nilanga, highest proportion of respondents has reported that child was suffering by some chronic illnesses. However, majority of them have reported they do not have any illness since last two years.

Table No. 6.16 B
Distribution of Respondents According to
Need of Continuous Attention vs. Frequent Illness

	NEED OF CONTINEOUS ATTENTION		Total	
		Yes		No
FREQUENT ILLNESS	Common Cold	33	5	38
		86.84	13.16	100.00
	Fever	19	1	20
		95.00	5.00	100.00
	Not specific	37	6	43
		86.05	13.95	100.00
Total		89	12	101
		88.12	11.88	100.00

Common cold and fever, these two types of the infections are more prominent among the mentally retarded children. This is quite obvious that they are not able to distinguish between cleanliness and dirtiness.

6.17 Ear infection during childhood:

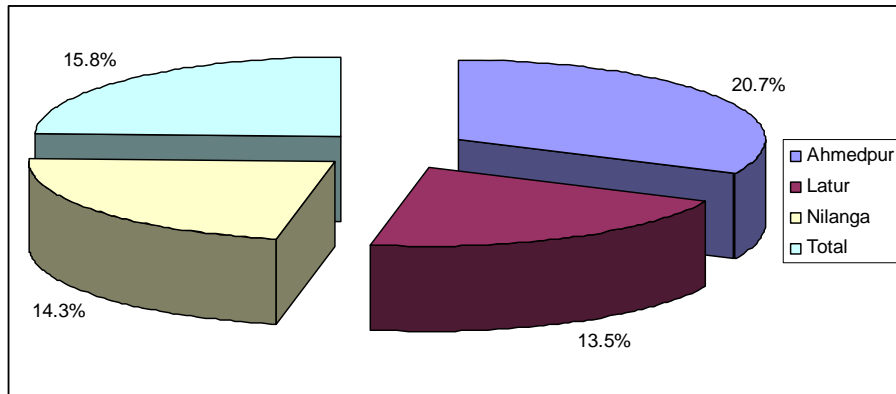
The function of ear as one of the sense organ doesn't only finite in hearing, but also in balancing the whole body. So, most of the times, when children get cold, cough or fever, if it is not controlled, the first effect will be in ear and hearing capacity. Once they are unable to hear, the brain couldn't learn to speak, thus child becomes hearing impaired and mute. Similarly, when the child gets otitismedia (Ear infection), it emerges from external part of the ear to the ear drum and ear drum to the estishotion tube in the internal part of ear. It is very closer to brain, so there is maximum chance to get infection in brain from this medium. Due to this, the brain stops working and children get mental retardation.

TABLE NO. 6.17
DISTRIBUTION OF THE RESPONDENTS ACCORDING TO
EAR INFECTION IN CHILDHOOD

Village	EAR INFECTION IN CHILDHOOD		
	Yes	No	Total
Ahmedpur	6	23	29
	20.7%	79.3%	100.0%
Latur	5	32	37
	13.5%	86.5%	100.0%
Nilanga	5	30	35
	14.3%	85.7%	100.0%
Total	16	85	101
	15.8%	84.2%	100.0%

Chart No. 6.5

Ear Infection during Childhood



Ear infection has the special significance for mental retardation. As like the chronic illness, 16% of the respondents have reported that during common cold and fever, there was a frequent ear infection and the child was not able to recognize that illness.

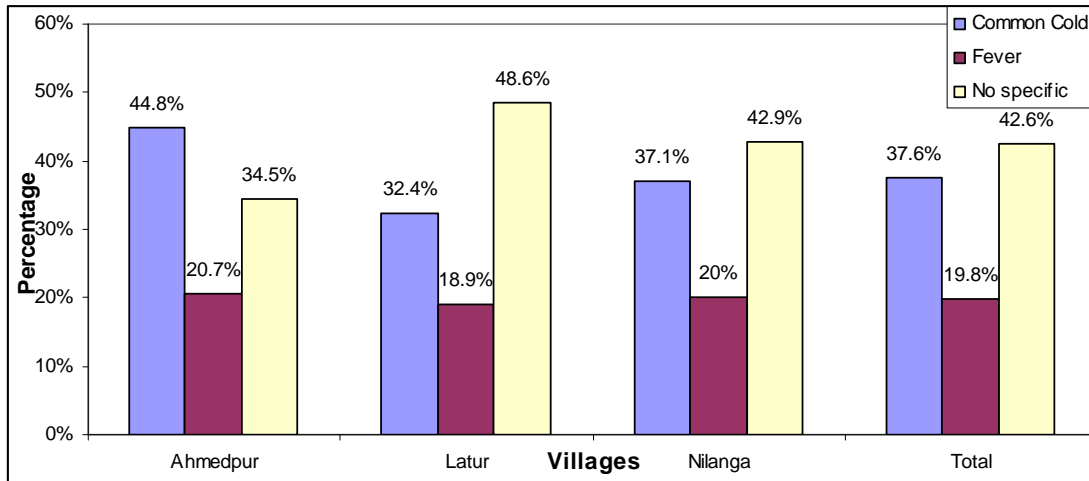
6.18 Frequent morbid condition of the child:

Children in early age have very less immunity power. Living in this world, taking nutritious food only, the children develop resistance power gradually. But again, while developing this immunity power, they come across with different diseases and if there is no enough immunity power to fight with the diseases, child gets infection. So, children are more prone to diseases. The more prevalence of diseases makes more vulnerability towards mental retardation.

TABLE NO. 6.18
DISTRIBUTION OF THE RESPONDENTS ACCORDING TO
FREQUENT ILLNESSES

Village	FREQUENT ILLNESSES			
	Common Cold	Fever	No specific	Total
Ahmedpur	13	6	10	29
	44.8%	20.7%	34.5%	100.0%
Latur	12	7	18	37
	32.4%	18.9%	48.6%	100.0%
Nilanga	13	7	15	35
	37.1%	20.0%	42.9%	100.0%
Total	38	20	43	101
	37.6%	19.8%	42.6%	100.0%

Chart No. 6.6
Frequent Morbid Conditions



In continuation of the earlier two tables, the above table shows the morbid condition of mentally retarded child. In all the blocks more or less same trend have been observed. For example, 38% respondents have reported common cold is the frequent morbid condition followed by 20% reported frequent fever. Considerably high proportion of the respondents, that 43% respondents have reported that there are several opportunistic infections which is not very specific but can occur at any time.

6.19 Attending school:

The mentally retarded children need special school, where they can learn in their own way as their capacity. They not just focus on education, but also teach the basic things such as dressing sense, fooding manner, responding others, toileting manners etc. Generally, these children need more exposure to learn more, so they should be send to school. Children are also interested to go to school, if they find it favourable to them. They interact with the same type of friends in the school, from where the school can do rehabilitative activities in inter-group approach.

TABLE NO. 6.19
DISTRIBUTION OF THE RESPONDENTS ACCORDING TO
SCHOOL ATTENDANCE

Village	ATTENDING SCHOOL REGULARLY		
	Yes	No	Total
Ahmedpur	6	23	29
	20.7%	79.3%	100.0%
Latur	8	29	37
	21.6%	78.4%	100.0%
Nilanga	12	23	35
	34.3%	65.7%	100.0%
Total	26	75	101
	25.7%	74.3%	100.0%

Very surprising observation is observed from the above table. Though the government's effort for integrating disabled child in mainstream of education, along with the normal children, about 75% of the respondents are not sending their child in school regularly. Naturally, the chances of aggravating the problem are always more in these children. No large variation has been observed in this situation, whereas independent study or self study is discussed in following table.

6.20 Self study of mentally retarded child:

It is already known that mentally retarded children have different needs and the education is also different, which includes holistic development and socialization of these children. As the children are very slow learner, the teachers should be well trained and full of patience. They don't have handwriting or any type of activities to do as homework or class work of school, but they are made learnt in different ways. They work in group and learn very gradually.

Often, they are very interested in dancing, so the teachers also engage the children in dance programmes. They have tendency to practice the same thing when they learn new things, so they keep on dancing in the home as well. The children having minor mental retardation can go to school, study the school curriculum and also do their homework and self study.

TABLE NO. 6.20
DISTRIBUTION OF THE RESPONDENTS ACCORDING TO
SELF STUDY

Village	SELF STUDY		
	Yes	No	Total
Ahmedpur	5	24	29
	17.2%	82.8%	100.0%
Latur	2	35	37
	5.4%	94.6%	100.0%
Nilanga	5	30	35
	14.3%	85.7%	100.0%
Total	12	89	101
	11.9%	88.1%	100.0%

It is a known fact that, mental retardation itself is a problematic condition. One cannot expect that the child would perform his/her study independently. In all the blocks, hardly 12% of the respondents have reported that the child is able to do his study independently, whereas 88% of the respondents have reported he/she is not able to do any independent study.

6.21 Caretaker for the study:

Whenever the mentally retarded child needs whatever type of help, the caretaker should be available. As the mother is the caretaker in most of the cases, she is the one who help child in study. She needs to listen to the child carefully and try to answer. Even if they are practicing dance, mother should watch each and every step and should praise

them for promotion and self esteem. Mother keeps on helping the child to study and perform the task.

TABLE NO. 6.21
DISTRIBUTION OF THE RESPONDENTS ACCORDING TO TAKING HELP OF
FAMILY MEMBERS

Village	TAKES THE HELP OF THE FAMILY MEMBER		
	Yes	No	Total
Ahmedpur	10	19	29
	34.5%	65.5%	100.0%
Latur	10	27	37
	27.0%	73.0%	100.0%
Nilanga	8	27	35
	22.9%	77.1%	100.0%
Total	28	73	101
	27.7%	72.3%	100.0%

In continuation of the above table, unless a caretaker or any family member take the initiative for helping the mentally retarded child, it is not possible for him to undertake study independently. In Ahmedpur, about 35% respondents have reported that they have to take help of other family members for their study while in Latur 27% and in Nilanga 23% respondents have reported that he needs help for his study. In brief it is to say that unless there is help from family members, he/she cannot undertake his study.

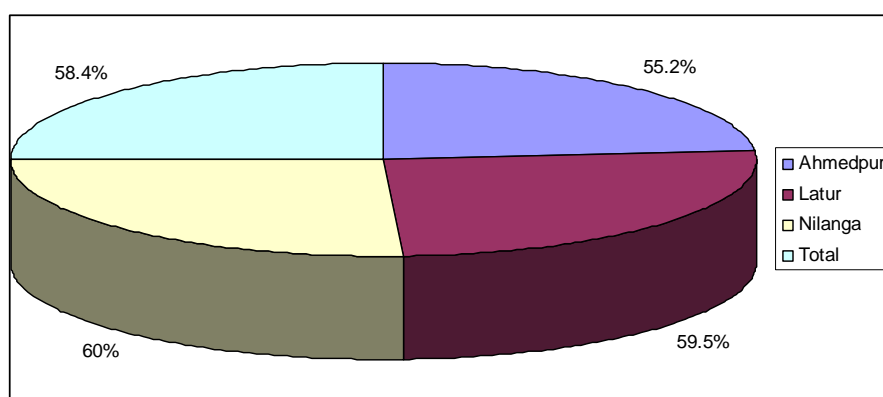
6.22 Liking and mixing in the group:

The liking and mixing in the group is only possible if the group is homogeneous. The mentally retarded children can easily mix up in the group of mentally retarded rather than of other group. The mentally retarded child is often neglected in other groups. They keep on teasing the child giving different names such as mad, crazy, psyche etc. Normal children don't accept the child in their group and child becomes neglected isolate.

TABLE NO. 6.22
DISTRIBUTION OF THE RESPONDENTS ACCORDING TO
ADJUSTMENT IN THE GROUP

Village	ADJUSTMENT WITH OTHER CHILDREN		
	Yes	No	Total
Ahmedpur	16	13	29
	55.2%	44.8%	100.0%
Latur	22	15	37
	59.5%	40.5%	100.0%
Nilanga	21	14	35
	60.0%	40.0%	100.0%
Total	59	42	101
	58.4%	41.6%	100.0%

Chart No.
Adjustment in the Group



The above table depicts though a child is suffering by mental retardation, he always tries to adjust with other children either in the family or of the neighbours. In all the blocks' more or less same trend is observed about adjustment. In brief it is to say that

these mentally retarded children have capacity to mould their behaviour consistent with others depending upon the situation.

6.23 Liking of colour of clothes:

Even the child is mentally retarded, the child has favourite colour, favourite dress etc. Some children couldn't perceive their own sex and they behave like a boy being a girl and want to dress up as boy only.

TABLE NO. 6.23
DISTRIBUTION OF THE RESPONDENTS ACCORDING TO
FAVOURITE COLOUR

Village	FAVORITE COLOUR				
	Red	Blue	Green	Not specific	Total
Ahmedpur	8	11	6	4	29
	27.6%	37.9%	20.7%	13.8%	100.0%
Latur	9	14	4	10	37
	24.3%	37.8%	10.8%	27.0%	100.0%
Nilanga	3	15	9	8	35
	8.6%	42.9%	25.7%	22.9%	100.0%
Total	20	40	19	22	101
	19.8%	39.6%	18.8%	21.8%	100.0%

About 20% of the respondents reported that the children like red colour, whereas 40% have reported blue colour and 18% have reported green colour. About 22% of the respondents have not reported any specific colour. Baring few variations, no drastic differences have been observed between blocks.

6.24 Watching the television:

There are three types of mental retardation on the basis of severity- severe, medium and simple. The children with severe mental retardation have no consciousness

about anything, so they have no concern even on television. But the children with remaining type of mental retardation can watch television, understand the characters, recognize the words used by the characters and even try to imitate the action as well as word. These children are most interested to watch television for time pass even for the whole day.

TABLE NO. 6.24
DISTRIBUTION OF THE RESPONDENTS ACCORDING TO
WATCHING TELEVISION

Village	WATCHING TELEVISION		
	Yes	No	Total
Ahmedpur	17	12	29
	58.6%	41.4%	100.0%
Latur	23	14	37
	62.2%	37.8%	100.0%
Nilanga	24	11	35
	68.6%	31.4%	100.0%
Total	64	37	101
	63.4%	36.6%	100.0%

It is seen from the above table that 2/3 of the respondents have reported that mental retardation likes to watch television and he/she takes interest in various cartoons as he/she see on the screen. This tendency is observed in all mentally retarded children without any significant differences.

6.25 Favourite Programmes:

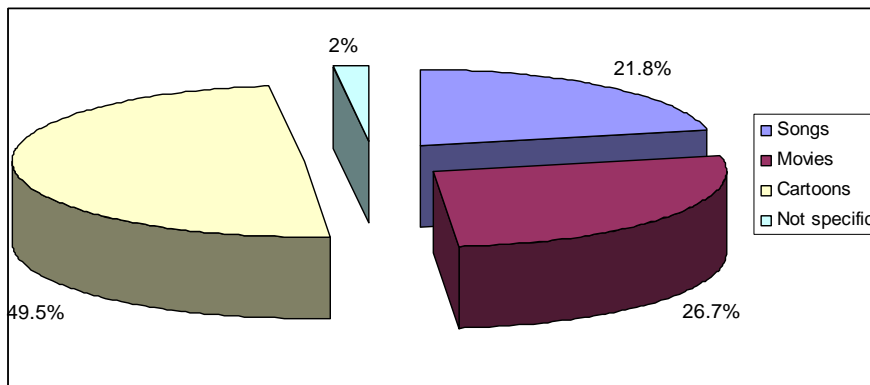
Every age group have own favourite programme in television. Similarly, children also have own favourite channels and favourite programmes. The mentally retarded children have own favourite programmes too. They often have main interest on watching

cartoon programmes. They keep on staring at television for the whole day for their favourite programmes.

TABLE NO. 6.25
DISTRIBUTION OF THE RESPONDENTS ACCORDING TO
FAVOURITE PROGRAMMES

Village	FAVOURITE PROGRAMMES				
	Songs	Movies	Cartoons	Not specific	Total
Ahmedpur	6	4	17	2	29
	20.7%	13.8%	58.6%	6.9%	100.0%
Latur	7	9	21	0	37
	18.9%	24.3%	56.8%	0.0%	100.0%
Nilanga	9	14	12	0	35
	25.7%	40.0%	34.3%	0.0%	100.0%
Total	22	27	50	2	101
	21.8%	26.7%	49.5%	2.0%	100.0%

Chart No.
Favourite Programmes



About 22% mentally retarded children have reported that they like songs, followed by 27% movies and about half of the mentally retarded children like cartoon

films, which is favourite among the children. In brief it is to say that cartoon films are more popular among mentally retarded children.

6.26 Liking about water:

Mentally retarded children are fond to play with water. Whenever they find water, they just start playing even if it is too dirty, they pour their palm in the water, observe the change, splash the water and try to concentrate. Sometime they just try to grasp the waves of water, as they feel it more interesting.

TABLE NO. 6.26
DISTRIBUTION OF THE RESPONDENTS ACCORDING TO
PLAY WITH WATER

Village	PLAY WITH WATER		
	Yes	No	Total
Ahmedpur	8	21	29
	27.6%	72.4%	100.0%
Latur	12	25	37
	32.4%	67.6%	100.0%
Nilanga	7	28	35
	20.0%	80.0%	100.0%
Total	27	74	101
	26.7%	73.3%	100.0%

The table above shows, the 27% of the mentally retarded children take interest in playing with water. This indicates that they do not have any fear of water, whereas rest of them do not take interest to play with water. This indicates there might be fear among mentally retarded children.

6.27 Liking of pets:

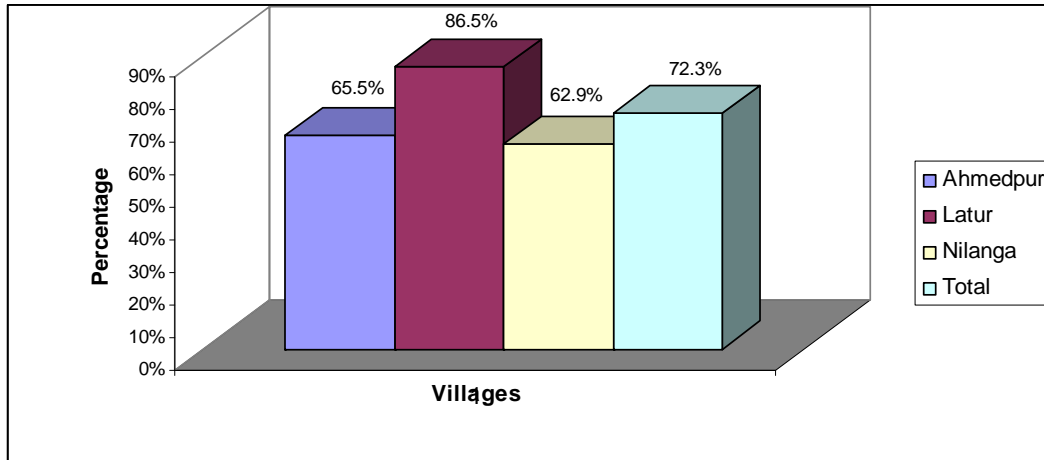
To love others is the innate desire of every individual. Generally, children like cat and dogs as they can play with them. The pet animal treatment is also one of the new therapies emerging in the society for treating mental retardation. However, this is very latest approach to deal with mental retardation during childhood.

TABLE NO. 6.27

DISTRIBUTION OF THE RESPONDENTS ACCORDING TO LIKING PETS

Village	LIKING PETS		
	Yes	No	Total
Ahmedpur	19	10	29
	65.5%	34.5%	100.0%
Latur	32	5	37
	86.5%	13.5%	100.0%
Nilanga	22	13	35
	62.9%	37.1%	100.0%
Total	73	28	101
	72.3%	27.7%	100.0%

Chart No.
Liking Pets



The table above shows that almost $\frac{3}{4}$ of the mentally retarded children like various pets. No large variation has been observed between blocks. Due to pet, he/she increases body movements which helps to prevent various illnesses and gets exercise in proper way.

6.28 Reaction of mentally retarded child about pets, favourite relatives:

Some of the mentally retarded children feel very comfortable to locomotors movements. Due to the pets, child moves from one place to another, try to catch it, try to feed, and try to keep them. In this process, they realize and understand how to react, how to tolerate, how to coordinate the movements. Naturally, this process helps to develop the skills needed for day to day life. He/she develops the skills related to loving others, controlling own anger etc. As this is the new therapy, though there is hardly any specific result, but this is being used throughout the world.

A qualitative data of this point indicates that child gets enjoyment when he is playing with the pets. This also helps in giving the instructions and following the instructions given by others. These movements are very essential to bring motor

coordination in a proper sequence. Indeed love and affection is two aspects which the child develops with the help of pets in form of reaction.

6.29 How mentally retarded child spends day?

Mentally retarded children generally like to do any one thing. Many of the mentally retarded children, they are most interested in dancing. So they rigorously practice dance and focus on dancing for whole day. They apply their whole effort only to one thing either dance or any other according to their interest.

The qualitative data on this point is collected. It shows that long hours of sleep, watching television, slow eating and playing with the pets, these are the four main activities in which the child engage throughout the day.

6.30 Perception about innate potentialities:

Every human being has innate capacities. This capacity is transferred from one generation to another. The environment provides the stimuli to explore the potentialities which take in shape in form of personality. As regard to mentally retarded child, there is hardly any stimulus for exploring his/her potentialities. Reception of the stimuli, this process does not take place before, function of the certain part of the brain almost paralyzed. Hence, there is no response from the mentally retarded child. However, parents should take sustained effort to develop minimum level of skills needed to live as a human should. Therefore, whether the parents are recognized, what their child can do is an important aspect. Among the parents, mother is very closely associated with the child. She must be able to understand and recognize the potentialities of the baby.

TABLE NO. 6.28
DISTRIBUTION OF THE RESPONDENTS ACCORDING TO
POTENTIAL QUALITIES OF THE CHILD

Village	POTENTIAL QUALITIES OF THE CHILD		
	Yes	No	Total
Ahmedpur	10	19	29
	34.5%	65.5%	100.0%
Latur	16	21	37
	43.2%	56.8%	100.0%
Nilanga	15	20	35
	42.9%	57.1%	100.0%
Total	41	60	101
	40.6%	59.4%	100.0%

Only 40% of the respondents were able to identify the potential qualities with mentally retarded child. This is naturally obvious that the parents may not be able to identify what are the potential qualities with the child and how one can develop this one. In all blocks, almost uniform picture is observed in this regard. In brief it is to say that there is hardly any effort by parents to recognize the innate potentialities of the child.

6.31 Efforts taken to explore potentialities:

Mother is the proximate relative, care taker and a human being of mentally retarded child. If the mother is alert, she may recognize the potentials of baby and make the efforts to develop minimum level of skills to perform his/her daily activities. Other family members like siblings, other close relative should also co-operate the mother in development of life skills. Unless sustained efforts are taken at the family level, it becomes difficult to develop the life skills. The blind faith and cultural practice are to be kept aside for his/her development. Otherwise the problem gets aggravated by blind faith, beliefs and cultural, religious treatment.

TABLE NO. 6.29
DISTRIBUTION OF THE RESPONDENTS ACCORDING TO
EFFORTS TAKEN TO ENHANCE POTENTIAL QUALITIES

Village	EFFORTS TATEN TO ENHANCE POTENTIALITIES		
	Yes	No	Total
Ahmedpur	17	12	29
	58.6%	41.4%	100.0%
Latur	22	15	37
	59.5%	40.5%	100.0%
Nilanga	24	11	35
	68.6%	31.4%	100.0%
Total	63	38	101
	62.4%	37.6%	100.0%

In continuation of the earlier table, as there is a failure from parents' side to identify the potentials of the mentally retarded child, the chances of making sustained efforts are obviously less. However, about 2/3 of the total parents have reported that they have made and attempt and making the efforts to develop its potential qualities.

6.32 Independent body Services:

Mentally retarded children are slow learners. It is not that, they can't learn anything. If there is somebody who takes care of the mentally retarded child properly, create such an environment where child can learn all the manners and make good habits. The child with mental retardation can also learn body wastage exit him/herself if they are taught properly.

TABLE NO. 6.30
DISTRIBUTION OF THE RESPONDENTS ACCORDING TO
SELF RELIANCE IN BODY SERVICES

Village	SELF RELIANCE IN BODY SERVICES		
	Yes	No	Total
Ahmedpur	24	5	29
	82.8%	17.2%	100.0%
Latur	30	7	37
	81.1%	18.9%	100.0%
Nilanga	25	10	35
	71.4%	28.6%	100.0%
Total	79	22	101
	78.2%	21.8%	100.0%

The table above shows that about 80% of the mentally retarded children are able to do their body services independently. This shows that though they are mentally ill, but at least they can manage their daily needs up to certain extent, but totally fails in neatness in behaviour. In all the blocks, no large variations have been observed in this regard.

6.33 Favourite Food:

During childhood, sour and sweet items are most favourite. The children eat various biscuits and confectionary. However, in daily diet, it is expected that child should eat square meal, which includes dal, rice, chapatti, desert, vegetables etc. Detail about the same is given in following table:

TABLE NO. 6.31

DISTRIBUTION OF THE RESPONDENTS ACCORDING TO FAVOURITE FOOD

Village	FAVORITE FOOD					
	Dal-Rice	Dal-Chapati	Dessert	Sweet	All Items	Total
Ahmedpur	5	4	4	8	8	29
	17.2%	13.8%	13.8%	27.6%	27.6%	100.0%
Latur	2	3	3	14	15	37
	5.4%	8.1%	8.1%	37.8%	40.5%	100.0%
Nilanga	5	6	3	11	10	35
	14.3%	17.1%	8.6%	31.4%	28.6%	100.0%
Total	12	13	10	33	33	101
	11.9%	12.9%	9.9%	32.7%	32.7%	100.0%

It is seen from the table that about 1/3 of the total respondents, sweets are more favourite and equal proportion of respondents, all items are favourite. Perhaps, there is no any specific favourite item. However, about 12% respondents have reported mentally retarded children like dal-rice and equal proportion of respondents have reported mentally retarded children like dal-chapati. This shows that if they develop the taste of particular item, it becomes favourite item for them.

6.34 Consciousness about various needs and activities

Generally, till the age of one, the children are not able to control to the exit of body wastages. Whenever the bladder is full, it just start, there is no consciousness regarding the exit to the children in the beginning of the life, but later on they just develop in their own way and control. The children become alert about the toilet before they exit. In this way they develop some sort of toilet habit. But as regard to mental retardation, those children do not have coordination between brain and organs. So, their brain don't get message about the toilet and brain can't make alert other organs for it. So, they have no alertness about the toilet.

The bedding habit is also based on the severity that whether they can do their own work or not. Most severe cases of mental retardation can't do anything, because they have no consciousness at all. But for other types of mental retardation, they can do simple household work, if they are taught slowly and simply. Bedding is one of the simple tasks to do. So, these children can maintain their bed, if they are made learned.

In case of dressing also, if they are taught effectively, they can do their dressing themselves, but if the design is new then they can't follow. In most of the case, the children get problem with shoe laces. But it is possible to make them learn all those things.

Eating food is favourite work for the mentally retarded children. They keep on eating until and unless they are provided. There is no limitation of eating in the mentally retarded children. Due to extreme eating behaviour, the child may develop obesity, which creates more problem in body functioning. There is no movement in the body on the one hand and the child is increasing the obesity by eating more on the other hand. It is really vulnerable stage. So, the caretaker should plan for the food of the child and should keep proper timing to have breakfast, lunch and dinner for the child. This will make the fooding habit systematic and also the stomach get some rest.

If the mentally retarded children are taught, they can have their meal on their own, but they lack the fooding manner. They know how to eat but don't know how to eat properly. So, it is responsibility of care taker that the child is having meal or not, how child is having, how to teach to eat properly etc. It is also the topic of concern whether the child spoils the meal or not, how much they eat and how much is needed to eat according to their body movement. Generally, mentally retarded children have tendency to eat more as there is no control in eating by the body. So, the caretaker has to consider the weight of the child, movement and calculate how much is needed. It is more harmful to make the child eat more.

TABLE NO. 6.32

DISTRIBUTION OF THE RESPONDENTS ACCORDING TO
SELF RELIANCE ABOUT TOILET AND DEFECATION

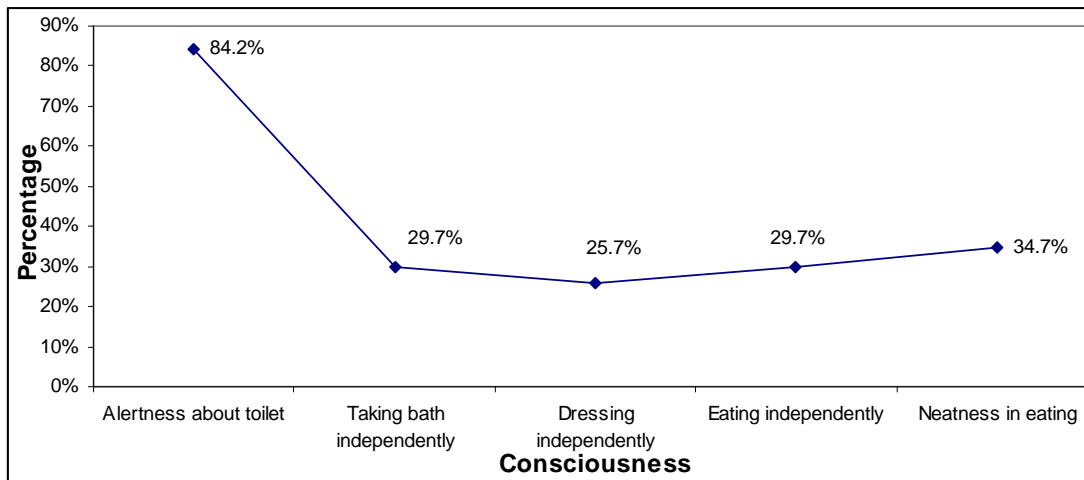
Village	INDEPENDENCE IN VARIOUS ACTIVITIES	
	Go for toilet	Go for defecation
Ahmedpur	28	28
	96.6%	96.6%
Latur	30	30
	81.1%	81.1%
Nilanga	31	27
	88.6%	77.1%
Total	89	85
	88.1%	84.2%

The above table indicates that about 88% of the respondents go for toilet independently. No large variation has been observed in the responses, whereas there are hardly 12% respondents who are not able to go for toilet independently. The same case is about defecation. About 84% of the mentally retarded children are able to go for defecation interdentally. This clearly indicates that they are aware about their body needs. The following table further explains consciousness about toileting, taking bath dressing, eating and neatness in the eating.

TABLE NO. 6.33
DISTRIBUTION OF THE RESPONDENTS ACCORDING TO
CONSCIOUSNESS ABOUT VARIOUS NEEDS AND ACTIVITIES

Village	CONSCIOUSNESS ABOUT VARIOUS NEEDS AND ACTIVITIES				
	Alertness about toilet	Taking bath independently	Dressing independently	Eating independently	Neatness in eating
Ahmedpur	27	11	10	10	13
	93.1%	37.9%	34.5%	34.5%	44.8%
Latur	29	8	6	10	8
	78.4%	21.6%	16.2%	27.0%	21.6%
Nilanga	29	11	10	10	14
	82.9%	31.4%	28.6%	28.6%	4.0%
Total	85	30	16	30	35
	84.2%	29.7%	25.7%	29.7%	34.7%

Chart No.
Consciousness about Various Needs and Activities



It is seen from the table that about 84% of the respondents are alert about their toilet, which means if they feel to attend the toilet they can manage, perhaps this is one of

the most important behavioural aspect among mentally retarded children. As regard to bathing habits, hardly 30% of the respondents are able to take their bath independently, this is mainly due to for toilet there is a consciousness, but for bathing one cannot find the consciousness. Hence the self reliance is comparatively less in all the mentally retarded children. The same case is observed about dressing also. They are not able to dress well or they are not conscious how to put and button the dress. Naturally, shabbiness in the dressing is observed to be prominent among mentally retarded children.

If they are hungry, they can demand for the food, but they don't know how much to eat. If they get food, they go on eating and eating. Naturally, there is over diet and due to this some other problems are invited. When they eat, they spoil food. This indicates they do not have proper coordination between body organs. In brief it is to say that except toilet, rest of the body services are not performed well mainly due to non-coordination of body organs.

6.35 Consciousness about various needs and activities

a) Hunger: There is no proper order in body functioning of a mentally retarded child. These children are unable to express their needs, and even their hunger. They show some different acts to notify others about their hunger. They show some hyperactive disorder and temper tantrum to gain attention of others towards he/her and tries to fulfil the hunger.

b) Drinking of tea/coffee/milk: With eating, drinking is also another choice of mentally retarded child. They have no choice as such, what they want to drink, but whatever is provided they just drink. There is no control over the drinking tea, as the brain does not control the child to drink in limit. They don't know what they are drinking, but they want more and more even if it is hot or cold. If it is hot and it make his/her mouth burned also, it doesn't matters, the theory of classical conditioning or conditional stimuli does not applies in this case.

c) Troublesome behaviour: Violent behaviour is one of the major problems of mentally retarded child. If they become violent, it becomes very difficult to keep them under control. There are several reasons, why they do not have their own control on their own behaviour. For such types of habits, most of the parents are also responsible. If the child is over pampered, he/she develops some egoistic behaviour and if it is not fulfilled, then they express their violent behaviour. Destruction of domestic items, making self injuries, throwing any items on others, beating the siblings, shouting loudly, crying loudly, are some of the forms of violent behaviour. Once child knows to show the violent behaviour, and attract the attention of family members, he/she repeats the same type of behaviour again and again. Therefore, keeping the control on his/her behaviour is an important.

Table No.
Distribution of Respondents according to Troublesome Behaviour vs.
Relationship of the Mentally retarded Child with Neighbours

	TROUBLESOME BEHAVIOUR			Total
		Yes	No	
RELATIONSHIP OF M.R CHILD WITH NEIGHBOURS	Friendly	11	2	13
		84.62	15.38	100.00
	Teasing	23	18	41
		56.10	43.90	100.00
	General	29	18	47
		61.70	38.30	100.00
Total		63	38	101
		62.38	37.62	100.00

The above table shows, those siblings or the children of the neighbours have friendly relations. Among them almost all children have the troublesome behaviour. However, teasing is the common phenomenon observed with the mentally retarded children.

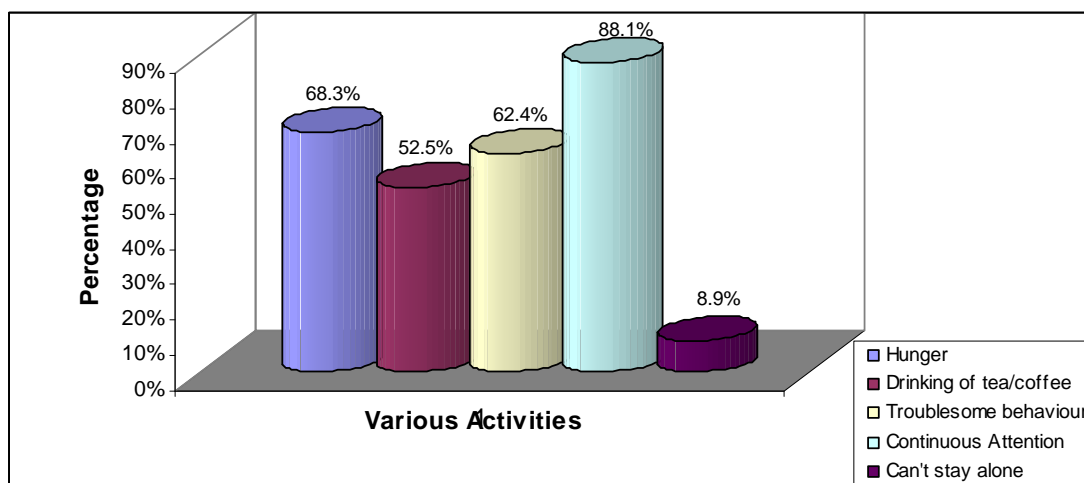
d) Perception about need for continuous attention: As discussed in earlier point, if the child has tendency to violent behaviour, parents have to keep continuous attention on his/her behaviour. Siblings or any other family members also take proper and adequate care, so that they will not create major problem in later life. To deal this aspect, adjustment at family level is very important. Though it is difficult and troublesome job/task, there is no alternative for this.

e) Able to stay alone: Human beings are social animal. They need friends, communication with others. They are unable to live alone for much time. They feel isolated when they are alone. But in the case of mentally retarded children, they don't know what the group life is, and don't feel the significance of group. Generally, they stay alone, do whatever they want to do, and keep on doing the same thing for whole day. They have no control over the body wastage exit. They don't care of wet clothes and dirty body.

TABLE NO. 6.34
DISTRIBUTION OF THE RESPONDENTS ACCORDING TO
CONSCIOUSNESS ABOUT VARIOUS NEEDS AND ACTIVITIES

Village	CONSCIOUSNESS ABOUT VARIOUS NEEDS AND ACTIVITIES				
	Hunger	Drinking of tea/coffee	Troublesome behaviour	Continuous Attention	Can't stay alone
Ahmedpur	20	21	16	25	2
	69.0%	72.4%	55.2%	86.2%	6.9%
Latur	27	6	31	35	1
	73.0%	16.2%	83.8%	94.6%	2.7%
Nilanga	22	26	16	29	6
	62.9%	74.3%	45.7%	82.9%	17.1%
Total	69	53	63	89	9
	68.3%	52.5%	62.4%	88.1%	8.9%

Chart No.
Consciousness about Various Activities



Hunger is the natural instinct. If they are hungry, they are demanding the food. About 2/3 of the respondents of all the blocks have reported that there is a consciousness about hunger but are not conscious about how much to be eaten. Only half of the respondents are able to take liquid food neatly. Again, one finds that there is no proper coordination in muscular movements. In brief it is to say that due to lack of coordination they have to face lots of difficulties.

As they do not have proper coordination, they may spoil food items or they may not be able to give adequate attention of the family members. Naturally it becomes intolerable to keep the behaviour under control. In real sense, they are not doing anything purposively. Due to this situation only, 88% of the respondents have reported that they need to provide continuous attention in their day to day behaviour. Due to this attention, parents can't live such children alone in the family. They have to take care for that someone must be at home to look after this child.

6.36 Caring by Siblings:

Generally, there is no sound relationship between mentally retarded children and their siblings. Siblings normally don't accept the mentally retarded child in the family and misbehave with them. They don't even accept the child as own sibling. They show their guiltiness of being a sibling of mentally retarded child. Very few siblings try to understand the real condition of child and try to help out the mentally retarded child. But many of the times, they get irritated due to worthless caring.

TABLE NO. 6.35
DISTRIBUTION OF THE RESPONDENTS ACCORDING TO
SIBLINGS' TAKE CARE

Village	SIBLINGS' TAKE CARE		
	Yes	No	Total
Ahmedpur	24	5	29
	82.8%	17.2%	100.0%
Latur	17	20	37
	45.9%	54.1%	100.0%
Nilanga	21	14	35
	60.0%	40.0%	100.0%
Total	62	39	101
	61.4%	38.6%	100.0%

It is seen from the table above that, about 2/3 of the respondents have reported that the siblings of the mentally retarded child are taking minimum level of care in absence of parents. However, the large variations have been observed in care by siblings. In Ahmedpur, 83% respondents followed by Nilanga 60% and Latur 46% have reported that siblings are taking care during the absence of caretaker.

6.37 Who is the caretaker?

The closest person for these children is own mother. The mother takes care of those children and tries her best to settle the child, make learn to the basic things of living. Mother helps in taking bath, dressing, fooding, latrine exit, and also to teach to be socialized. These mothers should be more patient and should know the condition of her child. They should be motivated to learn and to do new things.

TABLE NO. 6.36
DISTRIBUTION OF THE RESPONDENTS ACCORDING TO
ALTERNATIVE CARE TAKER

Village	ALTERANATIVE CARE TAKER		
	Yes	No	Total
Ahmedpur	23	6	29
	79.3%	20.7%	100.0%
Latur	19	18	37
	51.4%	48.6%	100.0%
Nilanga	28	7	35
	80.0%	20.0%	100.0%
Total	70	31	101
	69.3%	30.7%	100.0%

The above table indicates, in 70% of the families, there is a provision of alternative care taker. This might be due to the joint family system that exists in blocks. In Ahmedpur and Nilanga, about 80% and in Latur about 52% respondents have reported there is alternative arrangement for care taking.

6.38 Perception about guilty feeling:

Everything has the cause or number of causative factors behind. A child being a mentally retarded also has many causes. In the case of congenital mental retardation, the genes of parents play a vital role. In case of consanguineous marriages, the risk factor is more. If a child is born mentally retarded due to consanguineous marriages, the parents develop a great guilty feeling about own husband-wife relationship.

In the case of late mental retardation, the causes could be some childhood diseases. If the child becomes mentally retarded due to some illnesses, then the parents feel guilty as they did not care properly and did not treat child in time. They feel guilty in both the way.

TABLE NO. 6.37
DISTRIBUTION OF THE RESPONDENTS ACCORDING TO
GUILTY FEELING ABOUT MENTAL RETARDATION

Village	GUILTY FEELING ABOUT MENTAL RETARDATION		
	Yes	No	Total
Ahmedpur	25	4	29
	86.2%	13.8%	100.0%
Latur	32	5	37
	86.5%	13.5%	100.0%
Nilanga	20	15	35
	57.1%	42.9%	100.0%
Total	77	24	101
	76.2%	23.8%	100.0%

Very surprising observation is observed from the above table that, 76% of the respondents have reported that they have guilty feeling about the birth of mentally retarded child. In Ahmedpur and Latur, 86% respondents have reported they have guilty feeling. But in Nilanga, only 57% respondents felt birth of mentally retarded child is not accepted but it is the curse of god.

6.39 Providing opportunity to mix in the community:

Generally, the families who have mentally retarded child feel very guilty and don't want to expose the child in the community. They confine the child within the house and even within a single room, so that, they couldn't broaden their knowledge and get exposure of new things.

n social gatherings, they are not permitted to participate. Parents leave the child in home before going to any gathering. They develop fear that, the child might disturb in the gathering by making something awful act and they will have to feel guilty in front of others. But, in fact parents should provide opportunity to mix up in the community. This helps child to learn by exposure, they know new people and it can help in broadening mind.

TABLE NO. 6.38
DISTRIBUTION OF THE RESPONDENTS ACCORDING TO
PARTICIPATION IN PUBLIC PROGRAMME

Village	PARTICIPATION IN PUBLIC PROGRAMME		
	Yes	No	Total
Ahmedpur	14	15	29
	48.3%	51.7%	100.0%
Latur	16	21	37
	43.2%	56.8%	100.0%
Nilanga	20	15	35
	57.1%	42.9%	100.0%
Total	50	51	101
	49.5%	50.5%	100.0%

The table above shows that only 50% of the respondents allows mentally retarded child to participate in public functions such as marriage, gathering or domestic level functions. 50% of them are not allowing mainly due to the strong guilty feeling about the birth of mentally retarded child.

6.40 Reaction of guests:

Generally, guests keep in coming to any family. If there is any mentally retarded child in the family, the parents try to put the child far away from the guests. They may

lock the child in one room and child may react by knocking the door or crying. If it is not done and child is exposed to the guests, depending upon the severity of mental retardation, the child can act an awful act in front on guest. Some mentally retarded children even spit on others or exit their body wastage and many more. The guest may develop stigma as reaction or sympathy towards the family members. This makes the parents feel guilty and the guest may develop fear or hate towards the child. It may affect on the relationship between family and guest.

When guilty feeling is there, definitely the comments of relatives or friends hurts significantly. Those who are matured and believe that this is the natural condition, they do not react negatively, but in some of the societies the birth of mentally retarded child is considered as an outcome of previous generation, they may react negatively.

Summary

In this chapter, the details about nature and extent of mental retardation, it daily activities, health problem, psychological status and the efforts made by family for treatment, education and rehabilitation have been discussed in detail. The main focus was on childhood mental disorders various types, its causes and problems. Adequate emphasis have been given on the problems related to depression, anxiety disorders, autism, eating disorders, Panic Depressive illness, Schizophrenia, Bipolar disorder etc. It was found that, the information collected from the parents of the mental retarded child, the age of mentally retarded child was reported to be 25% below 3 years, 31% 4-5% and 23% of 6-10 years. As regard to the sex of mentally retarded child is concerned, 75% of them were males and 25% were females. As regard to the ordinal position, mental retardation in the first child is observed to be prominent in all the blocks. About 60% of the respondents have mentally retarded child in their first delivery. About 30% were in second and hardly 5-6% 3rd, 4th and 5th respectively.

Mental retardation is the complex disease. For illiterate women, it becomes very difficult to identify mental retardation; it was observed that only 6% families have

reported that they have identified these problems at birth, whereas 80% have diagnosed mental retardation within first 6 months and rest of the respondents have diagnosed after 6 months. No movement, no response and still eyes, these are the main prominent symptoms they have identified among mentally retarded children. However, there are relatives or grandmothers who have recognized the baby is suffering by mental retardation. About 87% of the mothers have identified themselves that her child is not normal and has some deformities. Assuming some deformities, 25% of the respondents have referred their child to doctor, about 70% were waiting for few months and hardly 5% of the respondents have reported that they preferred to take religious treatment.

As regard to the advice of the doctor, though they prefer to have religious treatment, they have also made an attempt to sought advice from medical practitioner and about 80% of them have taken treatment from general practitioner. Only 18% have taken treatment from Psychiatrist. As regard to the special care and need of mentally retarded children, it was found that half of the respondents have reported that their children need help for various body services. 26% have reported that they have to taken special; care about their behaviour and 22% of the respondents reported they have to support for body movements.

About 85% of the respondents have the problem of independent mobility and 73% of the respondents have reported that their child is not able to recall the way he went for coming back. Half of the respondents were not able to identify their relatives and most of them were interested in playing with pets. Hardly 17% of the respondents had reported that their child is suffering from some chronic illness and as regard to the various infections. 15% have reported ear infection, 37% have reported common cold and other infections. 74% of the respondents are not attending school regularly and 28% of the respondents are not taking help of any outsider, they themselves manage daily activities. About 59% of them have reported that there is a problem with siblings and about 40% of them have reported that blue is their favourite colour. About 2/3 of the respondents watches television regularly and cartoon is their favourite shows.

ardly 26% like to play with water and majority of them like various types of pets. Very surprising observation has been observed is that about 40% of the respondents have reported that they have tremendous qualities in child who needs to be developed. However, only 62% respondents have reported they have taken efforts for development. There is a large variation in liking of food but one of the significant observation is that sweet and soft food are the most favourite food items. Almost all mentally retarded children need support for toilet services and it was found that though they need help, 84% are alert about toilet, 30% are going toilet independently, 25 are able to dress properly and 30% are able to eat properly. Almost 68% are very conscious about their hunger, 53% are conscious about drinking tea and coffee, 63% have troublesome behaviour and 88% have reported that they need special attention; At family level the siblings are taking adequate care. However 70% of the respondents have reported they have made alternative arrangements for care.

Due to mental retardation, about 76% of the parents have strong guilty feeling. Naturally, they are least interested in participating in public functions. In brief, it is to say that in this chapter, various dimensions of mental retardation is discussed in detail.

CHAPTER SEVEN

ATTITUDE OF FAMILY MEMBERS AND COMMUNITY TOWARDS MENTALLY RETARDED CHILDREN

The attitude of the general of the general population towards mental retardation is not positive. Generally, this attitude is always influenced by culture and blind faith. They do not have any understanding of scientific knowledge. Generally congenital malformation is the main reason for disability. There are various factors responsible for congenital malformation. Mother's health, mother's nutritional status, health status during delivery, work culture and nature of work is one of the most important factors in developing disability among the children.

After knowing the mental retardation by the parents or community, instead of taking scientific treatment, parents usually prefer the religious treatment first and if they couldn't get any outcome, then they will try to allopathic treatment. In case of illiterate parents, they are not aware about medication. But the traditional health inlayer practitioner suggests that they should go for religious treatment rather than allopathic treatment. Naturally, these cultural practices and blind faiths further elevate the problem. If they take scientific medicine in time, they may get help to overcome these problems, but religious treatment always creates more complexities.

The neighbours, relatives, all other community persons do not see this problem scientifically, but they view this problem as a social stigma. Most of the time, these families have faced the problem of social stigmatization. In rural areas, there is hardly any school, counselling or training centres for mentally retarded children. Naturally they are deprived of taking scientific treatment. Availability, affordability and accessibility of the services makes much more difference in treating various diseases related to mental illness.

At school level also, the teachers are not aware about how to deal with either slow learner or mentally ill child. Naturally, they do not get adequate support from community also. The detail about the family members' attitude towards child is given in following table:

TABLE NO. 7.1
DISTRIBUTION OF THE RESPONDENTS ACCORDING TO FAMILY MEMBER'S
ATTITUDE

Village	FAMILY MEMBERS ATTITUDE TOWARDS MENTALLY RETARDED CHILD		
	General	Sympathy	Total
Ahmedpur	0	29	29
	0.0%	100.0%	100.0%
Latur	0	37	37
	0.0%	100.0%	100.0%
Nilanga	8	27	35
	22.9%	77.1%	100.0%
Total	8	93	101
	7.9%	92.1%	100.0%

It is seen from the table that 92% of the family members are looking towards mentally retarded child with sympathy, whereas only 8% looks towards the child with the general attitude.

7.1 Attitude of the Community Towards family:

The family having mentally retarded child is considered different than other families in the community. Each and every family is recognized by different names or characteristics in the community and in case of family having mentally retarded child, it is popular with the child in the community. Some community people may feel pity towards the family having the mentally retarded child, whereas some may not feel anything bad for the family. Some may recognize the child as mad person and tease the

family. And even some may develop fear towards the child and don't visit the family. They may oppose to the family sometimes.

Usually, stigmatization is strongly observed in all the blocks. There is a general impression that their parents have done something wrong in earlier period. Hence, they got mentally retarded child. There the various reactions about this situation.

7.2 Nature of interaction with neighbours:

The nature of interaction depends upon the severity of the mental retardation in the child. The family members having mentally retarded child are always busy with extra care of the child. Many of the times, they may not get time to interact with the neighbours. When they get interacted also, the family members have only a topic to talk about own mentally retarded child. They may share their own difficulty and sorrow of having a child like that. The neighbours may be tired of talking about the same topic and may also gossip about the matters of family having mentally retarded child.

TABLE NO. 7.2
DISTRIBUTION OF THE RESPONDENTS ACCORDING TO NATURE OF
INTERACTION

Village	NATURE OF INTERACTION			
	Friendship	Teasing	General	Total
Ahmedpur	5	18	6	29
	17.2%	62.1%	20.7%	100.0%
Latur	3	11	23	37
	8.1%	29.7%	62.2%	100.0%
Nilanga	5	12	18	35
	14.3%	34.3%	51.4%	100.0%
Total	13	41	47	101
	12.9%	40.6%	46.5%	100.0%

More than 86% of the respondents have reported that there is general reaction towards mentally retarded child, but considerable proportion of the respondents have reported that there is teasing by the children of neighbours and only 13% establish friendship with mentally retarded children.

7.3 Reaction of Mentally Retarded Child to negative attitude of neighbours:

As the mentally retarded child is different, he/she may not find any good playmates in the neighbourhood. They are isolated in the community. If they interact with other children in the community, they may find problem of adjustment. Neither the community children, nor the mentally retarded child can get adjust with each other. They may develop fear to each other or normal children tease and don't accept the mentally retarded child in their group. They may put different names such as Mad, Crazy, Psyche, because they don't know the difference between mentally ill and mentally retarded. The child may develop irritation from them and misbehave with them. Some mentally retarded children may not understand what others are doing with him/her and may remain silent, but some children may throw temper tantrum to the negative attitude of neighbours.

TABLE NO. 7.3 DISTRIBUTION OF THE RESPONDENTS ACCORDING TO REACTIONS FOR NEGATIVE TREATMENT

Village	REACTIONS OF MENTALLY RETARDED CHILD FOR NEGATIVE TREATMENT						
	Anger	Irritating	Crying	Cool	Frightened	General	Total
Ahmedpur	9	6	5	1	8	0	29
	31.0%	20.7%	17.2%	3.4%	27.6%	0.0%	100.0%
Latur	23	3	2	0	8	1	37
	62.2%	8.1%	5.4%	0.0%	21.6%	2.7%	100.0%
Nilanga	19	0	10	2	3	1	35
	54.3%	0.0%	28.6%	5.7%	8.6%	2.9%	100.0%
Total	51	9	17	3	19	2	101
	50.5%	8.9%	16.8%	3.0%	18.8%	2.0%	100.0%

The reactions are obviously negative. If the neighbours or friends are not treating mentally retarded child with respect. 505 of the respondents have reported mentally retarded child express anger and became violent, whereas 18% have reported, the child gets frightened and equal proportion of respondents have reported, the child cries if someone troubles. In brief it is to say that expression of anger always invites the violent behaviour among the mentally retarded children.

7.4 Perception about responsibility of mental retardation in child:

In Indian Society, almost all blames are given to woman for everything. If she could not get male child, she is hold responsible for female child. If any problem is observed in child, for that also, she is hold responsible. In brief for any unusual things in the family, she is the responsible person. This conception is observed every time irrespective of caste and religion. Therefore, the enquiry about the perception about to have mentally retarded child, whether vested with father or mother, there is a misconception that the mentally retarded child is the outcome of curse of the god. The mother of child has done major mistake in her past life. Hence, she got mentally retarded child. Thus, the entire responsibility is given to women only. In real sense, it is the outcome of genetic factors and the prevailing environmental condition.

TABLE NO. 7.4

DISTRIBUTION OF THE RESPONDENTS ACCORDING TO RESPONSIBILITY OF MENTAL RETARDATION

Village	RESPONSIBLE FOR MENTALLY RETARDED IN THE CHILD			
	Mother	Father	Both	Total
Ahmedpur	18	4	7	29
	62.1%	13.8%	24.1%	100.0%
Latur	17	4	16	37
	45.9%	10.8%	43.2%	100.0%
Nilanga	15	2	18	35
	42.9%	5.7%	51.4%	100.0%
Total	50	10	41	101
	49.5%	9.9%	40.6%	100.0%

About half of the respondents in all the blocks have reported for the birth of mentally retarded child, mother is responsible and only 10% have reported fathers are responsible and 40% of the respondents have reported both are responsible.

7.5 Change in behaviour of parents due to mentally retarded child:

No parents can imagine that they get an abnormal child. Every parents want perfect child, but it is not applicable in every cases. There are always two aspects, positive and negative. The reaction of parents must be different when they know about mental retardation in their child for the first time. They may not accept the reality and try to take care of the child, but if the child has another sibling, some parents don't get time to take care of mentally retarded child properly.

The parents have to make several alterations in their own behaviour as well as the behaviour of other siblings. Particularly, adjustment and tolerance are two important aspects which are needed among the parents.

7.6 Future of Mentally Retarded Child:

Children are future of nation; they are the one, who will take responsibility of the nation. So, they should be given proper guidance and care. But while talking about mentally retarded child, the future is different. Many of the times these children are unable to live their life fully. They may get opportunistic diseases such as malnutrition, diseases due to obesity and infections. They may create problem in leaving life before. If they are given proper care and education they may do something in future. But till the time, society doesn't accept the capability of children. These children are good in dancing. So, they may develop their career in dancing. In this way they should develop own career.

Almost all parents are insecure about the future of their mentally retarded children. This anxiety becomes more prominent when they are economically poor and are not able to provide financial security for his future.

Summary

In this chapter, the attitude of the family members, community and the teachers, siblings and friend circle is described in detail. Generally it is observed that the attitude towards mentally retarded children is either sympathetic or apathetic. Overprotection itself creates the problem among the mentally retarded children. Generally it is observed that sympathy is prominent among the parents about their child. 92% of the respondents have reported they are very sympathetic and are always trying to protect or give the sympathy to their child. When the child grows, it is expected that child should have interaction with peer group or the neighbouring children. It was found that 47% have general reaction, 40% are observed to be teasing and only 13% have the friendly relation. When, something happens against the mind of mentally retarded children, they express anger or follow the irritating behaviour. It was observed that 50% of the respondents have reported their express anger, 18% have reported they are frightened, 16% have reported they are crying and 9% have reported there is an irritating behaviour.

Mental retardation is the natural condition but always it is observed that it is given to the mother. About 50% of the respondents are hold mother is responsible for mental retardation of the child, whereas only 40% have reported father and mother both are equally responsible for mental retardation. To deal with the mentally retarded child, parents have to mould their own behaviour. It is observed that almost all parents are moulding themselves consistent with situation. Almost all parents have great anxiety about the future of child. In brief it is to say that the attitude towards child is not very conducive for his behaviour.

CHAPTER EIGHT

FUTURE OF MENTALLY RETARDED CHILD

Every individual is trying to achieve security of life. This security may be in form of material or the psychological. This security itself is an inevitable part of life. As regard to mentally retarded child, parents are more worried about his security. Their anxiety about day to day care, medication, and meeting the daily necessities are at fore front. Naturally, every parents tries to provide security to mentally retarded child by saving money and making the provision for his/her future for deploying a person to take his/her care or admitting him/her for institutional care.

It is fact that, mentally retarded child is totally dependent on others for various aspects. Even for his/her body services he/she has to take the help of others. Up to certain extent parents can provide these aspects to certain age, but definitely not throughout the life. To make him/her self reliant, there is a need to provide training related to life skills. These trainings are very gradual and slow process. Even after the sustained efforts, it becomes very difficult to make him/her self reliant. There are certain institution imparting life skills training along with vocational training.

In rural areas, awareness about education of mentally retarded child is grossly absent. Naturally, parents do not take any cognition for his/her life skills development and education. Generally, it is observed that the special schools of mentally retarded children are located either in urban areas or at town places. The parents staying in rural areas not ready to leave their child alone even for the treatment or his/her development. In absence of parents' association, most of the children become over emotional and these emotions create other psychological problems.

In absence of parents' association, usually there is a close relative who takes care of child. However, the anxiety always remains with them. Security about his/her future and self reliance in the body services, these are main two problems prominently observed

in mentally retarded child. Providing only financial security does not solve any problem. Indeed it creates some other problems which may be avoided if parents would have taken care in time for his/her rehabilitation.

Rehabilitation is very prolonged and complicated process. Not only the physical rehabilitation, but psychological ability and physical strength need to be developed in mentally retarded child to live at minimum level of happiness. Sympathy and anxiety, these are the two most complicated aspects of the human behaviour, continuously creates various problems among the parents. Therefore, conscious efforts at appropriate time are needed for his/her rehabilitation.

8.1 Provision for future:

The mentally retarded children are exclusively dependent on their parents. The parents have to take care of them in all aspects including exit of body wastage. But the parents also have limitation, and have always dilemma in their mind that till when they should take care of the mentally retarded child. They can't take care through out the life. So, some parents may make provision for their children. They may save money for their future endeavour or appoint someone to take care of child. And even there are certain schemes and provisions from the government side in the education or occupational guarantee of mentally retarded people, so it is also the responsibility of the parents that, they should connect the child with these programmes.

Some of the parents make the investment or some of them transfer their land, but the chances of exploitation by the other members either within the family or within community are always more. Hence, almost parents are worried about the future of their child.

8.2 Parents' effort for education of mentally retarded child:

It is very hard to engage a mentally retarded child in any type of education or training programmes. They need special education by specially trained teachers. The methodology and subject matter may also vary than in normal education. So, in most of

the cases, the parents are also supposed to get special trainings to understand the nature of education, the mentally retarded children should get, so that the parents can put their full strength in the development of mentally retarded child. The special schools are costly than other normal schools, so the parents also should make provision for money to engage their child in the education.

In rural areas, it is observed that when facilities are inadequate, parents become helpless to make the effort for education of the child. The qualitative information was collected in this regard indicates that they are conscious about their future but totally unable to give lifelong security.

Table No.
Distribution of Respondents According to Information about
Schools vs. Efforts taken for sending in school

	INFORMATION ABOUT SCHOOLS			Total
		Yes	No	
EFFORTS TAKEN FOR SENDING IN SCHOOL	Yes	91	0	91
		100.00	0.00	100.00
	No	7	3	10
		70.00	30.00	100.00
Total		98	3	101
		97.03	2.97	100.00

The table above indicates though the parents have taken the efforts to send their children, they are aware about the education of mentally retarded children.

8.3 Information about the schools of mental retardation:

There are very few schools for mentally retarded children and which is only confined in cities or towns. In most of the cases, parents are not ready to send their children alone and far from their eyes. The education for these children is must, so it is

responsibility of parents to collect information about the special schools and engage their child in one of them.

TABLE NO. 8.1
DISTRIBUTION OF THE RESPONDENTS ACCORDING TO
INFORMATION ABOUT SCHOOLS

Village	INFORMATION ABOUT SCHOOLS		
	Yes	No	Total
Ahmedpur	29	0	29
	100.0%	0.0%	100.0%
Latur	35	2	37
	94.6%	5.4%	100.0%
Nilanga	34	1	35
	97.1%	2.9%	100.0%
Total	98	3	101
	97.0%	3.0%	100.0%

It is seen from the table above that almost all parents are aware about the special schools for mentally retarded children. In most of the district places, schools have been developed to impart either training or guidance to mentally retarded children.

8.4 Efforts made to get admission in school for mentally retarded child:

It is obvious that, the number of special schools is not enough to engage all the mentally retarded children. They are costly in comparison too. So, the parents who are engaged in agricultural occupation find the expenditure on education very high. In some of the cases, they could not afford the expenses.

TABLE NO. 8.2
DISTRIBUTION OF THE RESPONDENTS ACCORDING TO
EFFORTS TAKEN FOR SENDING IN SCHOOL

Village	EFFORTS TAKEN FOR SENDING IN SCHOOL		
	Yes	No	Total
Ahmedpur	29	0	29
	100.0%	0.0%	100.0%
Latur	34	3	37
	91.9%	8.1%	100.0%
Nilanga	28	7	35
	80.0%	20.0%	100.0%
Total	91	10	101
	90.1%	9.9%	100.0%

About 90% of the respondents have taken efforts to get the admission in the school convenient to them. However, it is observed that their economic condition doesn't permit them to spend considerable amount for schooling.

8.5 The psychological condition during absence of parents:

Almost all the children develop Separation Anxiety Disorder during their early age. Whenever they are separated from their parents, they start crying, show temper tantrum and want to follow the parents. It is normal as the parents are only people, on whom the children can rely upon. But, if the act is repeated continuously and is more frequent and more severe then, it is a behavioural problem. In the case of mentally retarded children, they couldn't find anyone else who can replace the parents, so they have high rate of separation anxiety disorder. The child feels support less and develops fear and self esteem. They are unable to say their real problem, so they just feel uncomfortable. Some of the mentally retarded children, they continuously cry until and unless they don't see their parents.

Almost all parents are insecure because they feel there is hardly anyone who will tolerate the behaviour of child, the way they are tolerating.

8.6 Caretaker during absent of parents:

It is very difficult to take care of a mentally retarded child. In the family, mother is the one, who is most close to the child and is also a caretaker of the child. But when, parents are unavailable or absent, the child becomes violent, uncomfortable. Somebody should be there with the child always to take care. This somebody could be other family members, or someone who is close to the child. The person should know all about the nature of the child and nature of the mental retardation. The child should accept the person to be the caretaker.

The close relatives, elder siblings, family members of the mother are the various sources of alternative care taking system of mentally retarded children. However, no specific responses were put forward by the respondents.

8.7 Perception of parents about the safety of child:

There is no proper coordination between the organs and systems in mentally retarded child. So, the child doesn't know what reaction they should show in different actions. They are unable to decide what's correct and what's not. They can't think of their own safety as they are unaware of any type of vulnerability. In this case, the parents are the one who should take care of child, his/her safety in anything. The parents should be alert every time in any of the thing about the child.

As the mentally retarded child is very slow learner and doe not understand anything timely, the parents may perceive the child as dependent and try to help him/her as much as they can.

TABLE NO. 8.3
DISTRIBUTION OF THE RESPONDENTS
ACCORDING TO SECURITY INFUTURE

Village	PERCEPTION ABOUT SECURITY IN FUTURE OF MENTALLY RETARDED CHILD		
	Secure	Insecure	Total
Ahmedpur	0	29	29
	0.0%	100.0%	100.0%
Latur	0	37	37
	0.0%	100.0%	100.0%
Nilanga	2	33	35
	5.7%	94.3%	100.0%
Total	2	99	101
	2.0%	98.0%	100.0%

Almost all parents are unsecured about the security in future of mentally retarded children.

8.8 Perception of parents about Self-reliance in future:

Every parents want to make their children self reliant, independent. Some children may understand about their role and what should be done very properly, whereas some may not understand. In case of mentally retarded child, it is very difficult to make him/her self reliant. Some parents really try their best to make their child self-reliant and work hard, even though it is very hard. Many of the parents are tired of any sort of efforts to make the child self reliant. They rather support the child as much as they can.

TABLE NO. 8.4
DISTRIBUTION OF THE RESPONDENTS ACCORDING TO
SELF RELIANCE IN FUTURE

Village	SELF RELIANCE IN FUTURE		
	Self Reliant	Dependent	Total
Ahmedpur	0	29	29
	0.0%	100.0%	100.0%
Latur	0	37	37
	0.0%	100.0%	100.0%
Nilanga	3	32	35
	8.6%	91.4%	100.0%
Total	3	98	101
	3.0%	97.0%	100.0%

In continuation of the earlier table, almost all parents are not sure that their child will be self reliant in future. Naturally, their anxiety goes on increasing and this psychological problem is the main hurdle of the development of mentally retarded children.

Summary

In this chapter, the provisions for the future of mentally retarded children have been discussed in detail. Most of the parents those who can afford for the future provision, they are making lifetime arrangement for their children. The security of life is the burning problem among the parents of all mentally retarded children. It is found that most of the parents have made some provision for his future by investing money. Though the parents are interested in providing education or vocational training, the schools are not available in adequate number and wherever it is available, the cost is not affordable.

Naturally, there are several limitations on the rehabilitation process of the child. Majority of the parents are aware about the special schools.

Considering the present condition of disability most of the parents have made attempt to send their child in normal school but they have very bad condition which has created several problems. The psychological conditions are extremely problematic of the parents when they are away from the child. However, some of the parents have made the arrangement for taking care of their child. Parents are not sure about the security and future of the child. About 98% of the respondents have reported that they are insecure about the future of their child. This situation is mainly due to anxiety.

Chapter Nine
Summary, Conclusions and Recommendations For Further Studies

List of Paragraphs

9.1 Summary

9.2 Conclusion

9.3 Recommendations

CHAPTER NINE
SUMMARY, CONCLUSIONS AND RECOMMENDATIONS FOR
FURTHER STUDIES

In the first chapter a detailed review of literature has been undertaken, which highlights the theoretical background of this subject. Particularly the researcher has given the detail information about mental retardation, its causes, problems and various services that are available in India. The issue of mental retardation is not concerned with any state or nation but its incidence has wide applicability. India being the second most populous country in the world, the proportion of mentally disables people in this nation is alarming. Unfortunately, no national survey or comprehensive information on mental retardation has been collected on which basis, government can formulate the policy. Therefore, it is not possible to estimate the number of mentally handicapped children because of paucity of trained manpower and material resources, Up to certain extent; the National Sample Survey has been carried out from them to time without showing much consensus in their findings. Only the viable alternative left is to work out and estimate on the basis of world rate of mental retardation. According to the present estimation, 3% of the population is supposed to be retarded of which 15% is mildly retarded. On this background the researcher has conducted extensive review of literature on the point the researcher has been carried out. In the first chapter researcher has given the hypothesis and objectives of the study.

In the second chapter, the researcher has given the details about methodology adopted for the study. This chapter includes a detailed elaboration on the various methods that has been used in social sciences to investigate various solutions for social problem. The researcher has given the rationale behind this topic, scope of study and sampling design. In sampling design, detail about the criteria for selection of sample, geographical area of study, tool of data collection, method of data collection, nature of tools, plan for analysis and the tentative plan of presentation has been given in detail to the extent that can achieve maximum level of scientific approach in Social Sciences.

The third chapter is devoted for explaining the socio-economic background of the respondents who are mainly the caretaker of mentally retarded child. This includes age of respondents, sex, education, primary and secondary occupation and income. These are the factors which are closely associated with mental retardation. In any social situation, these are the factors which can create the problems in life styles or daily routine of an individual.

Economic condition is directly concerned with mental retardation and the treatment for mental retardation. Enrolment in the voting, resident of the village, family composition, age, sex, education, and occupation of the each members, type of family, addiction and type of addiction, these points are highlighted in detail. As regard to the age, most of the caretakers are above 36 years of age and younger age caretakers are comparatively very low. Females are main caretakers in all blocks whereas if there are some problems to the female male takes care. As regard to the education, illiteracy is predominantly observed in all blocks. The educational level is observed to be low in all the blocks. Agriculture is the main occupation followed by service and business. However, other opportunistic businesses are also there. To support main occupation, secondary occupation is also observed to be significant in all the blocks. In secondary occupation, dairy is the prominent in all blocks. One point is to be noted here that some other problems related to continuity of education is also observed. As regard to the income, most of the families have very less income and it is further observed that to provide the treatment it is comparatively much more difficult. Those who are staying in village, they are enrolled in the voter's list, irrespective of whether they are

citizen of the village or not. However, 80% of the respondents are the citizen of the village.

In all blocks, nuclear type of family is observed predominantly and addiction of family member is a prominent. Tobacco chewing is the main form of addiction. Use of iodized salt is observed to be absent in all blocks.

In chapter four, the researcher has given various factors associated with the delivery of mother and the complications during delivery. Various complications which are likely to be associated with mental retardation are given in detail. Especially mother's age at marriage, father's age at marriage, illness during pregnancy, history of still birth, history of mental retardation either in mother's or father's family have been discussed in detail. Consanguineous marriages and relations prior to marriage is discussed in detail. History of abortion, information about X-ray exposure, addiction of mother and monthly expenses on medication of mentally retarded child is given in detail.

It is observed that substantial proportion of mothers have got married before 18 years of age. Naturally, early marriages may cause mental retardation in new born baby. Father's age at marriage is distinctly different from the age of mother. However, late marriages are observed to be very prominent in all the blocks. Illness during pregnancy definitely creates problem to new born babies. It was observed that there is a percept ional difference about the illnesses. Though most of the respondents have reported that they do not have any problem of illness during pregnancy, but their perception about illnesses might be different than the conventional terminologies we use in the medical field. As regard to the history of still birth it was found that there is hardly any report about the history. The same case is observed about the mental retardation. However, it was observed that there is history of mental retardation in mother's family. About the Consanguineous marriages, substantial numbers of the parents have consanguineous marriages of cross cousin type. Naturally, one can observe that mental retardation is bound to be there. As regard to the tendency of abortion among the mothers, it was found that among the 95% of the mothers have tendency of abortion. This might be due to early marriages or late marriages. This is also the symptom of poor maternal health. Most of the women are not aware that the

exposure of X-ray may create complications and hence they may get mentally retarded child. Therefore, the X-ray Exposure was observed to be prominent in all blocks. Addiction of mother is found to be closely associated with mental retardation. Most of the women have habit of either chewing tobacco or use of masher. As regard to the expenses on the medication, it was prominently observed that irrespective of their economic condition, they have to spend 1,500 for medication of mentally retarded child every month. This may not be directly related to mental retardation, but these expenses are on opportunistic infections.

The fifth chapter explains the health, living conditions and the problems of behaviour of mentally retarded child. When the child is not able to take care of himself, someone has to look after this child continuously. If the mentally retarded child is not aware about his body services, the problem gets further aggravated and more complications are created. Of course, mother's role in child's health is more significant. It is observed that though mother's do not had any complications during pregnancy, they got mental retardation in their child. The age of mother at the delivery of mentally retarded child is observed to be a prominent reason for mental retardation. Majority of the women delivered mentally retarded child, before they complete 18 years of age and half of the deliveries have been conducted at home. Naturally, the traditional Birth Attendant, mother in law or mother or Traditional Dai has attended the delivery. If the mother is educated, then she may enrol her name in Primary Health Care Centre to seek advice from doctor for her health. Most of the women have sought advice from the trained doctor and also taken the supplementation of various vitamins. Birth weight of the baby is an excellent indicator of poor health condition. Naturally it also indicates the socio-culture aspect of the community. Almost 2/3 of the children were born below the expected weight. As most of the women got married in early age, had delivered the baby before completion of 18 years, they could not complete all trimesters. The expected movements and response of the child soon after birth was observed to be significant and very less proportion of women had given first feed within first six hours. Prolonged duration of breast feeding is one of the main reasons for malnutrition. Most of the mothers are not aware about MMR. However, the immunization status is observed to be nice in all blocks. As regard to the family planning methods, most of the women have regular practice of birth control methods.

The sixth chapter is dealt with daily activities, health problem, psychological status and efforts taken by the family to overcome the problem. Among the mentally retarded children, health problems are observed to be more, because they are not aware about various sources of infection and also they do not take any precaution to avoid illnesses. The age of mentally retarded child in this regard it is observed to be vital significant. About $\frac{1}{4}$ of the children were less than 3 years of age and mostly they are the males. Either first or second child got mental retardation in the family. Recognizing mental retardation in child was observed to be delayed as it was diagnosed by either parents or doctors within first six months. The conventional concepts of movement such as no movement, no response, no lip movement or eye movement etc are the main elements due to which they have recognized the mental retardation among their children. Mother is the proximate person for taking care and to rear. Naturally, mother is the person who recognizes mental retardation in her child. Of course, due to the cultural impact, most of the mothers have not sought medical advice from the doctor. It was reported they were waiting for certain period to confirm mental retardation. After confirmation, they sought advice from medical doctor who is the general practitioner in or nearby village. Most of the mentally retarded children have got medical treatment for diluting mental retardation and also sent to the schools. It was reported that these children need help for movement and needs substantial attention on their behaviour. About half of the children need help for their body services.

As they have mental retardation, they cannot move one place to another place independently. For that they have to depend on others. About 85% of the respondents have to depend on others for their mobility. As the children are not able to recall from where they came or they cannot memorize their relatives, it was the major problem. Most of the children have liking to play with pets. Almost all are healthy without any chronic illness but they face frequent opportunistic illnesses that are causing from local environment. Therefore morbid condition is observed to be more among mentally retarded children. Though mentally retarded children are enrolled in the school, they are not attending school regularly or doing study independently. They have to take help of family members for their study. Adjustment is the prominent problem among all the children. Otherwise there is a large variation in adjustment problem. Their favourite colours and programmes are just like normal children.

Almost all of them like to watch the television and cartoon films are the most favourite programme of the children. Playing with water of affection with pets are also some of the positive points among mentally retarded children.

Usually they spend their time in watching television or playing with pets. Most of the family members have failed to identify the potentiality of the child. Naturally hardly any efforts have been made to develop potential quality. About 80% of the parents have reported self reliance in various activities which is the positive symptom towards improvement. Sweet items are more popular among mentally retarded children.

As a part of their habit, for toilet service they can go independently. There is alertness about the toilet but fail to take bath independently. Very few of them are able to take bath or proper dressing or eating or neatness in the behaviour. Majority of them are conscious about hunger, drinking tea and coffee etc. But they need continuous attention for their progress. The siblings in the family are adjusting with him for various works and parents have made some alternative arrangement to take care of mentally retarded children. Guilty feeling among the parents and social stigmatization is also observed to be prominent in these families. Naturally, there are several restrictions on the participation either at family functions or in public functions.

Attitude of the family members, relatives, community people or other children are very important for rehabilitating mentally retarded child in occupation. Perhaps, mainstreaming of the life of the child is the main challenge in front of their parents. The seventh chapter provides a detailed elaboration on attitude of the family members, community and neighbours towards mentally retarded children. It was observed that instead of giving the opportunity, the family member always treat the child with sympathy. That may create a problem in rehabilitation process. When the child mix up with other children of the society or community very few of them develop friendship, whereas most of them tease the child. Of course, neutral behaviour or response is observed to be prominent. When, mentally retarded child gets negative reaction, the child express anger and become violent is the main problem. Usually, it was observed that blame is given to the mother for having mentally retarded child. Most of the parents are worried about the future of mentally

ill child and parents have to make several adjustment or changes at domestic level to cope with the situation.

The eighth chapter explains the perception of parents about the future. In this chapter, the enquiry was made about what efforts parents have taken for his future and what is the security of his life. It was found that due to poor economic condition, parents have hardly taken any effort or made any special provision for better future of child. Whatever the education is available, they are providing education to a child without making any special efforts. Most of the parents are aware about special schools of mental retardation. As such types of special schools are not available at village level and they could not afford the education in city. Thus, they fail to provide education. For his life there is hardly any security and most of the parents are of the opinion that he cannot be self reliant in future.

In last chapter, summary, recommendations and conclusions are given along with necessary appendices and bibliography.

CONCLUSION

From the above discussion following are the main conclusions of the investigation:

1. Due to poor economic condition, there are several limitations on medication, treatment, education and rehabilitation.
2. Most of the parents are either illiterate or less educated. Hence, they may not have the scientific outlook about the nature and problem of mental retardation.
3. In most of the blocks, necessary facilities are grossly lacking and wherever it is available it is not possible to afford the cost of treatment.
4. Due to nuclear type of families, the retardation problem becomes more prominent and hence this is one of the most important social problems.
5. Addiction among the mothers might be one of the main reasons for mental retardation.
6. Early marriages are observed to be very prominent in all the blocks and the marriages during young age is also observed in which women is not competent to bear the child.

7. The illness during pregnancy has resulted into still birth and there is very close association between the history of mental retardation either by mother's side or by father's side.
8. Consanguineous marriages are observed to be a prominent reason of mental retardation as it was found in almost all blocks particularly cross cousin marriage and son of maternal aunt. In this mental retardation is prominently observed.
9. Strong history of abortion, X-ray Exposure, addiction of mother is also some factors which are prominently observed among mentally retarded children.
10. As most of the deliveries have been conducted at family level, has laid complications. One of the most important cause for this situation is most of the mothers were below 18 years. Thus, complications during pregnancy, delivery and morbid conditions are also observed to be the prominent reasons.
11. Negligence towards health during pregnancy and avoiding the treatment prescribes by the doctors are also important reasons behind mental retardation.
12. Low birth weight is an outcome of malnutrition during intra-uterine condition and extremely poor health condition of the mother.
13. The average duration of first feeding is considerably delayed due to blind faith and belief.
14. Prolonged period of breast feeding creates several problems in the development.
15. Ignorance of MMR is one of the most significant reasons for mental retardation.
16. Usually the first child is observed to be mentally retarded. This situation is an outcome of either early age of marriage or early age of delivery or premature delivery.
17. Most of the mothers are not educated. Hence, there is considerably delay in identifying mental retardation among children and after recognition, instead of taking scientific treatment they prefer to take religious treatment, which is more serious and needs to be tackled on top priority basis.
18. Non-availability of doctors and inadequate facilities related to psychiatric treatment is one of the most leading causes of high incidence of mental retardation. Most of the caretakers are not literate. Hence the problems of mental retardation further gets aggravated by lack of care.

19. The dietary habits, behavioural problems, self reliance, frequent infections, these are the some of the most important problems of mentally retarded children.
20. High morbidity is one of the burning problems among mentally retarded children.
21. Continuous support and dependency are the major issues of mentally retarded child care.
22. Most of the parents are not sure for their sustainability in treatment.
23. Parents are not able to identify the potentialities of the child which is creating major problem in their rehabilitation.
24. The over sympathy and apathy these are two extreme approaches as regard to the care of mentally retarded children and both are dangerous for their development.
25. The guilty feeling and avoiding the responsibility of care, this tendency is observed to be more prominent among all the parents.
26. Anxiety, insecurity, and inadequate resources are the main hurdles in timely treatment, medication, education, and rehabilitation of the children.

RECOMMENDATIONS

1. Considering the above conclusions, following recommendations are given:
2. To create adequate and sufficient infrastructure for treatment and rehabilitation of the parents.
3. Parents' Education and orientation about the mental retardation should be undertaken.
4. The general people should understand the difference between mental retardation and mental illness firstly. So, adequate information regarding the difference should be available through various forms of media, so that the general people don't call any mentally retarded child as mad person.
5. The general people need to be sensitized about the talents of mentally retarded children, so that the people won't say these children are useless and dependent children.
6. Community based Rehabilitations (CBR) services should be provided, so that the mentally retarded children, their parents and the whole community will unite for the rehabilitation of these children.

7. Vocational trainings should be provided to mentally retarded children according to their need, interest and ability so that they can lead their life better with safety and security.
8. The parents also should plan for the future social security of these children as well as the social security policies from government side also should be drawn.
9. The overprotection of parents makes these children more dependent. So, proper care with proper training and chances to be independent also should be given.

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