

**AN INVESTIGATION INTO THE KNOWLEDGE AND ATTITUDES OF  
THE COMMUNITY TOWARDS THE MENTALLY RETARDED  
CHILDREN**

**BY**

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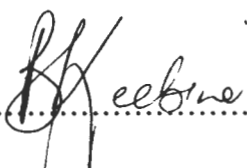
**Submitted in partial fulfillment of the requirements for the  
degree of Master of Arts in Life skills and Counselling in the  
Department of Social Science .**

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**DATE SUBMITTED: OCTOBER 2003**

## DECLARATION

I **Boitumelo Joyce Keebine** herewith declare that this dissertation for the degree of Master of Arts in Life Skills and Counseling in the Department of Social Work at the University of North West hereby submitted, has not been previously submitted by me for a degree at this or any other University. I also declare that this dissertation is my own work in design and that all material contained herein has been fully acknowledged.

SIGNED  .....

DATE *10/10/03* .....

## **DEDICATION**

This dissertation is dedicated to the memory of my beloved father **Radikgetsi Ntoko Bethuel Mogapi** who passed away in 1967. I am truly indebted to him and will always love him.

## **ACKNOWLEDGEMENTS**

My deepest appreciation goes to my God and my Father who has appointed people in His position to help me complete this research project. I thank God for the lives of the following wonderful people:-

- ✚ Professor Anderson, my supervisor who helped, encouraged and gave me support. He is a mighty man of valor.
- ✚ My beloved husband and father of my children Ntwaesele Haccius who always expressed confidence in me and encouraged me to go on when the going got tough. I really find it very difficult to express what his love and prayers have meant in my career life especially when I was writing this report.
- ✚ My sons, Oreneilwe, Makgatswane and baby Aobakwe. Their endurance and patience enabled to reach my goal. I feel proud of them
- ✚ My dearest mother Keletlhokile, for having brought me up the way she did. She will remain my mentor forever.
- ✚ I FINALLY SALUTE THE HOLY SPIRIT

## **ABSTRACT**

This study covers literature review and empirical research studies where twenty (20 ) parents of the mentally challenged children of Retlametswe Special School in Mafikeng and twelve (12) teacher of Bophelong and Retlametswe Special Schools were selected and interviewed. This study was undertaken to investigate the knowledge and attitudes of the community towards the mentally disabled/retarded children.

The findings of the study revealed that :-

- ✚ Community members have negative attitudes towards the mentally disabled children.
- ✚ Mentally retarded children are regarded as a burden by some of their parents and the community at large.
- ✚ The community members still hold stereotypes and myths about mental retardation.
- ✚ Mental retardation runs in families.
- ✚ Mental retardation can be prevented.

The study therefore suggests that:-

- ❖ The stereotypes and myths be replaced by positive attitudes.
- ❖ Suitable programs to support the mentally disabled and their parents be put in place.
- ❖ Teachers working in special schools be remunerated accordingly.
- ❖ The services of mental health team be made available.
- ❖ Financial and emotional support be given to parents of the mentally disabled children/

## LIST OF TABLES

<b>TABLE</b>	<b>PAGE</b>
TABLE 1 :GENDER PARENTS	45
TABLE 2: AGE OF PARENTS	45
TABLE3: MARITAL STATUS OF PARENTS	46
TABLE 4: ACADEMIC QUALIFICATIONS OF PARENTS	47
TABLE 5: MATERNAL AGE	49
TABLE 6 :BREATHING SCORES OF BABIES	52
TABLE 7: RESPONSE OFCHILDREN TO BIRTH	53
TABLE 8: REACTION OF SIBLINGS & FATHERS	56
TABLE. 9: RESPONSE OF NEIGHBOURS	57
TABLE 10: HOME VISITS BY TEACHERS	60
TABLE11 :PARENTAL VISITS TO SCHOOL	60
TABLE 12 . INVITATION TO HELP	61
TABLE 13: GENDER TEACHERS	63
TABLE 14 :AGE OF TEACHERS	64
TABLE 15 : QUALIFICATIONS OF TEACHERS	64

TABLE 16 : TEACHING EXPERIENCE	65
TABLE .17: TYPE OF DISABILITY	68
TABLE 18: GROUPING OF CHILDREN	68
TABLE 19 :HOME VISITS	71
TABLE 20 : REQUEST TO HELP	72
TABLE 21 : RESPONSE OF COMMUNITY	73
TABLE 22: THE NEED FOR SUPPORT	74
TABLE 23 :ATTITUDES OF TEACHERS	75

## LIST OF FIGURES

FIGURE		PAGE
FIG:	INCIDENCE	48
FIG 2	MENTAL RETARDATION IN FAMILIES	49
FIG. 3	EMOTIONAL STATUS OF PARENTS	50
FIG. 4	HEALTH STATUS OF PARENTS 51	51
FIG. 5	FINANCIAL STATUS OF MOTHERS	53
FIG.6	EMOTIONAL FEELINGS	54
FIG. 7	RESPONSE OF MOTHERS	55
FIG. 8:	SGBMEMBERS	58
FIG. 9:	BULDINGS	58
FIG. 10	SUPPORT GROUPS	59
FIG. 11:	FUND-RAISING	62
FIG.12:	SOCIAL GRANTS	62
FIG. 13:	FAMILY BACKGROUND	66
FIG. 14	NCIDENCE OF RETARDATION	67
FIG. 15	ATTITUDES OF TEACHERS	70
FIG .16	NORMAL SCHOOL TEACHERS	70
FIG. 17 :	INSTITUTIONALIZATION	73
FIG. 18 :	INTER-PROFESSIONAL TEAM	76
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## **PRELIMINARIES**

- (i) TITLE PAGE
- (ii) DECLARATION
- (iii) DEDICATION
- (iv) ACKNOWLEDGEMENTS
- (v) ABSTRACT
- (vi) LIST OF TABLES
- (vi) LIST OF FIGURES
- (vii) TABLE OF CONTENTS

## **TABLE OF CONTENTS**

### **CHAPTER 1**

1.1. General Introduction	1-2
1.2. Objectives	2
1.3. Statement of the problem	3-4
1.4. Significant of the research	5
1.5. Hypothesis/ Assumptions	6
1.6. Limitations	6-7
1.7. Definition of concepts	7
1.7.1. Knowledge	7
1.7.2. Attitudes	7-8
1.7.3. Community	8

1.7.4. Mental Retardation	9
1.7.5 Disability	9
1.7.6 Children	10
1.8 Research Methodology	10
1.9 Research Design	11
1.9.1 Descriptive Design	11
1.10 .Methods of data collection	11-12
1.10.1. Literature review	12
1.10.2. Personally administered questionnaire	12
1.11. Sampling	13
1.12 Presentation of Data	14

## **CHAPTER 2**

2.1. Introduction	15
2.2 Incidence and prevalence	15-20
2.3 Causes of Mental Retardation	20-23
2.4 Levels of Mental Retardation	23
2.4.1 Mild mental retardation	23-24

2.4.2 Moderate Mental Retardation	24-25
2.4.3 Severe Mental Retardation	25
2..4.4 Profound Mental Retardation	25-26
2.5 CONCLUSION	26

### **CHAPTER 3**

3.1. Introduction	27
3.2. Knowledge and attitudes of the community	27-35
3.3 CONCLUSION	35

### **CHAPTER 4**

4.1 Introduction	36
4.2 Feelings, fears and experiences of parents	36-38
4.3 The kind of support required	39-42
4.4 CONCLUSION	42-43

## **CHAPTER 5**

5.1. Introduction	44
5.2 Questionnaire for parents	44-63
5.3 Questionnaire for Teachers	63-76
5.4 CONCLUSION	

## **CHAPTER 6**

6.1. Introduction	77
6.2 Restatement of objectives	78
6.3 Discussion of the main findings	79
6.3.1 The nature and extent of attitudes	79
6.3.2 The knowledge and attitudes of the	80-81
6.3.3 The kind of support needed	81-82
6.3.4 Prevention programs	82-83
6.4 Empirical findings	83-84
6.5 Recommendations	84-86
6.6 CONCLUSION	86-87
REFERENCE LIST	88-92

### **APPENDICES**

APPENDIX A: QUESTIONNAIRE FOR PARENTS	93-96
APPENDIX B: QUESTIONNAIRE FOR TEACHERS	97-100

## CHAPTER 1

### 1.1 GENERAL INTRODUCTION

Our society makes available a variety of services to support childbearing in families with normal children. Parents of normal children can turn to professionals such as physicians, nurses, teachers and guidance clinics, to standard community services including baby-sitters, recreation programs and welfare departments or to friends and families when various kinds of sustenance are needed. It is however very disappointing to note that these resources are less likely to be available to the family with a retarded child because of professional ignorance, societal rejection and because of different ways in which the handicapped child is out of step with his/her normal peers [On-line 2002].

Families with retarded children have life-long reality problems with which they must learn to cope. To do this, these families need the wholehearted support of the community. Whenever a retarded child is born in the home, the budget becomes strained. This strain is caused by expenses on special medication, psychiatrists, psychologists and physiotherapist's treatment. Parents may also be required to pay a lot of money to transport these children from home to treatment centers or special schools. Unlike non-retarded children who have a well developed sense of autonomy, retarded children require minute -by-

minute supervision for much longer than is necessary ( Seed, 1989:20).

Most of the young parents, especially single parents, especially single parents of mentally disabled learners find it very difficult to cope with the upbringing of their children. Disabled children therefore sometimes run the risk of isolation and rejection by their own parents, friends, sibling and community members. Added to these pressures and setbacks may be financial problems and tensions created by the child's immature self-control. It should be noted that the relationship between a retarded child and his/her family members is more complex and ambivalent than the ordinary.

The researcher has investigated how much the community members know about mental disabilities. The researcher further made a thorough investigation on attitudes of community members towards the mentally disabled children. Terms or concepts like mental disabilities, mental handicap and mental illness were inter-changeably used throughout this research.

## **1.2. OBJECTIVES**

Well-formulated objectives play a decisive role in its successful implementation. The objectives of this research are as follows:

- ❖ To determine the nature and extent of mental disabilities among children;
- ❖ To determine the knowledge and attitudes of the community towards mental retardation ;and
- ❖ To establish a need of resource support for parents of children with mental disabilities.

## **1.3. STATEMENT OF THE PROBLEM**

Most people think that disability is unproductive and expensive. Mentally disabled people ( adults and children) run the risk of isolation , rejection, and segregation from other people. Very little or no attention at all is given to the children by members of the community. Children with mental disabilities are a burden to their parents and support is not available. In most instances when people meet the mentally disabled children, they tend to fix their interests on the children's disability rather than on their abilities.

Children with mental disabilities require special care, special diet, accommodation, clothing, toys, transport and full-time supervision. All this is obviously a financial strain to the family. Mentally disabled children need to begin a learning program when they are still very

young. They need specialized teaching to make use of their abilities and to develop those senses which are impaired, unfortunately all the above mentioned resources are hard to come by.

Since there are no pre-schools for mentally disabled children, these children are looked after in their own homes. Parents have to teach them self-help skills at an early age so that they can eventually take their place in the community. Parents can successfully do that with the help and support of the advisory teacher who have to visit the home and give advice on learning and teaching programs. Since the service of the advisory teacher has not yet been made available, children and parents experience frustration. Absence of pre-schools or day care centers also makes the lives of parents of children with mental disabilities even more difficult.

Programs that have been put in place for prevention of child abuse are more suitable for normal children. Although the mentally disabled children are more vulnerable to verbal, emotional, physical and sexual abuse than normal children, no provision has been made to protect them, instead, it is demanded of them by the justice system to defend themselves against the perpetrator in cases where they have been sexually molested. There is an urgent need for the justice system, the social services and education departments to be challenged on this issue.

#### **1.4. SIGNIFICANCE OF THE RESEARCH**

The research will serve as an eye and ear opener to the community members and all relevant stakeholders so that they learn to listen to the voice of the mentally disabled children which is crying out for help. The research will also help and teach community members to treat the mentally retarded with respect and dignity. To love and support them in which ever way possible.

The research will be used to make an earnest appeal to politicians, professionals and business people to join hands to uphold parents of the disabled children and to give them financial and other forms of support.

Hopefully pathological labels and stigma will be addressed through training in life or adaptive skills which include communication, self-care, home-living, health and safety as well as functional academic skills. The researcher will finally suggest and recommend a way forward in terms of intervention, prevention rehabilitation and treatment programs which may be put in place and be used by the community to improve the status and conditions of the mentally disabled children.

## **1.5. HYPOTHESIS/ ASSUMPTIONS**

- ❖ Parents from low socio- economic status regard their mentally retarded children as being a blessing while those from high economic status regard them as a burden.
- ❖ Mentally disabled children may be so severely disturbed by having a handicapped child that they develop physical or emotional problems and are unable to cope.
- ❖ There is a higher incidence of marital problems in families where there is a handicapped child.
- ❖ Parents of disabled children will benefit from parental support groups.

## **1.6 LIMITATIONS**

Although the research study has some significance, it also has limitations. Limitations are obstacles that the researcher can come across and such obstacles can affect the research outcome ( Mosiane, 1988).

In this research, the researcher was not able to gain access to records of psychiatrists, psychologists and other mental health workers. The researcher found it difficult to obtain information from social workers, clinics and hospitals because of the limited time frame and lack of adequate funds.

The researcher was limited by using only parents of the children of Retlametswe Special school and the eight staff members as target population or respondents. Four teachers from Bophelong Special school were also given questionnaires. The researcher was therefore not able to generalize the results since the targeted population was not representative. The study can however be generalized to all Non-capacity (Black ) special schools in the North West Province respectively. Another limitation is that very few studies have been conducted on the attitudes of community members towards the mentally challenged children.

## **1.7. DEFINITION OF CONCEPTS**

The concepts knowledge, attitudes, community, retardation, disability and children have been defined as they are used in the study.

### **1.7.1 KNOWLEDGE**

According to Page (1978: 196), knowledge means, the collection of facts, values or information to which man has access through study, intuition or experience.

### **1.7.2 ATTITUDES**

Eagly & Chaiken (1993: 1), in Manstead & Hewstone (1999:35) define an attitude as an attitude as a psychological tendency that is expressed by evaluating a particular activity with some degree of favor

or disfavor. According to Openheim (1992: 175), an attitude is a state of readiness, or tendency to respond in a certain manner when confronted with certain stimuli .. He further states that attitudes are forced by beliefs and often attract strong feelings which may lead to particular behavioral intents.

According to Morgan, King & Robinson (1981:450) as cited by Mosiane (1998), attitudes refer to a learned predisposition to behave in a consistent evaluative manner towards a person, group of people, an object or a group of objects. Statt (1981), Lefton (1985), Goldenstein (1984) and Feltham & Dryden (1983), assert that, attitudes are long-lasting, learned predispositions to respond to other, events and life in certain ways.

Attitudes are also defined as general evaluations people make about themselves, other persons, objects or issues or a tendency to respond and react against any idea or object .

### **1.7.3. COMMUNITY**

Mitchel (1979:31)as cited by Mosiane (1998) explains that the term community denotes a collectivity of people who occupy a geographical area, people who are together engaged in income and political activities and who essentially constitute a self-governing social unit

with some common values and experiencing feelings of belonging to one another.

According to Statt (1981), community is a group of people who share similar beliefs and customs and who may live in the same area. Statt (1981), further clarifies that the community ranks second only to the family among the oldest and most basic human institutions. Members of a community are linked by emotional bonds. They share a sense of belonging and feel an obligation towards other members of the group.

#### **1.7.4 MENTAL RETARDATION**

Retardation comes from the word 'retard', which means to hinder, delay or slow the advance or progress of. It means to be delayed [on-line]. Robinson & Robinson (1976: 26) define mental retardation as a state of incomplete mental development of such a kind and degree that the individual is incapable of adapting himself to the normal environment.

Mental handicap is traditionally defined in either medical or psychological terms. The medical definition restrict the term to people who can be identified by some variable damage to their bodies or some failure to develop in recognizable physical ways. The psychologist attempt to restrict it to people whose performance in intelligence or other tests does not reach the level characteristic of their age group (Anderson, 1982:13).

### **1.7.5 DISABILITY**

According to Blaxter (1976;1 ) disability means to be less able, to be at a disadvantage in earning one's living or in the ordinary activities of every day life. Blaxter (1976: 1) further explains that, society has defined the disabled, as a group which it wishes to help and that an elaborate structure of services has been established.

### **1. 7. 6 CHILDREN**

English Oxford Dictionary (1987: 167) defines children as young human beings of either sex, from before birth to the completion of physical development. The Child Act of 1983 ( Act No. 74 of 1983 as amended) explains that a child is someone who is under the age of eighteen years and stands in a particular relationship to his parents.

According to Mekingwe (1991) the word child means the following:-

C- Care

H-Home

I-Intimacy

L-Love

D-Discipline

In other words, the child is a person who needs care, shelter or home, love and discipline from his/ her parents in order to develop and mature normally.

## **1.8. RESEARCH METHODOLOGY**

According to Mitchel (1979:25), methodology refers to the techniques that a particular discipline uses to manipulate data and to acquire knowledge. Methodology encompasses techniques such as research design, methods of data collection and sampling ( Oxford 2000:507). Dyer (1995: 39) states that the selection of a research method involves making a decision about how the data is actually to be collected in an investigation.

## **1.9. RESEARCH DESIGN**

Grinnel (1987:219), articulates that research design refers to the overall plan which includes every aspect of a proposed research study from the conceptualization of the problem right through to the dissemination of the findings. Research design is thus guidelines for investigative activity and not hard fast rules that cannot be broken. Since the objectives of this research are descriptive in nature, descriptive design was used.

### **1.9.1. DESCRIPTIVE DESIGN**

According to Babbie (1986:9) descriptive design is an attempt to develop an initial rough understanding of some phenomenon and the precise measurement as well as the reporting of the characteristics of some population or phenomenon under study. According to Reid (1984: 71), a descriptive research design is the one which describes

the characteristics of a population when the characteristics of interest are known. Since this research is basically descriptive, it will seek to describe the level of knowledge and attitudes of the community towards the mentally challenged children.

### **1.10 METHODS OF DATA COLLECTION**

Reid (1984:9) states that data may be collected from questionnaires, through interviews, observation of direct interaction and use available material such as case records and statistical data. In addition literature review and experience surveys can be used to gather available data.

For this specific research, the researcher used literature studies as a major tool for data collection. Another data collection method which was used is a questionnaire. The questionnaire for parents was administered by the researcher herself i.e. the researcher read questions aloud to those parents who could not read and write and she also made ticks at appropriate or chosen places.

#### **1.10.1. LITERATURE STUDIES**

According to Babbie (1992: 11), literature review is the systematic identification, location and analysis of documents, containing information related to the research problem. Literature review was used to help clarify the problem, identify and relate previous research in the area of the study and lead logically to the question to be

studied. Literature studies was also used in order to get information on the extent and nature of the problem causes and effects of attitudes of the community towards mentally disabled children.

### **1.10.2 PERSONALLY ADMINISTERED QUESTIONNAIRES**

Polansky (1976: 62) defines a questionnaire as a common research instrument which comprises a series of questions that are filled by all participants in a given sample. According to Mogotsi (1996) data sometimes lie buried deep within the minds or within the attitudes, feelings or reactions of men and women. Mogotsi (1996) further explains that, an instrument that could be used to observe beyond the physical reach is a questionnaire. The researcher made appointments to meet parents at convenient places and times. A separate questionnaire was given to the teachers of Bophelong and Retlametswe Special Schools respectively.

### **1.11 SAMPLING**

According to Polit (1993), sampling refers to the process of selecting a portion of the population to represent the entire population. Polit (1993) also indicates that scientists work with samples because it is more economical and efficient to do so. He further stresses that the need for data in a specified time period, usually makes it imperative for the researcher to sample. The researcher used probability sampling design called systematic sampling to select respondents.

This design requires a complete listing of the individuals in the form of a sampling frame but involves drawing individuals at a regular, predetermined interval from the sampling frame. A list of 60 parents of the mentally retarded children of Retlametswe Special School was drawn and every third name was randomly selected. A total number of twenty names were selected and later requested to respond to the questionnaire.

The researcher used purposive sampling to recruit teachers from Bophelong and Retlametswe Special Schools. These teachers were chosen because they have experience and information in special school education.

### **1.12. PRESENTATION OF DATA**

This study is arranged as follows:

- Chapter 1: an introductory paragraph which also outlines the purpose of the study,
- Chapters 2-4: concentrate on selected literature that is relevant to the subject under study,
- Chapter 5: Presents the analysis of empirical study
- Chapter 6 : Contains the discussion of the main findings, conclusion and recommendations.

## **CHAPTER 2**

### **THE NATURE AND EXTENT OF MENTAL RETARDATION IN CHILDREN**

#### **2.1 INTRODUCTION**

This chapter is an overview of the incidence and prevalence of mental retardation, the causes of mental retardation and the levels of mental retardation as described by different authors.

#### **2.2 INCIDENCE AND PREVALENCE OF MENTAL RETARDATION**

The Arc [on-line:2002] reviewed a number of prevalence studies in the early 1980's and concluded that 2.5 to 3.0 percent of the general population suffer from mental retardation. Based on the 1990 census, an estimated 6.2 to 7.5 million people are mentally retarded. Mental retardation cuts across the lines of racial, ethnic, educational and economic backgrounds. It can occur in any family [on-line].

According to the World Health Organization (WHO, 1981). At least 40 million people suffer from severe forms of mental and neurological disorders such as schizophrenia, brain damage and dementia. Twenty million are incapacitated by less grave mental and neurological conditions such as severe neurosis, mental retardation and peripheral neuropathy.

According to Kneisel & Wilson (1983) a retarded person has difficulty learning. The more complex the learning task, the more evident the retarded person's limitations. It has further been alluded that retardation may result from disordered brain functioning, either secondary to structural or metabolic disease or from a failure to develop physiological maturity due to genetic abnormality, disease or profound lack of stimulation.

Persons with mental retardation comprise an estimated 2.5 percent to 3 percent of the population. Factors such as poverty, poor nutrition and lack of adequate health care increase the prevalence rate. One out of ten families nationwide is directly affected by mental retardation [on-line]. Rutter (1975) in Newton (1988), states that variables that are found to be associated with mental disorders are family discord and disruption, parental illness and criminality as well as social disadvantage. He further alludes that children in large families are more likely than children in smaller families to have psychiatric problems. Child psychiatric disorders are also more common where fathers have a laboring or semi-skilled manual work.

According to Peck & Hong (1988) people with mental handicaps have a special a range of special needs in many different areas like: physical function, learning and understanding social skills, communications and independent living skills Sometimes mental retardation is caused

by abnormal genes inherited from parents. Peck & Hong further clarify that a woman who drinks alcohol during pregnancy is more likely to have a baby with mental retardation called Fetal Alcohol Syndrome.

Severe mental impairment is said to occur in at least three or four of every 1000 people in any population. Kneisl & Wilson (1983) state that, estimating the population at 36 million, there are at least 130 000 severely handicapped people in South Africa but it is probable that only a small percentage of these have been properly assessed or offered adequate help ( Kneisl & Wilson, 1983).

Statistics show that a disproportionate segment of the mentally retarded population comes from the groups that are most disadvantaged socio-economically ( Cockerham, 2000:150). Retarded people may hold jobs, have social contacts and live independently. Nathan & Harris (1980) explain that the majority of retarded people can learn far beyond the expectations which were traditionally imposed on them. It is further argued that more males than females are retarded and that retardation can co-exist with psychological disorders and physical disabilities.

According to Anderson (1982:12) up until 1886, the mentally handicapped people were officially classified with lunatics. Many were shut away in back rooms of their homes, farmed out as cheap laborers or otherwise maltreated. Perhaps some were amicably or

otherwise accepted as 'village idiot'. Anderson further articulates that although there is no longer the same anxiety about agencies, mentally handicapped people are still treated as if they were a burden and a danger.

Newton (1988:20) elucidates that a true picture of prevalence of psychiatric disorders in the population can only be derived from surveys which assess the psychiatric state. Other factors which have been identified as contributing to the development of childhood psychiatric disorders are age, sex, temperament, brain damage, educational retardation and parental mental illness.

In most schools or hospitals for mentally handicapped people, a small number of children or adults will be found who suffer not from a mental handicap, but from other conditions like: emotional adjustment, epilepsy and adult psychosis (Anderson, 1982:139). In the past, most mentally handicapped people lived in large hospitals under the care of psychiatrists and nurses, Nowadays most live in the community where their educational, social and medical care is mainly provided by family doctors. Other terms of this condition include mental deficiency, mental sub normality, mental handicap and most recently, learning difficulties ( Gath, Gelder & Mayon, 1994).

People with mental disabilities tend to know less than those without, which is also a function of the inferior education that they have.

People with mental disabilities have become used to the paternalistic system of care by the state or charities. They trust authority figures and behave in similar manner in time of crisis or trouble (Stavis, 1991). It has been also stated that factors such as poverty and lack of adequate health care increase the prevalence rate. Family discord and disruption as well as parental illness are found to be associated with mental disorder.

Mental retardation occurs among children throughout the world. In its most severe form, it is a source of great hardship to parents as well as an economic burden on the community. The incidence of mental retardation seems to increase markedly at ages 6, to peak at age 15 and to drop off sharply thereafter. These changes in incidence reflect changes in life demands. During early childhood, individuals with only a mild degree of intellectual impairment, who constitute the vast majority of the mentally retarded often appear to be relatively normal. Their sub-average intellectual functioning only becomes apparent when difficulties with school work lead to a diagnostic evaluation (Carson , Butcher & Coleman, 1992: 504).

According to Sue, (1997). The mentally challenged people may experience problems in social skills. For example they may be too friendly or inappropriately affectionate. They may pester others, show off or use inappropriate behavior in an effort to seek praise or approval. Sue further clarifies that mental retardation is not a disease

nor is it a mental illness. People cannot therefore catch or be infected with mental retardation from anyone. Persons with mental retardation may have learning problems which include; memory deficits, problem solving and difficulty making decisions or choices . They may have a short attention span. May be easily distracted and may have a high expectation of failure which can result in a tendency to give up easily [ On -line:2002].

Knopf (1984:303), articulates that, the incidence of mental retardation is virtually impossible to estimate accurately. It varies with the definition, the diagnostic criteria, the age as well as the socio-economic level on which prevalence figures are based. He further stimulates that, in the absence of a national survey of all instances of mental retardation, incidence estimates tend to come from small sample surveys, extrapolated guesses and the experience of workers in the field. Most studies show that mental retardation is higher in males, in black children than in white, in lower socio-economic levels as contrasted with the middle and upper classes (Knopf, 1984:302).

### **2.3. CAUSES OF MENTAL RETARDATION**

Wilson & Kneisel (1983), indicate that the causes of retardation are generally grouped according to the time of influence of the offending factors that is, prenatal, postnatal and socio-cultural causes. Syphilis, rubella and toxoplasmosis diseases are all infections that may cause

neurological damage to the fetus and result in mental retardation when contracted by a pregnant woman. Since poverty often necessitates an inadequate diet, it makes sense to assume that poor mothers are more likely to have children who are retarded because of maternal nutrition. Income level, not race seems to be the crucial factor tying maternal malnutrition and infant intellectual deficit together (Nathan & Harris 1980).

Gupta (1993) and Moldin (1995) in Cockerham (2000:63) envisage that genetic factors are important in the transmission of certain mental disorders, notably schizophrenia and mood disorders. Although the exact genetic factor in mental disorders are not known at present, some hypotheses favor the notion that abnormal behavior is related to a single dominant gene. It has been stated that marital status and the presence of young children in the home is also related to the presence of psychiatric symptoms [on-line:2002]

There is a long-standing popular view that heredity play a primary causative role in mental retardation. While it is true that many forms of mental retardation tends to run in families, known hereditary diseases or chromosomal abnormalities are evident in only a small number of these cases. A recent study of 722 retarded individuals found that 16 percent of the cases could be linked to genetic causes (Knopf, 1984;304). It has been further stated that mental retardation is not a unitary entity that appears in the same form, at the same

time. It is not always produced by the same causal factors, and it can result either from one circumstance that may appear before, during or after birth.

The age of the mother is related to the risk of having a retarded child with the teen-age mothers and women over 35 years having higher risks. Older mothers are more likely to have children with chromosomal abnormalities as well as multiple births. Erickson (1978:73) further articulates that both younger and older mothers have increased risks for complications during pregnancy, labor and delivery. He also states that theoretically, a child with optimal genetic material and physical backgrounds who is deprived of environmental stimulation post natively would become mentally retarded.

Collins (1996:30) argues that some sources of tertiary disabilities are obvious. For example inadequate housing, stigma, poverty, unemployment and marginalization within society. Rogers (1996) in Abosch & Collins (1996: 33) explain that there is very little understanding in the community of the problem of mental illness, and a lot of fear. Collins also stipulates that there is a feeling that mental retardation be swept under the rug and that people be locked away and that this problem must be dealt with.

Many of the strictly medical conditions which lead to mental retardation arise at a higher incidence among the poor because of

deficiencies in medical care. These problem areas include poor prenatal care and poor baby follow-up. Purely environmental deficits undoubtedly influence the mental development of the children adversely [on-line].

According to Sue, (1997), certain features of the environment may contribute to retardation.. Among these are the absence of stimulating factors or situations, alack of attention and reinforcement form parents or significant others and chronic stress and frustration. In addition, poverty, lack of adequate health care, poor nutrition and inadequate education place children at a disadvantage.

## **2.4 LEVELS OF MENTAL RETARDATION**

According to Knopf (1984:303) scores and levels of retardation must be interpreted as indicative of present functioning rather than as a stereotyped and fixed prediction of the child's future limitations. The four levels of mental retardation are described as follows:-

### **2.4.1 MILD MENTAL RETARDATION**

This is the largest category accounting for almost 90 percent of all retardates. . Although as adults their intellectual levels is much like that of children aged eight to eleven, with proper training and special education, many of the mildly retarded are able to make an adequate

social and vocational adjustment. When employed, they typically hold unskilled jobs that yield a low income. They frequently need supervision in the management of their limited work skills and they are particularly vulnerable to unemployment as the economy fluctuates (Knopf, 1984).

Knopf, further alludes that the vast majority show no signs of brain pathology or physical aberrations that would readily distinguish them from normal. Many of the retarded children are unidentified until the academic demands of school make their deficiencies apparent. According to Carson, Butcher and Coleman, (1992: 505) the social adjustment of such persons often approximates that of the adolescent although they tend to lack the normal adolescent's imagination, inventiveness and judgment.

Davidson & Neale (2002; 437) ,explain that the mildly retarded people are not always distinguishable before they enter school. They further stipulate that although the mentally retarded adults may need help with social and financial problems, they may marry and have children.

#### **2.4.2. MODERATE MENTAL RETARDATION**

This is a category that accounts for approximately 6 percent of all retardates. Persons who function at this level are very slow to learn and their conceptualization skills are very limited. While they have

some command of spoken language, typically they cannot read or write. With proper training they are capable of acquiring self-care behaviors and of performing routine chores in the home or in a sheltered workshop. In school they are considered trainable, and they are eligible for special education classes that emphasize the development of practical and basic self-help skills ( Knopf,1984: 304).

### **2.4.3 SEVERE MENTAL RETARDATION**

Carson et.al (1992: 506) elucidates that individuals in this group are sometimes referred to as dependent retarded. Among these individuals, motor and speech development are severely retarded and sensory defects and motor handicaps are common. They usually do not speak in early childhood but can learn communication during school years. They can develop limited levels of personal hygiene and self-help skills which somewhat lessen their independence. They however require special training to teach them rudiments of hygiene, speech and other basic skills. Most of them require constant consistent supervision and care throughout their lives. As adults they live either with families, in group homes or when necessary, in facilities that can provide skilled medical or nursing care [on-line:2002].

#### **2.4.4. PROFOUND MENTAL RETARDATION**

The term life-support is sometimes used to refer to individuals in this category. Most of these persons are severely deficient in adaptive behavior and unable to master any but the simplest task. Severe physical deformities, central nervous system pathology and retarded growth are typical ( Carson et, al. 1992:507.) According to Knopf, (1984), individuals in this group are institutionalized and require constant supervision and frequent medical care. As a group, their life expectancy is short with death often occurring during the childhood years. They show little evidence of hearing, but some manage to learn to walk, to acquire partial self-care in feeding and going to the toilet.

Davidson & Neale (2002:438) articulate that, profound mental retardation require total supervision and often nursing all their lives. It is further stated that, the mortality rate during childhood for people with profound mental retardation is very high.

#### **2.5 CONCLUSION**

Parents, significant others and community members need to be brought on board and be equipped with skills which will enable them to identify mentally retarded children during early stages of life. Early identification will alleviate problems of rejection by siblings and community members and may also help solve the problem of denial which is experienced by many parents who have mentally retarded children.

## **CHAPTER 3**

### **THE NATURE AND EXTENT OF THE KNOWLEDGE AND ATTITUDES OF THE COMMUNITY**

#### **3.1 INTRODUCTION**

This chapter looks at how much the community know, react and treat the mentally retarded children. Myths and stereotypes held by the community members are also discussed.

#### **3.2 KNOWLEDGE AND ATTITUDES OF THE COMMUNITY**

It is clear that psychiatric illnesses and their treatment meet with a very mixed response. Mangen (1982:77), states that attitudes are extremely varied and for many are shaped by ignorance and superstition. He also explains though there has been some changes over time in the perception of mental disorders, individuals in any community may hold conflicting views. Prejudice becomes entrenched because people tend to associate mental disorder only with psychotic conditions, which because of symptoms of marked aggression are perceived as a threat to the safety of the community. According to Mangen (1982:80), information about mental disorders in newspapers and films occurs relatively infrequently and when it does, its presentation is distorted.

Some of the stereotypes are that the mentally handicapped are children who will never grow up and that they are sick or sub-human.

Knopf (1984:319) explains that while little if any data are available to assess public attitudes towards mental retardation in this country, inferences can be drawn from an examination of the institutional environment in which some retardates are required to live. The living conditions in institutions for the retarded together with the analysis of the political and social forces have been described as being deplorable. Braginsky (1971) in Knopf (1984), argues that many children have been institutionalized because they were rejected and unwanted by their families and not because of mental retardation per se.

Braginsky and Braginsky (1971) in Knopf (1984:318) also claim that residential facilities and labels such as "mental retardation" are used primarily by society and parents as ways to justify their acts of abandonment and to alleviate the guilt that accompanies these actions. They further stress that it is not unusual for the retardates to be rejected by his or her family, shunned by employers, ostracized by peers, denied heterosexual relationships and ignored by the community. According to Knopf, (1998:318), parental attitudes and reactions to their mentally retarded child are regarded as important influences in shaping the lives of both the family and the handicapped child.

Society remains ignorant about the capabilities and rights of people with mental retardation to do things such as enjoying community living, obtaining employment, voting and being protected from abuse

and neglect. People with mental retardation have not been given respect to which they are entitled as citizens nor have they received the support they needed to enable them to exercise their rights. Despite much progress in expending public policy at all government levels, the fundamental rights of people with mental retardation have not yet been fully acknowledged or received. People with mental retardation have basic legal, civil and human rights as other citizens. Fairness and justice dictate the need for additional legal protection to enable people with mental retardation to exercise such basic rights [on-line:2002].

According to Peck & Hong (1988), working with people who have a mental handicap is not easy. It can often be stressful, difficult, unpleasant, dirty as well as mentally and physically demanding. Professional trainers need to have a combination of the right attitudes an understanding of the relevant theory and experience in the technical aspects of their work as well as effective interpersonal skills. The amount of public tolerance and understanding is clearly important when considering the degree to which community care is feasible. Attitudes of the wider community appear to be neutral or significantly favorable as long as social distance can be maintained.

A known element in the rehabilitation model is handicaps which occur when a person's disabilities place him at a disadvantage relative to others in society. This occurs through stigma and discrimination as

when employers are reluctant to hire individuals with a mental illness. Handicap also occurs because society does not provide settings where mentally ill persons can find accommodation and compensation for their impairments and since mentally ill persons require a special social environment to compensate for their problems, overcoming their handicaps is much more difficult [on-line].

Mabetoa (1979), relates that up until the end of the 18<sup>th</sup> century, mental institutions, asylums and workhouses were the only predominant form of care for mental defectives. They were treated with great indifference. They were also looked upon as being possessed of demons and this was the basic reason for putting them away locked doors. Mabetoa (1979) highlights that, the main objective was to protect society rather than to care for the individual. Treatment of the lunatics was harsh. Previously when a child learned slowly in a regular education classroom, the tendency was to blame the child's disabilities. Earlier ways led to special education classes that we now know that the stigmatize many children, deprive them of opportunities to learn about their peers and also deprive the average child of having friends who have mental retardation [on-line:2002].

Harris & Nathan (1980), explain that, the gloominess which once surrounded the treatment and education of the mentally retarded, has begun to dissipate. They further argue that, it is now known that the overwhelming majority of retarded people who are conscious and have

minimal macular control can learn. Many of them can live far beyond the expectations which were traditionally imposed on them. How mental retardation is perceived is undergoing a fundamental change. Until recently it was considered a hopeless condition that required institutionalization. It is now known that with training, even people who are severely handicapped can make intellectual and social gains. Other research data however indicates that, the prevailing attitudes towards the retarded throughout history have ranged from contempt to reverence. Luther for example considered the retarded as persons in whom the devil sits where their souls should have been. Concurrently however, there also exists the view that the retarded persons are either blessed or unusually 'wise fools' [on-line].

According to Harris & Nathan (1980), once a mentally retarded person has to be institutionalized, the prevailing attitude in our society becomes one of hopelessness and resignation. The apathy is broken occasionally by sensational public disclosures of the filth, inhumane treatment, and indifference at one or another institution for the mentally retarded. Unfortunately, the public mainly sees its responsibility to the retarded as one of providing funds for custodial care, if possible though always within the constraints of the public budget. For the retarded child in a public school, this attitude often results in the creation of a special class that is more than a baby-sitting service run by well-trained but poorly specialized people. They also indicate that, it is hard to conceive that, in a society that sends

people to the moon, retarded people sit neglected on wooden benches. The saddest thing about this social failure is that we have the knowledge and resources to make the lives of the retarded meaningful and productive yet we often choose to ignore them ( Harris & Nathan 1980).

It is disappointing to note that, parents, teachers and doctors instead of trying to listen to the retarded child as a desiring subject, integrate him/her as an object of treatment and rob him/her of his speech. Mentally challenged children are robbed off their speech because other people do not believe that they have ideas or that any ideas they may have would have any value.. It is unfortunate to note that other people lack skills when it comes to talking with the mentally handicapped. According to Newton (1988), such skills need to be developed while sometimes only patience is needed. Sometimes an interpreter or special skills in using non-verbal techniques may be required.

Newton (1988), also clarifies that, society has been protected from the need to learn how to communicate with mentally handicapped people by the long history of segregation and specialization in their services. The society is concerned with helping mentally handicapped people to learn to behave conventionally so that the rest of society comes to see them in a more ordinary light. Newton (1988) highlights that, in one sense, special schools make children different, but in another sense

they make them more ordinary, by removing competitive pressures in which they will always lose the struggle. Such specialization can lead to underestimation of what can be achieved and the institutional cycle can commence again. It has further been stipulated that, a very similar dilemma exists for social workers. Mentally challenged people are often regarded as abnormal and treated in stigmatizing and rejective ways. They are therefore appropriate candidates for social work help, but the attachment of a stigmatizing process and it becomes a matter of fine judgment whether social workers should seek to provide help themselves, or try to make it available through less stigmatizing channels.

The mentally handicapped adolescent, like all normal adolescents, begin to see things differently from their parents. They need help to find their own voices. Their problem is exacerbated by their lack of social skills and by the protectiveness of their parents. The mentally handicapped child is often under much closer parental supervision and may have fewer opportunities to find cooperative partners. One of the ways in which mentally handicapped people do not fit norms of our society is that there is no clear way of defining when they are able to make their own decisions and be free of parental or family supervision. There are also people who argue that, mentally handicapped people have no sexual needs, unless others arouse them and that it is no kindness to make them aware of needs they can never satisfy [ on-line:2002].

It should be noted that handicapped people are much better than able to speak for themselves than is often allowed. It suits society very well to leave damaged children in the care of their parents. The society avoids facing one of the moral dilemmas which such children present. Parents are on the other rarest prepared for it and many of them experience acute disturbances and may have their lives disturbed. Some people seem to experience the handicapped child itself as an affront or an insult. They are shocked and can only resent the experience. Others are thrown into embarrassment and confusion and deal with it by withdrawal. Neighbors who would normally expect to come and congratulate may be faced with sudden embarrassment. The mentally ill persons suffer from social isolation, lack of daily living skills, unemployment and homelessness. They are still treated as if they were a burden and danger [on-line].

According to Abosch & Collins (1996:40) the public orientation to disordered behavior has changed because its meaning has been redefined. For the first half of the twentieth century, the person committed to an insane asylum, was the abnormal person. Committed to an insane asylum, was the abnormal person. The dichotomy between normal and abnormal was the dichotomy between sane and insane. The insane was considered a deviant whose condition was dangerous enough to himself and others to warrant his removal from society. Abosch & Collins(1996:42) explain that the terms the

community use to describe people with low intelligence are prone to carry a strong evaluative component. They emphasize that the most commonly used term 'mental handicap' carries the least negative connotations. The amount of public tolerance and understanding is clearly important when considering the degree to which community care is feasible. Attitudes of the wider community appear to be neutral or significantly favorable as long as social distance can be maintained.

### **3.3 CONCLUSION**

Persons with mental retardation and developmental disabilities desire opportunities to be full contributing members of society. They desire to live, to love, to work and to play. They share the dignity and worth which is innate in every human being and each of them possess unique disabilities, preferences, needs and goals. People with disabilities prefer when given the option, to live and receive services and support in their own homes, schools, workplaces and local communities. It is important to increase the abundance of opportunities and alternatives available to all members of the community particularly for those individuals who have historically been denied participation.

## **CHAPTER 4**

### **TO DETERMINE THE SUPPORT NEEDED BY PARENTS OF CHILDREN WITH MENTAL DISABILITIES**

#### **4.1 INTRODUCTION**

Most parents of mentally retarded children are criticized for refusing to accept their children's disability and for failing to take responsibility of their children's upbringing. This chapter is going to look at challenges and problems experienced by parents of mentally retarded children. The kind and level of support needed by these parents will be highlighted.

#### **4.2. FEELINGS, FEARS AND EXPERIENCES OF PARENTS OF MENTALLY RETARDED CHILDREN**

All prospective parents hope for a normal and healthy child. While abnormality is disappointing, emotionally disturbing, and difficult to accept, the diagnosis of mental retardation is particularly shocking and troublesome for most affected parents. Perhaps this is attributable to the pessimistic assumptions commonly held in our society that imply that the retarded child's potential and future outlook are dismal and hopeless (Knopf, 1984). Knopf, ( 1984:316), also states that, it may be that such a diagnosis is threatening and

guilt provoking to parents because it reflects uncomfortably on the family line in terms of either inheritance or some biological defect. The fear that the child will either have to be permanently banished to an institution or if kept at home, will become an object of ridicule and embarrassment to members of the family are real possibilities and problems. Moreover, the sudden prospect of having to cope with and manage a poorly understood condition is sufficient in itself to arouse a great deal of anxiety in most parents ( Knopf, 1984:316)

Since nothing in our culture prepares young adults for the arrival of a damaged child, most parents are unprepared for such a bad event, but they are especially keyed up for a good one. For the majority of parents, learning that their child is handicapped comes as a staggering blow. They love the child because it is their baby, they hate it because it is travesty of their hopes. The mixture of feelings can be devastating. Many parents have thoughts of killing the child. Repressed thoughts recur in dreams, sometimes they persist for decades, often they are converted into sickness or depression. When volcanic thoughts like these are not given vent, people often conspire consciously to repress them ( Newton, 1988).

According to Newton (1988), every aspect of the daily routine may present special difficulty and may require inordinate amount of time. He stresses that parents need support from several people with special skills like pediatricians, orthopedic surgeons, physiotherapists and

occupational therapists are needed. Newton also emphasize that, the help required is of detailed kind not easily reduced to a textbook. Much of it could only be offered by an expert who had watched the daily routines at home to spot the child's peculiar needs and the parent's peculiar response.

Kibel & Wagstaff (1997: 320), explain that, helping the parents to cope is of great importance and should start at the time of diagnosis. Telling parents that their child is impaired must be done with great sensitivity. The diagnosis must be given with gentleness and empathy but strongly enough for the message to be understood. The family of a mentally impaired child needs ongoing support. Their grieving may recur or be accentuated every time their affected child fails to reach milestone or achieve less than normal children of similar age.

Reynolds (1987: 124), explains that, the effect of having a mentally handicapped child in the family are far-reaching. For the family with a mentally handicapped child, the extra cost and loss of earning is high. In addition to financial problems, there is an emotional distress and strain put upon a marriage when a mentally handicapped child requires constant care.

#### **4.3 THE KIND OF SUPPORT REQUIRED BY PARENTS OF MENTALLY RETARDED CHILDREN**

Parents need to be made to understand that a child with special needs does not need a special environment but assistance and support to benefit from the same environment as everyone else. They also have to understand that a child with a disability deserves the same dignity as other children. Parents need to be empowered so that they are able to contribute equally to the resolution of their children's problems and would not just take instructions from professionals. Parents should also be made to understand that getting rid of barriers to the inclusion of disabled children, does not depend only on an individual but also on the community [on-line:2002].

According to Liberman (1988:21), environmental interventions attempt to provide with supportive persons, supportive settings or both. Liberman explains that, a support person might reduce a person's disability and handicap through a number of different roles, that is, as advocate, a companion, a counselor or advisor. Attempts at making the setting more supportive focus more on the programs or resources within the environment rather than on the support per 'se'. It has also been indicated that the main identifying feature of both types of supportive interventions, is that they do not attempt to systematically and directly change the patient's behavior. Rather the attempt is

simply to support and accommodate the patient's present level of functioning ( Liberman, 1988:22).

A position statement of the council for exceptional children (1993), is that a continuum of services must be available for all children, youth and young adults. Children with disabilities should be served whenever possible in general education classrooms in inclusive neighborhood,, schools and community settings. Such settings should be strengthened by specially trained personnel and other appropriate supportive practices. It has also been stressed that people with disabilities prefer when given option, to live and receive services and support in their own homes, schools, workplace and local communities. It is important to increase the abundance of opportunities and alternatives available to all members of our community particularly for those individuals who have been denied full participation [ on-line].

Despite their frustration and bitterness towards professionals, families continue to see professionals as key resources in their time of need. Liberman (1988:22) states that these people want more information translated to their level of comprehension, so that they can grasp the reality of their present and future situation with an ill relative. They want to know how to deal with disturbing behavior such as withdrawal, aggression, mood swings and inadequate daily living skills. He also articulates that the dependency foisted on families by

major mental disorders can cause spouses to neglect each other and thus threatening the integrity and satisfaction of a marriage. Therefore families, need assistance in deciding how much they can invest emotionally and economically in the continuing care and support of a chronically ill relative. They need to sort out their entangled web of emotions and make realistic decisions about their future and the future of their sick relative.

Children with disabilities have a right to special care, education and training designed to help them achieve the greatest possible self-reliance and to live full active lives in society. The office of the status of disabled persons has been established in the office of the Deputy president and more recently, a parliamentary committee on children, youth and the disabled. For children with disabilities there is still much to be done. Although their parents or guardians are entitled to apply for state disability grants from the Department of Welfare, applicants are faced with a number of problems that violate their rights to administrative justice. Ultimately, their rights to access to social security and special care is violated by problems such as having to wait for too long for applications to be processed. Sometimes they are not even given adequate reasons why their applications have been turned down [ on-line:2002].

According to Bickwell & Hollins (1985), it is important that an emphasis be placed on community awareness and education.

Acceptance of people with mental retardation has driven the planning process for the community land. It is important to identify the strengths of people with mental retardation and to value their contribution in planning for their options supports and services. Advocacy and service coordination are necessary elements to address the needs of persons with mental retardation across their life span within the community. Early identification and intervention, crisis services and inclusive day care are necessary supports for families and community to enable them to care for their children .

Wilkin (1979:24), states that each handicapped person should live with his own family as long as this does not impose an undue strain on them or him and him and his family should receive full advice and support.

#### **4.4 CONCLUSION**

A multi-professional team can be a very useful strategy and tool suitable for the implementation of living standards of the mentally disabled children. Within the multidisciplinary team, the key worker must be chosen. A key worker will be the family's contact person and serve as a link between the family and the team ( Bickwell & Hollins: 1985, 281).

Nathan & Harris ( 1980, 438), states that mental health services are another important component of the support programs of parents of children with mental disabilities. It has further been stated that the psychologist's contribution lies in the areas of clinical research, diagnostic assessment and behavioral treatment. Nathan & Harris also explain that, the social worker's knowledge of community's helping agencies enables them to refer patients and their families to the most appropriate resources.

## **CHAPTER 5**

### **PRESENTATION OF DATA ANALYSIS**

#### **5.1 INTRODUCTION**

This chapter focuses on the presentation and analysis of data. It also outlines the background information of the respondents with regard to their knowledge and attitudes towards the mentally retarded children. According to Barker, Pitstrang & Elliot (1994: 218), analysis means establishing what the findings are and how they answer the research question. Interpretation means understanding the findings in terms of their broader implication. According to Kerliger (1980) as cited by Reid (1984: 243), data analysis is the categorizing, ordering, manipulating and summarizing of data to obtain answers to research questions. Barker, Pitsrang & Elliot (1994), states that, the goal of analysis is to use data to answer each of the research questions. The questionnaire for parents was the first to be analyzed, and that for teachers was analyzed thereafter.

#### **5.2 QUESTIONNAIRE FOR PARENTS**

Table 1 presents the gender of twenty parents of the children of Retlametswe Special School.

**TABLE 1: GENDERPARENTS: N=20**

<b>SEX</b>	<b>#</b>	<b>%</b>
MALE	2	10
FEMALE	18	90
<b>TOTAL</b>	<b>20</b>	<b>100</b>

The above information reveals that 90 % of the respondents are females and only 10 % of them are males. The difference illustrates that, mentally challenged children are generally left in the care of women. These women are incidentally either divorced or have never married as will be indicated later on in the study.

Table 2 indicates the ages of the respondents (parents).

**Table 2: AGE OF PARENTS : N=20**

<b>AGE</b>	<b>#</b>	<b>%</b>
Below 25	4	20
Between 25 & 35	2	10
Above 35	14	70
<b>TOTAL</b>	<b>20</b>	<b>100</b>

As reflected in Table 2, on page 45, 70 % of the parents of the mentally disabled children are above thirty five years old. Only a small number of parents who have mentally challenged children are between ages 25 and 35 .

The Table below presents the marital status of parents of children with mental disabilities.

**TABLE 3: MARITAL STATUS OF PARENTS : N=20**

<b>MARITAL STATUS</b>	<b>#</b>	<b>%</b>
DIVORCED	7	35
WIDOWED	6	30
SINGLE	4	20
MARRIED	3	15
<b>TOTAL</b>	<b>20</b>	<b>100</b>

Table 3 indicates that, the majority of the mentally disabled children are left in the care of single women. At least 85 % of them (divorcees, widowed and single) who are faced with challenges of bringing up their retarded children single handed. According to Newton (1988), variables that are found to be associated with mental disorders and family discord and disruptions.

Table 4 shows the academic qualifications of parents of the mentally disabled children.

**TABLE 4: ACADEMIC QUALIFICATIONS OF PARENTS: N =20**

<b>EDUCATIONAL LEVEL</b>	<b>#</b>	<b>%</b>
NO SCHOOLING	7	35
PRIMARY EDUCATION	7	35
SECONDARY EDUC.	5	25
TERTIARY EDUCAT	1	05
<b>TOTAL</b>	<b>20</b>	<b>100</b>

Table 4 illustrates that 70 % of the parents of children with mental disabilities have very little or no education at all. This situation makes it difficult for them to deal with additional responsibilities of providing required stimulating environment for their mentally disabled children. Additional and constant supply of special diet and medication increase the financial burden.

The Fig.1 below presents the incidence or prevalence of mental retardation within the immediate families.

**Fig. 1: INCIDENCE OF MENTAL RETARDATION WITHIN THE IMMEDIATE FAMILIES N= 20**

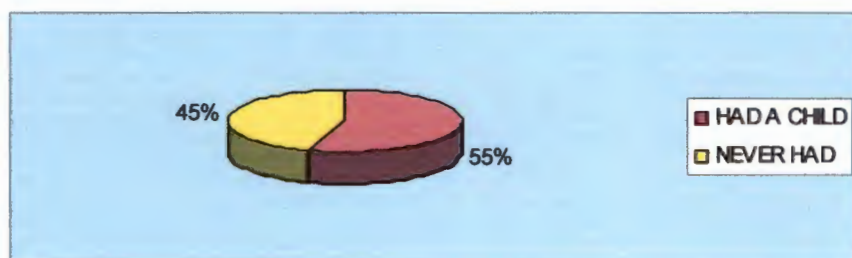
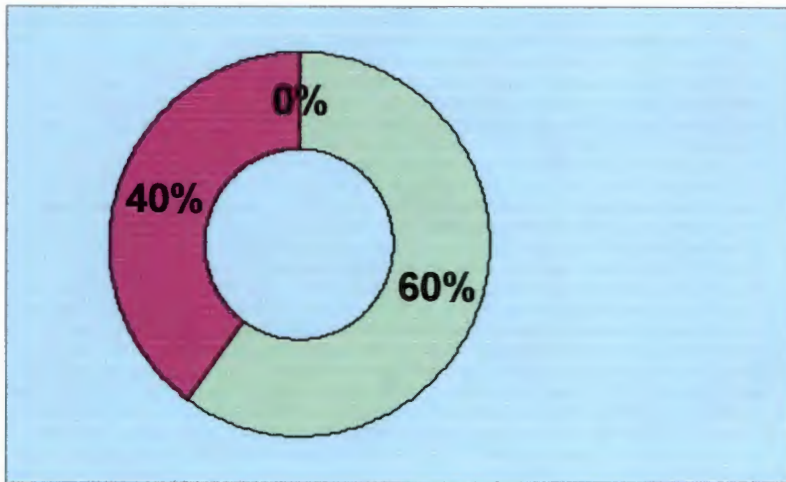


Figure 1 indicates that mental retardation is familial or that it is inherited. 55 % of the respondents indicated that they had children who were mentally retarded before they had this other one. Knopf (1984) and Peck & Hong (1988) stress that heredity plays a causative role in mental retardation.

Fig. 2 below highlights the occurrence of mental retardation within families as was presented by parents of the mentally disabled children.

**FIG 2: MENTAL RETARDATION WITHIN THE EXTENDED FAMILIES: N=20**



The Figure 2 above 60 % of the parents indicated that they have had somebody in the family/ relative who was mentally retarded. This confirms the conclusion reached in Fig. 1 earlier on.

Table 5 presents the age of parents when they had their mentally retarded children.

**TABLE 5: MATERNAL CHILD BEARING AGE N=20**

AGE	#	%
Below 16	7	35
Between 21 and 35	4	20
Above 36	9	45
<b>TOTAL</b>	<b>20</b>	<b>100</b>

Table 5 on page 49 shows that 45 % of the mothers who had babies when they were above 36 years followed by those who were under age. (below 16 years), gave birth to mentally retarded children. According to Erickson (1978) the age of the mother is related to the risk of having a retarded child with teenage mothers and women over 35 having higher risks. Erickson further articulates that, older mothers are more likely to have children with chromosomal abnormalities.

The Figure 3 below shows the emotional status of mothers of mentally retarded children when they were pregnant with their retarded children.

**FIG 3: EMOTIONAL STATUS OF MOTHERS DURING PREGNANCY :**

**N=20**

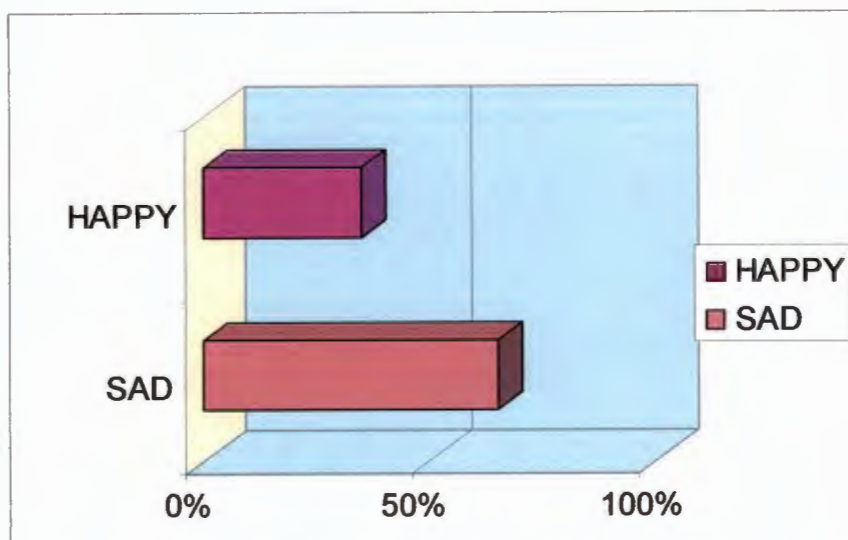


Fig. 3 on page 50 illustrates that the emotional status of the mothers during pregnancy have negative effects on the unborn baby or fetus. The above Figure shows that the majority of mothers who felt sad during pregnancy gave birth to mentally disabled children.

Figure4 presents the health status of parents during pregnancy.

FIGURE 4 : HEALTH STATUS OF PARENTS DURING PREGNANCY:

N=20

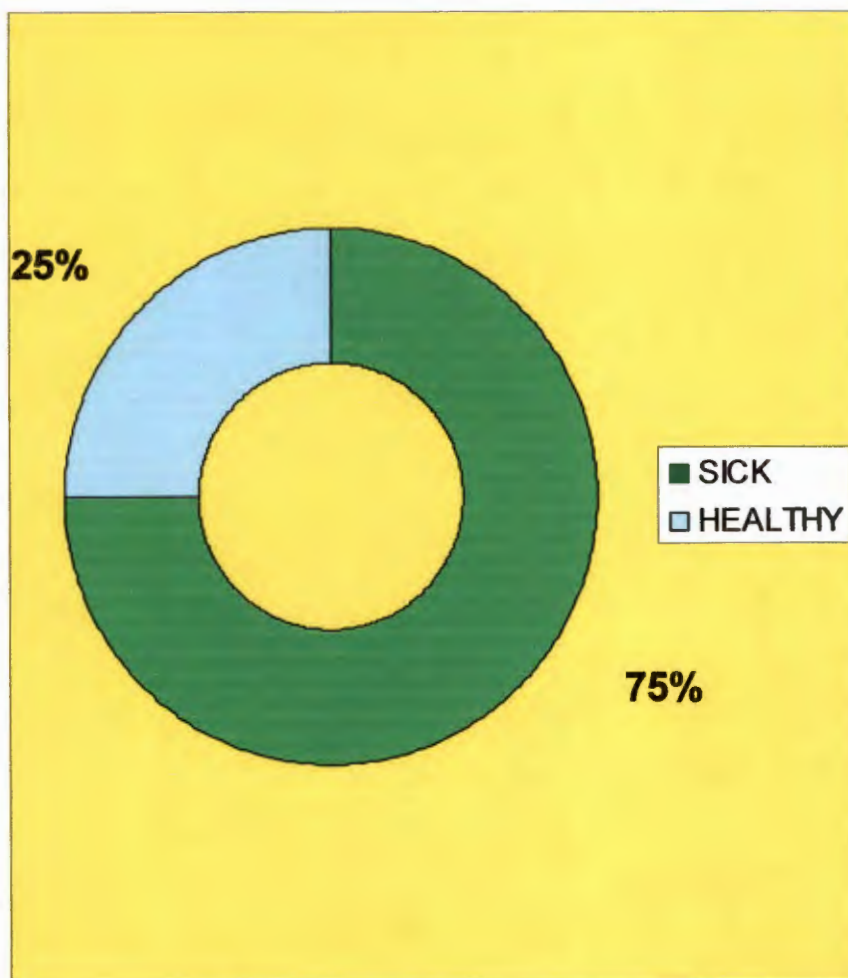


Fig. 4 above indicates that 75 % of the mothers of mentally disabled children were sick during pregnancy. Although not necessarily applicable to the present respondents Wilson & Kneisol (1983),

indicated that, syphilis, rubella and toxoplasmosis diseases are all infectious diseases that may cause neurological damage to the fetus and result in mental retardation when contacted by a pregnant woman.

The Table below indicates the breathing score or breathing pattern of the mentally retarded child during birth as presented by parents.

**TABLE 6: BREATHING SCORES OF BABIES DURING BIRTH : N=20**

BREATHING	#	%
PROPER BREATHING	8	40
IMPROPER BREATH.	12	60
TOTAL	20	100

Table number 6 above shows that 60 % of the children who were born mentally challenged or those who showed symptoms of mentally challenged or those who had symptoms of mental retardation later on, did not breathe properly during birth. According to Knopf ( 1984), mental retardation is not always caused by the same causal factors, but can result from one circumstance that may occur before, during or after birth. For example a low breathing score or improper breathing may cause mental retardation as it was in most of the cases above.

Table 7 below shows the reaction of the mentally challenged children during the birth Process.

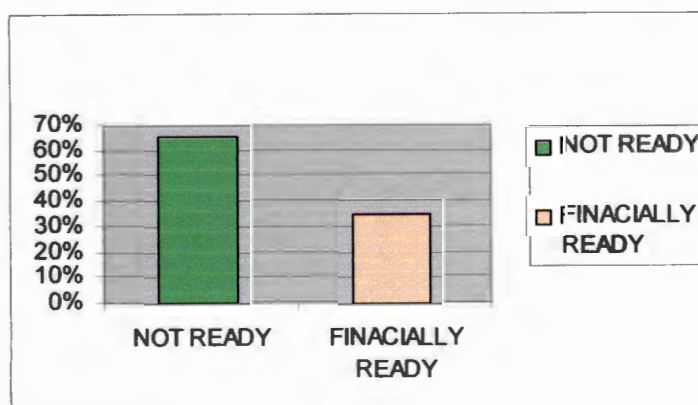
**TABLE 7 : RESPONSE OF BABY TO BIRTH : N=20**

<b>RESPONSE</b>	<b>#</b>	<b>%</b>
CRIED	8	40
DID NOT CRY	12	60
<b>TOTAL</b>	<b>20</b>	<b>100</b>

Table 7 indicates that only 40 % of the retarded children cried immediately after the umbilical cord was cut. Crying of a baby immediately after birth is a natural process that helps and allows the new-born baby to start breathing on its own. Failure or inability to cry often leads to brain damage which is a severe form of mental retardation. Those who failed to cry immediately and were aided to start breathing most probably became mentally disabled.

Fig. 5 below presents the financial status of parents during pregnancy

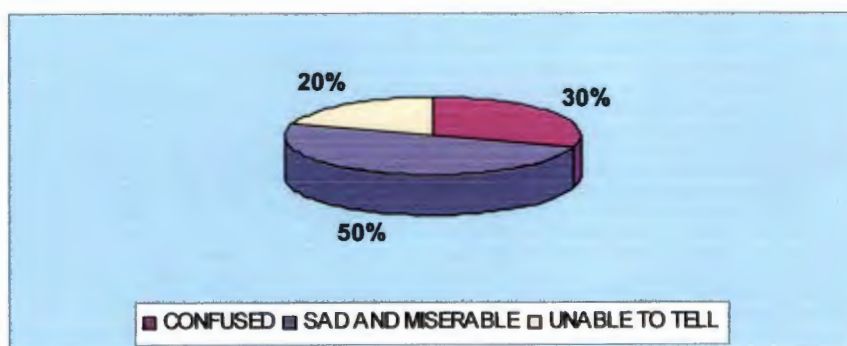
**FIG. 5 FINACIAL STATUS OF PARENTSDURING PREGNANCY: N=20**



The above figure shows that there is a close link between mental retardation and poverty or lack. About 65 % of the parents who ultimately gave birth to the mentally challenged children indicate that they were not financially ready to have these children. Statistics also show that, a disproportionate amount of the mentally disabled population comes from the groups that are socio-economically disadvantaged ( Cockerham, 2000).

Fig. 6 below illustrates the emotional feelings of mothers the very first time when they were told that their children were mentally disabled.

**FIGURE 6 : EMOTIONAL FEELINGS OF MOTHERS DURING PREGNANCY: N=20**

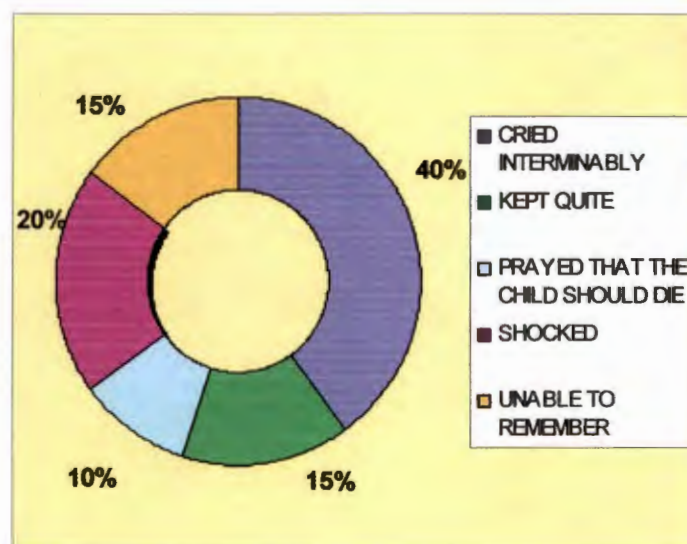


The above Figure 6 shows that a greater percentage of mothers or parents of the mentally disabled children felt sad and miserable when they were told for the very first time that their children were mentally handicapped. According to Newton (1988), for the majority of parents, learning that their child is mentally handicapped usually comes as a

staggering blow. They may love the child because it is their baby, and hate it because it is a travesty of their hopes.

Fig. 7 below indicates how the mothers reacted towards their mentally retarded babies.

**FIGURE 7: REACTION OF MOTHERS TOWARDS THEIR MENTALLY RETARDED NEW -BORN BABY: N=20**



The above Figure illustrates that most mothers cried interminably and uncontrollably when they realized the mental status of their children. Knopf ( 1984:318), articulates that significant others find it difficult to readily accept the member of the family who is mentally challenged. Knopf (1984), further stresses that parental attitudes and their reactions to their mentally retarded child are regarded as important influences in shaping the lives of both the family and the handicapped child.

Table 8 presents the reaction of spouse and siblings when they were told of the birth of a mentally retarded child and brother or sister in their family.

**TABLE 8 : REACTION OF SPOUSE AND SIBLINGS**

<b>REACTION</b>	<b>#</b>	<b>%</b>
ANGRY	3	15
ASHAMED	5	25
DISAPPOINTMENT	12	60
<b>TOTAL</b>	<b>20</b>	<b>100</b>

Table 8 indicates that 60 % of the significant others including parents and siblings, were to a certain extent disappointed by the arrival and birth of the mentally disabled children. They found it difficult to readily accept the child. Knopf (1984: 318), however states that parental attitudes and their reaction to their mentally challenged child are regarded as important influences in shaping the lives of both the family and the handicapped child.

Table 9 on page 57 presents the reaction of neighbors and friends to the arrival of a new-born mentally disabled baby.

**TABLE 9 : REACTION OF NEIGHBORS TOWARDS MENTALLY CHALLENGED CHILDREN**

REACTION	#	%
CARING & SUPP.	6	30
EMBARRASSED	7	35
REJECTED BABY	4	20
LAUGHED AT BABY	3	15
<b>TOTAL</b>	<b>20</b>	<b>100</b>

Table 9 indicates that, although 30 % of the neighbors became caring and supportive to the baby and mother, 70 % of them reacted with either embarrassment, rejection and joking to the mentally disabled baby. The reaction and attitudes of the neighbors can therefore be generalized to the community at large.

Fig. 8 below shows affiliation and membership of parents of the mentally handicapped children in the school Governing Body which is responsible for making key decisions in the school.

**FIGURE 8: SCHOOL GOVERNING BODY (SGB) MEMBERSHIP: N=20**

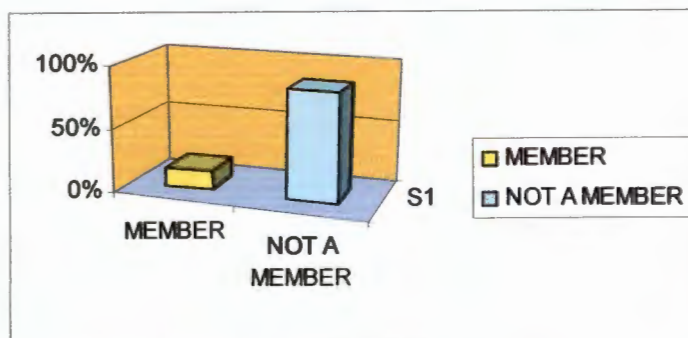


Fig. 8 above indicates that only 15 % of the parents are members of the school Governing Body. This implies that parents of mentally retarded children are not involved in decision making and do not therefore play any significant role in the education of their children.

Fig. 9 below shows the conditions of the buildings where the mentally retarded children are educated, trained or cared for.

**FIGURE 9: CONDITIONS OF BUILDINGS:N=20**

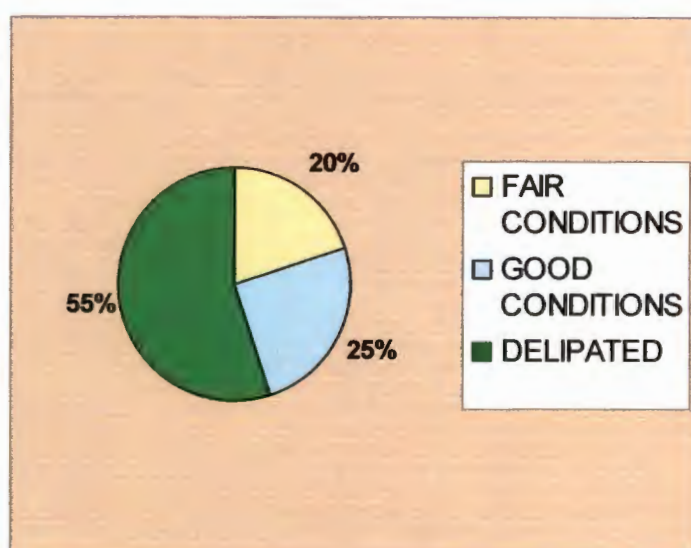


Fig.9 above illustrates that 55% of the buildings are either dilapidated or in a very bad shape. The surroundings are not conducive to learning. The deplorable conditions of the buildings also prove the lack of support by the government and members of the community to the mentally handicapped children and their parents.

Fig. 10 below presents the need for parental support groups by the parents of mentally retarded children.

**FIGURE 10: PARENTAL SUPPORT GROUP :N=20**

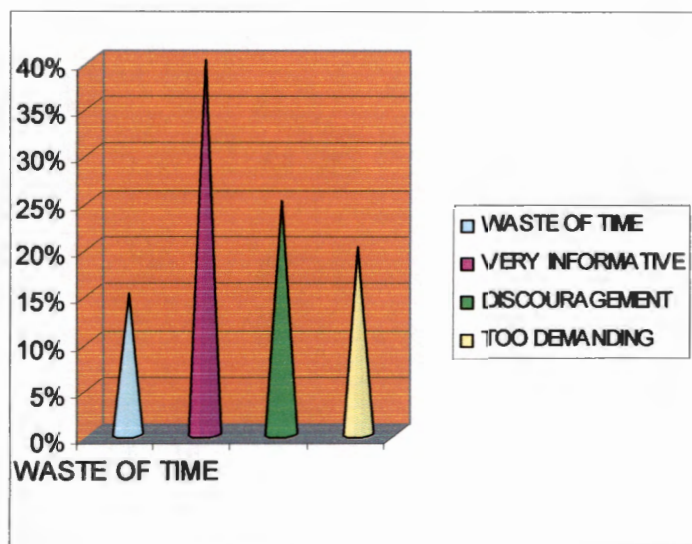


Fig. 10 above illustrates that the majority of mentally disabled children are in favor of parental support groups and regard them as being very informative. Very few regard them as a waste of time. According to Anderson (1982), it is of the greatest possible assistance for parents to meet others who have been through the cycle and know what it feels like. Anderson(1992) alludes that, fellow sufferers understand and can listen to their yearnings more readily than people who do not have personal experience on the matter.

Table 10 below presents visits by teachers of the mentally disabled children to the homes of the children they teach .to discuss problems and viable solutions with parents whilst Table 11 indicates parental visits to the schools or learning institutions.

**TABLE 10: HOME VISITS BY TEACHERS: N=20**

<b>VISITS</b>	<b>NUMBER</b>	<b>PERCENTAGE</b>
<b>OFTEN</b>	<b>3</b>	<b>15</b>
<b>SOMETIMES</b>	<b>8</b>	<b>40</b>
<b>NEVER</b>	<b>9</b>	<b>45</b>
<b>TPTAL</b>	<b>20</b>	<b>100</b>

Table 10 above shows that 45% of the teachers have never visited the homes of children and that if they do. They visit very seldomly. This makes it difficult for the teachers to help and teach the mentally retarded because effective teaching dictates that teachers should understand the family background of the child

**TABLE 11: PARENTAL VISITS TO SCHOOLS: N=20**

<b>VISITS</b>	<b>#</b>	<b>%</b>
<b>WEEKLY</b>	<b>2</b>	<b>10</b>
MONTHLY	2	10
ONCE IN A WHILE	12	60
ALMOST NEVER	4	20
<b>TOTAL</b>	<b>20</b>	<b>100</b>

Table 11 above indicates that only a small number (20%) of the parents visit the school regularly. This proves that parents of the mentally disabled children as compared to parents of normal children,

are not actively involved as they should be in the education of their children.

Table 12 below presents the incidents when parents of the mentally challenged children were invited by the teachers to visit the school to help

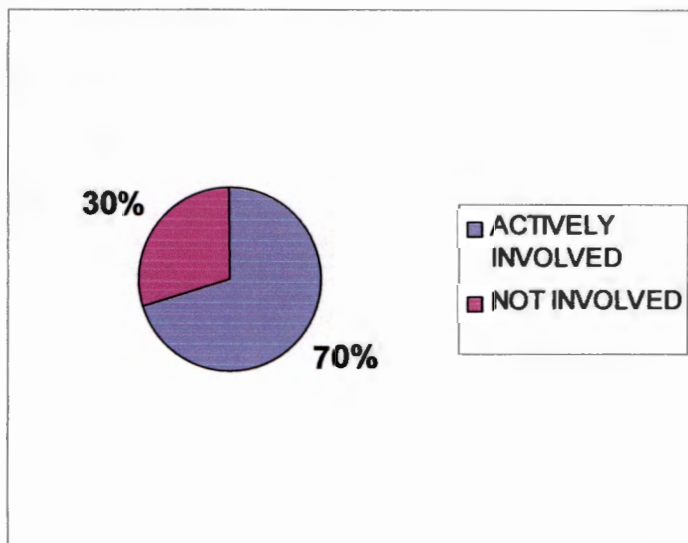
TABLE 12: INVITATION TO HELP : N=20

INVITATION	#	%
SOMETIMES	14	70
OFTEN	6	30
TOTAL	20	100

The Table above illustrates that teachers seldom invite parents to help. Fig 11 below shows that parents of the mentally retarded children are very cooperative and keen to help when asked to do so by the school..

Fig. 11 below presents the involvement of parents in fund-raising activities of the school

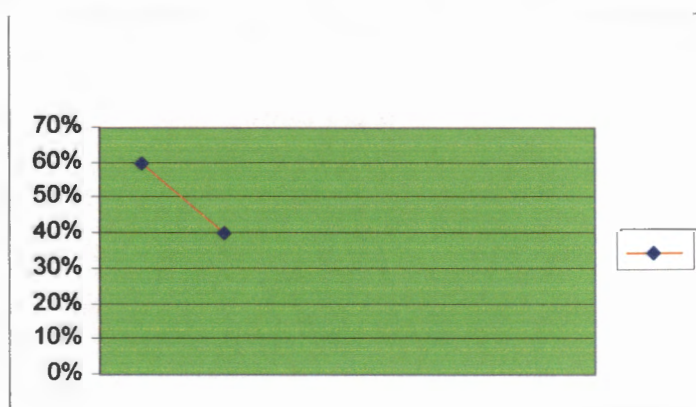
**FIGURE 11 INVOLVEMENT OF PARENTS IN FUND-RAISING ACTIVITIES : N=12**



The above Fig. 11 illustrates that parents of the mentally handicapped are ready to help and can be useful in fund-raising activities and other school affairs if they can be invited to do so. This has also been highlighted in Table 12 earlier on.

Fig.12 below indicates the need of financial social service grants by parents of the mentally challenged children.

**FIGURE 12: THE NEED FOR FINANCIAL SOCIAL GRANTS**



form of social service grants. Very few parents ( 40 %) indicated that they did not require any financial assistance. The plight of those who need financial help is supported by Reynolds (1984: 124) who states that, for the family with a mentally handicapped child, the extra cost and loss of earning is very high.

### **5.3 QUESTIONNAIRE FOR TEACHERS**

Table 13 below presents the gender of teachers of Bophelong and Retlametswe Special Schools in Mafikeng.

**TABLE 13: GENDER.TEACHERS: N=12**

<b>SEX</b>	<b>#</b>	<b>%</b>
MALE	1	8.3
FEMALE	11	91.7
<b>TOTAL</b>	<b>12</b>	<b>100</b>

Table 13 above demonstrates that the number of female teachers working in the two special schools for the mentally disabled children is far more than the males. The disproportionate number indicates that women have more courage and patience than men to teach and care for the mentally handicapped children.

Table 14 presents the age range of teachers of Bophelong and Retlametswe Special Schools.

**TABLE 14: AGE OF TEACHERS : N=12**

<b>AGE</b>	<b>#</b>	<b>%</b>
<b>Below 24</b>	<b>2</b>	<b>16</b>
Between 24 & 36	4	33.3
36 & Above	6	50
<b>TOTAL</b>	<b>12</b>	<b>100</b>

As indicated in Table 14 above, 50% of the teachers working at Bophelong and Retlametswe Special Schools for the mentally disabled children are thirty six years old and above. Teaching the mentally disabled children is demanding and challenging and younger teachers probably find it very difficult to teach them.

Table 15 below indicates the academic qualifications or educational level of teachers of Bophelong and Retlametswe Special Schools' per se'.

**TABLE 15: ACADEMIC LEVEL OF TEACHERS: N=12**

<b>EDUC. LEVEL</b>	<b>#</b>	<b>%</b>
MATRIC	4	33.3
DIPLOMA	7	58.3
DEGREE	1	8.3
<b>TOTAL</b>	<b>12</b>	<b>99.9</b>

Table 15 above demonstrates that only 8.3 % of the teachers have a university Degree. The majority of them seem to be content with a Diploma in Education and are currently not engaged in any studies. The working conditions of special school teachers make it difficult for them to improve their qualifications. The fact that they are not given any special remuneration for the extra and hard work they are doing also contribute to their reluctance to further their studies.. Butcher, Carson & Coleman (1988), on the other hand state that, programs like mainstreaming and inclusive education, require careful planning and a high level of teacher skill.

Table 16 shows the teaching experience of teachers in special education

**TABLE 16 : TEACHING EXPERIENCE IN SPECIAL SCHOOLS: N=12**

<b>NUMER OF YEARS</b>	<b>#</b>	<b>%</b>
2-4 YEARS	2	16.6
5-10YEARS	5	41.6
11-20 YEARS	3	25
21 YEARS& ABOVE	2	16.6
<b>TOTAL</b>	<b>12</b>	<b>99.8</b>

Table 16 indicates that 41.6 % of teachers taught at special schools for five to ten years. The majority of them indicated no intentions of leaving special schools to teach at regular schools. The . teachers seemed committed to work in deplorable conditions of special schools.

Fig.13 indicates the social backgrounds of children as presented by teachers.

**FIGURE13:SOCIAL BACKGROUNDS OF CHILDREN : N=12**

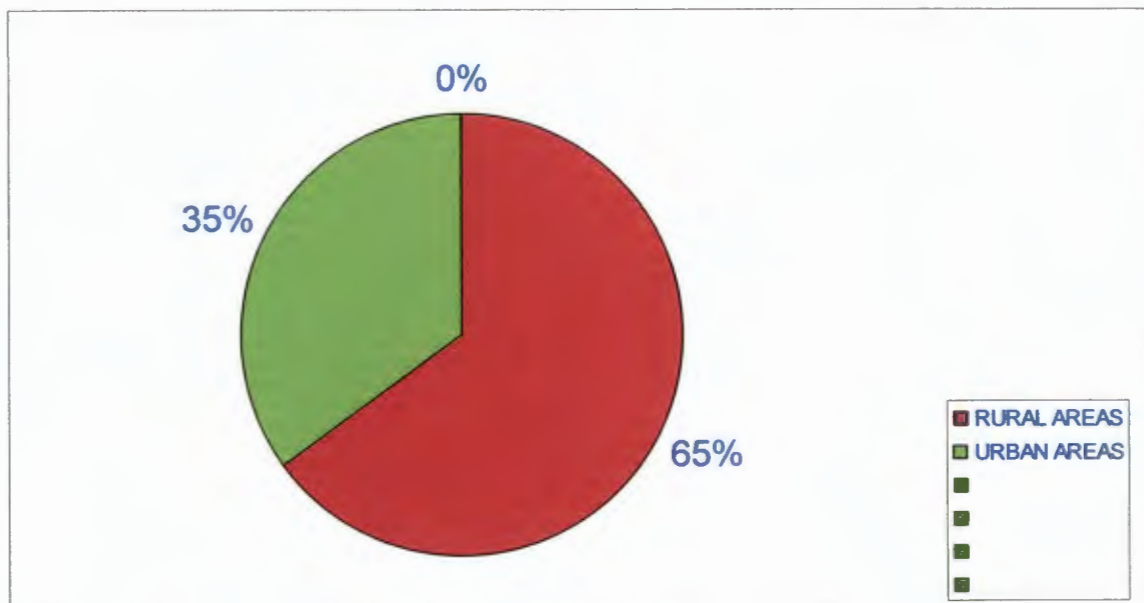


Fig. 13 illustrates that 65 % of the children in the two schools come from rural areas. According to information given by teachers, most of the learners come form the disadvantaged communities of Lomanyaneng and Stadt villages.

Fig.14 below shows the number of teachers who have children themselves, who are mentally disabled.

**FIGURE 14: TEACHERS WHO HAVE MENTALLY RETARDED CHILDREN:N=12**

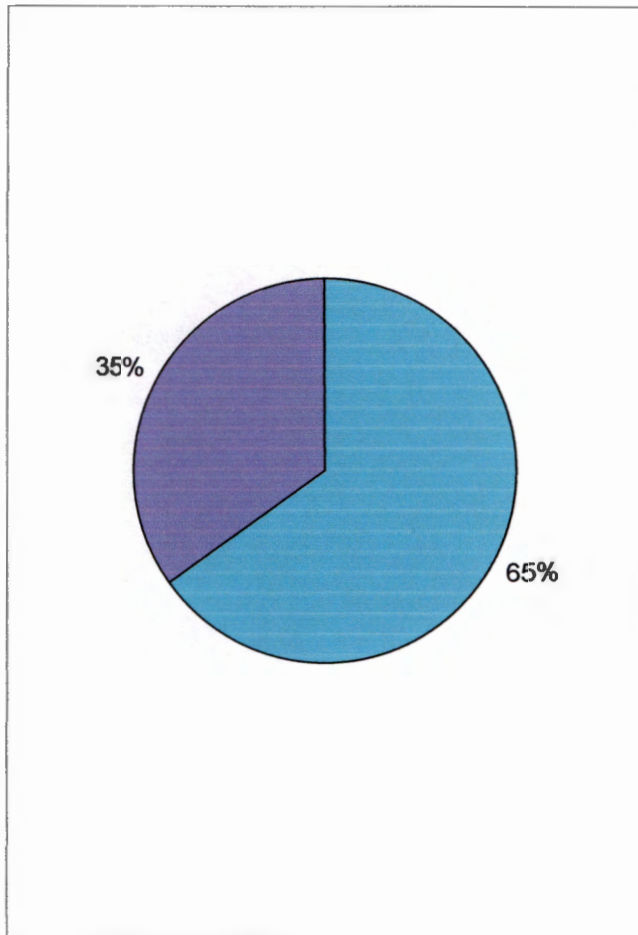


Fig.14 shows that 65% of the teachers of the two special schools also have mentally retarded children. This explains why most of them do not think of going to other normal schools. In other words they share the experience and pain of bringing their children up with parents. Those who teach the retarded children and also have mentally disabled children of their own understand what parents are going through and are compassionate to their learners for they share basic needs with their children.

Table 17 illustrates the type of disability in the two schools.

**TABLE 17: TYPE OF DISABILITY**

<b>DISABILITY</b>	<b>#</b>	<b>%</b>
MILD RETARDATION	2	16.6
MODERATE RETARD	3	25
SEVERE RETARD	5	41.6
PROFOUND RETARD	2	16.6
<b>TOTAL</b>	<b>12</b>	<b>99.8</b>

Table 17 indicates that the majority of children in the two schools are severely mentally retarded. There is an equal member of those who are mildly and profoundly retarded.. The type of children admitted in these schools calls for unfailing support from the community and mental health team.

Table 18 presents the grouping of learners in the two schools.

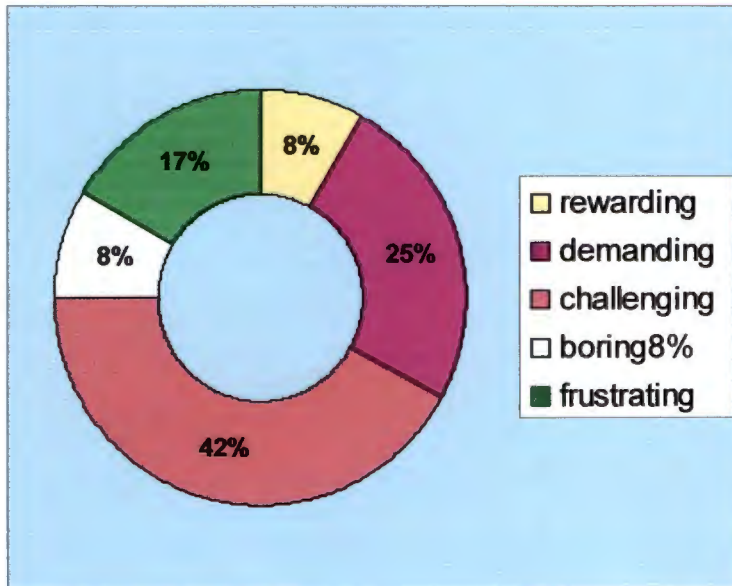
**TABLE 18: GROUPING OF CHILDREN**

<b>GROUP</b>	<b>#</b>	<b>%</b>
AGES	7	58.3
INTEREST	5	41.6
<b>TOTAL</b>	<b>12</b>	<b>99.9</b>

Table 18 shows that children of Bophelong and Retlametswe Special Schools are mainly grouped according to age than interest. Ability is completely not considered in placing children in classes

Fig. 15 below indicates the perception of special schools by teachers.

**FIG.15 ATTITUDES OF TEACHERS : N=12**



The above Fig. 15 indicates that 42 % of the teachers find teaching at special schools for the mentally disabled challenging, 25 % of them regard it as demanding. Only a small percent ( 25%) find teaching to be frustrating or boring.

Fig.16 presents the attitudes of normal school educators towards those teaching mentally disabled children.

**FIG.16 ATTITUDES OF NORMAL SCHOOL EDUCATORS TOWARDS SPECIAL SCHOOL EDUCATORS**

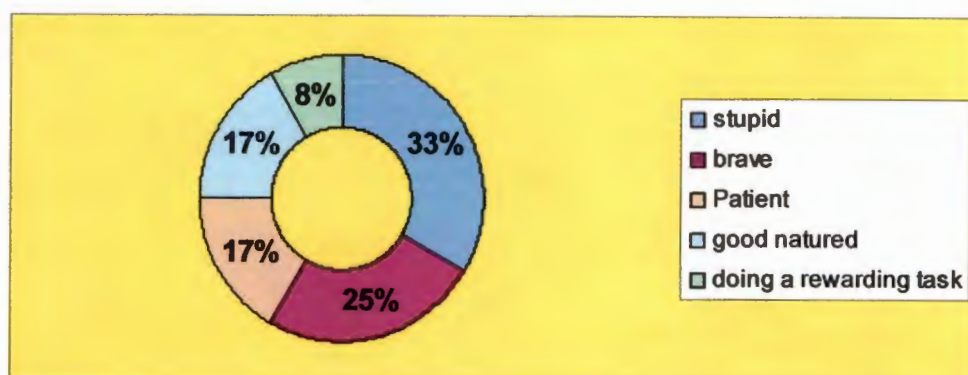


Fig. 16 illustrates that, although most younger teachers do not want to teach in special schools, they have a high regard for special school teachers. Whilst only 8% of them say that they are as stupid as the children they are teaching.92 % regard them as brave, patient, good natured and that they are doing a rewarding task . The high positive regard that special education teachers receive from their colleague, indicates a possibility of attitudinal change of the community towards mental retardation.

Table 19 like Tables 10 and 11 on pages 62 and 63 presents home visits to children's homes by teachers to discuss issues affecting the children and therefore I making the learning process difficult.

**TABLE 19 : HOME VISITS : N=12**

VISITS	#	%
SOMETIMES	2	16.6
NEVER	10	83.3
<b>TOTAL</b>	<b>12</b>	<b>99.9</b>

Table 19 confirms the findings as was presented in Table 10 on page 62. 83.3 % of the teachers stated that they never visit children's homes to discuss problems and solutions they encounter with children at school. Home visits is one area which is mostly neglected by special school teachers. This may be the reason why teachers find dealing with children's emotional and psychological problems ,demanding and challenging.

Table 20 below presents the attempts of teachers to get community members involved in the affairs and fund-raising activities of the school

**TABLE 20: REQUESTING THE COMMUNITY TO HELP: N=20**

<b>REQUEST</b>	<b>#</b>	<b>%</b>
NEVER	7	58.3
SOMETIMES	4	33.3
OFTEN	1	8.3
<b>TOTAL</b>	<b>12</b>	<b>99.9</b>

Table 20 above shows that 58.3% of the teachers never attempted to request help from the community members to help special schools in fund-raising activities.. The fact that only 42,6 % of the teachers have tried to involve community members in special education affairs shows reluctance and a sense of mistrust from the teachers. Failure to involve community members may be used as scapegoat by the latter to ignore their responsibility and to perpetuate the already existing myths , stereotypes and attitudes held by the community.

Table 21 below presents the response of the community when approached by special school educators to help .

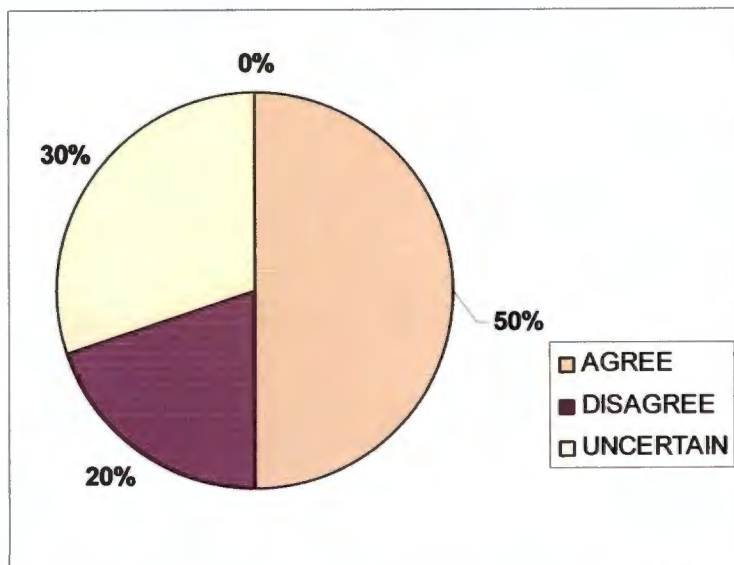
**TABLE 21: RESPONSE OF THE COMMUNITY: N=12**

RESPONSES	#	%
NEVER	8	66.6
SOMETIMES	4	33.3
<b>TOTAL</b>	<b>12</b>	<b>99.9</b>

Table 21 above indicates that 66.6 % of the community members never responded and simply ignored the request put across to them, hence the reluctance of teachers to involve them as highlighted in Table 20 earlier on.

The Figure 17. below indicates the feelings of special school educators about placement of mentally handicapped children in residential institutions.

**FIGURE17: PERCEPTION OF TEACHERS REGARDING INSTITUTIONALIZATION: N=12**



The above figure 18 illustrates that 50 % of the teachers feel that the mentally retarded children should be sent to residential institutions. Only 20 % of them are against banishment of mentally retarded children in residential institutions. 30% of the respondents were uncertain about institutionalization because they probably do not understand the disadvantages of institutionalization.

Table 22 below presents the perception of teachers about parental support groups.

**TABLE 22: THE NEED FOR A SUPPORT GROUP : N=12**

<b>RESPONSE</b>	<b>#</b>	<b>%</b>
AGREE	7	58.3
DISAGREE	3	25
UNCERTAIN	2	16.6
<b>TOTAL</b>	<b>12</b>	<b>99.9</b>

Table 22 above illustrates that 58.3 % of the teachers agree that parents of the mentally disabled children should affiliate to parental support groups. Parents also indicated that they were for the idea in Fig. 10 on page (6). Only 41.6 % are uncertain and disagree with the establishment and affiliation to parental support groups.

**TABLE 23: EXTENT OF KNOWLEDGE OF TEACHERS :N=12**

<b>RESPONSE</b>	<b>#</b>	<b>%</b>
KNOWLEDGEABLE	8	66.60
NOVICE	4	33.3
<b>TOTAL</b>	<b>2</b>	<b>99.9</b>

The above Table shows that 66.6% of the teachers do not have extensive knowledge about the development of the mentally retarded children and like other community members that regard the mentally handicapped as children who never grow up.. Teachers therefore do not treat the mentally handicapped with respect and dignity and never give them a chance to make decisions about their lives.

Fig .18 presents the necessity of inter-professional or mental health team as stated by teachers of Bophelong and Retlametswe Special Schools

**FIG. 18 INTER-PROFESSIONAL/ MENTAL HEALTH TEAM**

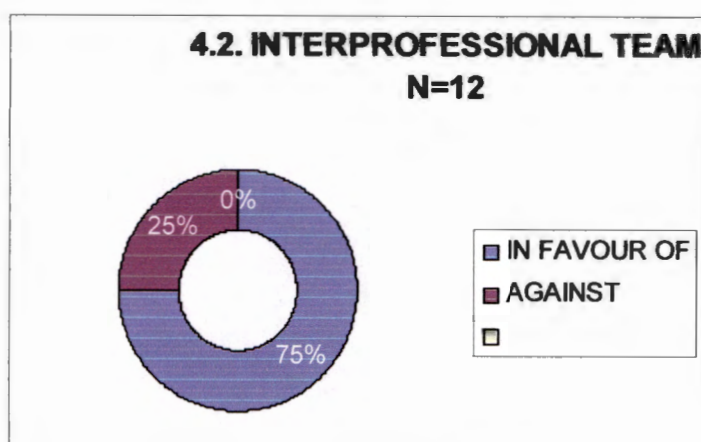


Fig. 18 above indicates that 75% of the respondents are in favor of the mental health or inter-professional team. In other words teachers find teaching the mentally disabled children without extra specialized help of other specialists, very demanding and challenging. Other specialists and professionals like nurses psychologists ,occupational therapists and speech therapist would be very helpful to teachers and children. According to Bickwel l& Hollins (1985), a multi-professional team is a very useful strategy and tool which is suitable for the upliftment of living standards of the mentally disabled children.

#### **5.4. CONCLUSION**

From the analysis of data it was concluded that, community members do have negative attitudes towards the mentally challenged children. Existing labels, myths and stereotypes make it very difficult for the mentally challenged to identify themselves with the society and to develop the feeling of belonging. Further analysis indicates that, even biological parents of the mentally retarded children, experience problems of creating or forming the necessary attachment bonds with their retarded children. The majority of parents cried interminably when they were told that their children were retarded and never had a chance to give their new-born babies the very first love.

## **CHAPTER 6**

### **6.1 INTRODUCTION**

Chapter 6 seeks to highlight the outstanding findings of the investigation. It also points out some research areas revealed by the study. This chapter further addresses the findings with a view to making specific recommendations and conclusions for the benefit of persons who may need to use the results.

Major findings are represented below under sub-headings with the key issues addressed in the study. Before discussing the main findings, objectives of the study will be restated.

### **6.2 RESTATEMENT OF OBJECTIVES**

The objectives of the study will be restated as follows:

- ❖ To investigate the nature and extent of mental disabilities among children;
- ❖ To determine the knowledge and attitudes of the community towards mental retardation and;
- ❖ To establish the need for resource support for the parents of children with mental disabilities.

## **6.3 DISCUSSION OF THE MAIN FINDINGS**

The main findings will be discussed as follows:-

### **6.3.1 THE NATURE AND EXTENT OF MENTAL DISABILITIES**

According to Newton (1988), persons with mental retardation comprise an estimated 2.5 percent of the population. Factors such as poverty, poor nutrition and lack of adequate health care increase the prevalence rate. Rutter (1979) in Newton (1988), explains that, one out of ten families nation-wide is directly affected by mental retardation.

It has been stipulated that, variables that are found to be associated with mental disorders are family discord and disruption, parental illness and criminality as well as social disadvantage [on-line]. Cockerham (2000), states that, a disproportionate segment of the mentally retarded population comes from the groups that are socio-economically disadvantaged. Cockerham (2000), further explains that, other factors which have been identified as contributing to the development of childhood psychiatric disorders, are age, sex, temperament, brain damage, educational retardation and parental mental illness.

### **6.3.2 THE KNOWLEDGE AND ATTITUDES OF THE COMMUNITY**

This study established that the community has negative attitudes towards the mentally retarded children. Rogers (1996) in Abosch & Collins (1996), explains that the attitudes of the wider community appear to be neutral as long as social distance is maintained. Abosch & Collins (1996) postulate that, community members still hold on the notion that, the word 'retarded' means dumb or stupid. Knopf (1984), articulates that there is very little data available to assess public attitudes towards the mentally retarded children in this country and that there is very little understanding in the community of the problem of mental illness and a lot of ignorance.

According to Wilkin (1979:12), there is still a pressing need for increased understanding and for further improvements in attitudes and services beyond those that have already taken place. Wilkin (1979) further articulates that, the fact that the mentally handicapped children and their families still experience problems of rejection and isolation needs to be corrected. Other research demonstrates that, the most crucial obstacles to the insertion of handicapped individuals is not their inability or lack of skills to perform specific tasks, but the attitudes and preconceptions of the society at large [on-line].

Knopf (1984:318), stresses that, it is usual for the retarded to be rejected by his or her family, shunned by employers, ostracized by peers, denied heterosexual relationships and ignored by the community. Mangen (1982), articulates that, mentally disabled persons are still treated as if they were a burden and danger. Mangen (1982) also articulates that information about mental disorders in newspapers, television and films occurs relatively infrequently and when it does, its presentation is distorted.

### **6.3.3 THE SUPPORT NEEDED BY PARENTS OF CHILDREN WITH MENTAL RETARDATION**

Kibel & Wagstaff (1997: 3200), explain that, helping the parents of mentally handicapped children to cope is of great importance and should start at the time of diagnosis. They further state that, telling parents that their child is impaired must be done with great sensitivity. It has also been stressed that, the diagnosis must be given with gentleness and empathy but strongly enough for the message to be understood. According to Kibel & Wagstaff (1997), the family of the impaired child needs ongoing support.

It is also very important for the community to note that, persons with mental and developmental disabilities, desire to be given opportunities that will enable them to become full contributing members of society. They want to live, to love and be loved, to work

and to play. People with disabilities, prefer when given the option, to live and receive services and support in their own homes, schools, workplaces and local communities [on-line:2002].

Many adults who are mentally handicapped, were presumed to be too disabled to work in competitive employment or function as productive members of the community. Consequently, special work environments called sheltered workshops were created to provide them with job opportunities. It is however important to note that, placing or providing jobs for the mentally disabled people in sheltered workshops does not make any difference in their lives neither does it solve any problem. Sheltered workshops serve to stigmatize and embarrass adults with disabilities. Many people especially the moderate and mildly retarded would rather stay unemployed than work in segregated, stigmatizing settings [on-line].

#### **6.3.4 PREVENTION/INTERVENTION**

According to Davidson & Neale (2001:441), prevention of mental retardation depends largely on understanding of its causes. Davidson & Neale (2001), further explain that, the field of medical genetics is not yet equipped to prevent the more severe genetic causes of mental retardation. Standing advances in genetics may however change this situation in the not -too-distant future. It has also been explained that, when the causes of mental retardation are known, prevention is

not possible but treatment to improve the person's ability to live on his/her own is an option (Davidson & Neale, 2001).

As further explained by Davidson & Neale (2001), when an impoverished environment is the source of mental retardation, enrichment programs can prevent further deficits and sometimes even overcome existing ones. According to Mabetoa (1979), mental illness can be prevented by public education, legislation and provision of adequate material and child health services.

#### **6.4 EMPIRICAL FINDINGS**

The study established that it is not only community members who have negative attitudes towards the mentally handicapped children and adults, but that even parents, siblings and significant others find it difficult to readily and unconditionally accept them.

It has also been established that, the society or community members still hold myths and stereotypes about mental retardation. The stereotypes and myths create prejudice and stigma which in turn makes the mentally handicapped children to be treated with scorn and resentment by the normal community members. Examples of stereotypes held by society about the mentally retarded is that they do not have sexual feelings and that they must be sterilized.

This study further established that, mentally retarded children are helpless and defenseless victims of verbal, psychological, sexual abuse, neglect and harassment. Personnel and teachers working with mentally retarded children are belittled and looked down upon by community members. The negative attitude will obviously make inclusive education and mainstreaming very slow and difficult to implement. The dilapidated conditions of many special school buildings, especially the non-capacity or black special schools including Bophelong and Retlametswe in the North West Province, show negligence and negative attitudes of the community. The government is in fact doing very little to improve the education standard of the mentally retarded as well as working conditions of the teachers.

The analysis revealed that, there is very little understanding and knowledge in the community of the problem of mental illness and a lot of ignorance. The society still maintain social distance and regard the mentally retarded children as a burden, a danger or a curse.

## **6.5 RECOMMENDATIONS**

This study suggests that intervention strategies, prevention and other relevant measures be put in place to help remove myths and stereotypes held by the community about the mentally retarded persons. The study recommends that teachers and trainers be empowered and be brought on board so that they are enabled to catch

up with other teachers and to compete if need be without feelings of inadequacy or inferiority complex.

The study recommends that teachers and trainers be equipped with knowledge and understanding of relevant theory and experience through regular workshops, seminars and in-service training. Public education, legislation and adequate teaching material as well child health services must be provided. Services of the mental health team comprising of psychologists, psychiatrists, social workers and psychiatric nurses should be provided. According to Nathan & Harris (1980: 24), the mental health team can provide mentally retarded children with more comprehensive care than any profession alone.

The government must make provision of adequate financial help and suitable living conditions its priority. Medical treatment, assessment procedures, training programs, leisure time activities as well as companionship should be provided. Community members should take the responsibility of providing adequate emotional and psychological social support. Young people should be educated by the community to accept and treat the mentally disabled persons as they do with the normal people.

Another recommendation is that, the government should take the responsibility of ensuring that, the existing services for the mentally challenged, reflect respect for the uniqueness of each person. Ways of

enabling the retarded child to mix with people who are not handicapped have to be worked out. The lack of privacy and dignity that comes with communal bathing, shared clothing and bedrooms in institutions for the mentally handicapped should never be accepted.

The study suggests and recommends that legal information and easily accessible representation for the mentally retarded children be made available. The Legal Aid Board could for example, be encouraged to make the mentally retarded their priority clientele. It is further suggested that skills training projects excluding the already existing welfare projects like cooking and sewing and cooking be put in place so that new skills and roles are learnt.

It is further recommended that the mentally retarded persons be motivated to live and release the residual potential. They should also be allowed independence to choose activities that do not make them burdens of other people.

## **6.6 CONCLUSION**

It is hoped that this study will give community members and all people who care for the mentally disabled children an insight into their psycho-social well-being and needs. The study will also be useful in the expulsion of misconceptions and myths about mental retardation. This study aims at helping community members that, mentally challenged as they can be, they are not societal misfits. After

reading this research, most people will know and start taking into cognizance that, the mentally handicapped persons are human-beings and that their disability is secondary.

## REFERENCE LIST

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## APPENDIX A

### QUESTIONNAIRE FOR PARENTS

This questionnaire has been designed to collect information on knowledge and attitudes of the community towards the mentally retarded children from parents of children of Retlametswe Special School in ( Imperial Reserve), Mafikeng. Respondents are requested to answer all questions and are urged to answer freely and frankly. The researcher will read questions and possible answers aloud ( where applicable) to the respondents and will make a cross (x) next to the chosen or given answer.

#### A.DEMOGRAPHIC DATA

1. SEX:  
Male .....  
Female .....
2. AGE:  
Below 24 .....  
Between 25 & 35 .....  
Above 36 .....
3. MARITAL STATUS:  
Married .....  
Single .....  
Divorced .....  
Widowed .....
4. ACADEMIC QUALIFICATIONS:  
Primary Education .....  
Secondary Education .....  
High School Education .....

Tertiary Education .....  
No schooling .....

## **B. INCIDENCE OR PREVALENCE**

5. Do you have any mentally retarded child except this one ?  
Do not have.....  
Has another one .....
6. Is there anybody in your relative who is mentally challenged ?  
Yes, there is .....  
There is no one .....
7. How old were you when you had this child ?  
Below 16 years .....  
Between 21 & 35 .....
8. How did you feel when you were pregnant ?  
Sad .....  
Happy .....
9. Did you suffer from any disease when you were pregnant ?  
Suffered .....  
Never suffered any .....
10. Was the baby breathing properly when it was born ?  
Yes .....  
No .....
11. Did the baby cry immediately after it was born ?  
Yes .....  
No .....
12. Were you and your spouse financially ready ?  
Yes .....  
No .....

## C. ATTITUDES

13. How did you feel when you were told that your child was retarded ?

- Confused .....
- Sad & miserable .....
- Very happy .....
- Unable to tell .....

14. How did you react when the news were made known to you ?

- Cried interminably .....
- Prayed that the child should die .....
- Jumped up to check the baby .....
- Do not remember what I did .....

15. When your husband and children were told they felt:

- Angry .....
- Ashamed .....
- Disappointed .....
- Happy .....

16. How did your neighbours respond to the baby ?

- They rejected the baby .....
- They laughed at the baby .....
- They became caring and supportive .....
- They felt embarrassed .....

## D. SUPPORT

17. Are you n SGB member ?

- Yes .....
- No .....

18. If yes, how long have you been a member ?

- Less than a year .....
- 1-2 years .....
- 3-4 years .....
- 5-6 years .....

19. How would you describe the buildings in your child's school ?

- Very smart .....
- In fair conditions .....
- Not in good conditions .....
- Dilapidated .....

20. In your own opinion the parental support group of which you are a member is:-

A waste of time .....  
Very informative .....  
Serves as a discouragement .....

21. How often do teachers visit your home to discuss problems related to your child's performance ?

Very often .....  
Often .....  
Sometimes .....  
Never .....

### **E. PROGRAMS**

22. How often do you visit your child's school ?

Daily .....  
Weekly .....  
Monthly .....  
Once in a while .....  
Almost never .....

23. Do you play any part in fund-raising activities of the school?

Yes .....  
No .....

24. If you ever received calls from school to help, how often did you help ?

Very often .....  
Often ....  
Sometimes .....  
Never .....

25. Do you think that mentally retarded children are entitled to social service grants ?

Yes .....  
No .....

**THANK YOU SO MUCH AND STAY BLESSED !!**

## **APPENDIX B**

### **QUESTIONNAIRE –TEACHERS**

This questionnaire has been designed to gather information on attitudes of the community towards the mentally retarded children from the educators/teachers of Bophelong and Retlametswe Special schools respectively. Respondents are requested to answer questions freely and frankly.

#### **A. DEMOGRAPHIC DATA**

Please mark whichever applies to you with a cross (x)

1. SEX:

Male           .....  
Female         .....

2. AGE:

Below 24                   .....  
Between 25 & 35         .....

3. ACADEMIC QUALIFICATIONS:

Matric                   .....  
Diploma                 .....  
Degree                  .....  
Senior Degree         .....

4. TEACHING EXPERIENCE:

Less than a year       .....  
2-4 years                .....  
5-10 years               .....  
11-20 years             .....  
21 years and above     .....

## **B. INCIDENCE AND PREVALENCE**

5. Where do most of children in your school come from?

Rural areas .....  
Urban areas .....

6. Do you have a mentally retarded child?

Yes .....  
No .....

7. Most children attending your school are:

Mildly retarded .....  
Moderately retarded .....  
Severely retarded .....  
Profoundly retarded .....

8. What is your personal observation regarding enrolment of new learners in your school during the past two years:

There is a marked decline .....  
There is an increase .....

9. How do you group pupils in your school?

According to ability groups .....  
According to age groups .....  
According to interest groups .....  
No grouping .....

10. Most children in your school come from:

Wealthy families .....  
Middle class families .....  
Poor families .....

## C. ATTITUDES

How do you find teaching at a school for the mentally retarded?

Boring .....  
Challenging .....  
Rewarding .....  
Frustrating .....

12. What do other teachers, teaching at regular schools say/think about you ?

That you are as well stupid and retarded .....  
That you are brave .....  
That you are meek and patient .....  
That you are good-natured .....  
That you are doing a rewarding task .....

13. What is your opinion regarding sexuality of mentally retarded children?

That they do not have sexual feelings .....  
That they should not enter into intimate relationships .....  
That they are humans and have rights to love and be loved.....  
They must be sterilized .....

## D. SUPPORT TO PARENTS

14. How often do you visit parents to discuss problems related to their children's performance?

Always .....  
Often .....  
Sometimes .....  
Never .....

15. How often do you request community members to help the school raise funds ?

Always .....  
Very often .....  
Often .....  
Sometimes .....  
Never .....

16. If you sent requests for help how often did they help?

Always .....  
Very often .....

Sometimes .....  
Never .....

**E. INTERVENTION STATEGIES/ PROGRAMS**

17. All mentally challenged children and adults must be institutionalized.

Agree .....  
Disagree .....  
Uncertain .....

18. Parents of mentally disabled children can benefit from parental support groups:

Agree .....  
Disagree .....  
Uncertain .....

19. A multidisciplinary team would be the best intervention strategy for the mentally retarded.

Agree .....  
Disagree .....  
Uncertain .....

20. Mentally retarded persons remain children forever and do not grow.

Agree .....  
Disagree .....  
Uncertain .....

**THANK YOU AND BE MIGHTILY BLESSED!!!**