The issue of mental retardation or handicap has an international stature. India being the second most populous country in the world, the proportion of mentally handicapped persons in the country is quite alarming. Unfortunately, no national census has been carried out, to estimate the actual number of mentally handicapped in India. Several sample surveys have been carried out from time to time. According to this estimate, about 3 percent of the population is supposed to be retarded, of which 75 percent is mildly retarded, 20 percent moderately severely retarded and 5 percent belong to the category of profound retardation requiring custodial care (Anima Sen, 1992).

Mental retardation has existed since pre-historic times, but the earliest evidence dates back only to pre-dynastic Egypt. Harris and Weeks (1973) noted certain skeletal anomalies associated with mental retardation through X-ray examinations of ancient Egyptian mummies. Guerra (1971) found evidence of mental retardation across temporal and cultural periods in the pre-colonial civilizations of the Mayas, Incas and Aztecs.

Superstitious thinking exorcism and fear of the retarded began to dissipate with the advent of renaissance. The first serious and systematic attempt to teach a retarded boy was made only in the nineteenth century when the French Physician, Jean Itard (1801) wrote about his endeavour to educate the feral child, Victor, otherwise known as the wild boy of Averyron. Though he failed in his pioneering
educational attempts, Itard aroused considerable interest in the retarded throughout Europe.

Equally important was the continuation of Itard's work by his student Seguin (1812-80), the most eminent figure in the nineteenth century in the training of the mentally retarded. The contribution of Alfred Binet (1857 - 1911), the founder of intelligence testing movement ushered in a new era for the identification and training of the mentally retarded. Since then, concerted efforts have been made to improve the quality of life of the mentally handicapped.

After a long period of apathy and neglect, the mentally retarded are becoming a concern for all professional groups in the health and social sciences.

I. The Concept of Mental Retardation.

The concept of mental retardation is made more complex because the varying disciplines that deal with it hold widely divergent viewpoints. The literature on mental retardation suggests strongly that conceptual issues are complex and somewhat unclear (Barnett, 1986; Tarjan, 1989). Professionals often respond to an initial request to define mental retardation by discussing what it is not and describing causes. Clarifying the concept of mental retardation has become increasingly complex as many previously unknown factors are taken into account.

Historical interest in mental retardation predates interest in many other handicapping conditions. Hippocrates and Confucius provided descriptions of mental
retardation that date back to several hundred years B.C. Some believe that mental retardation was implicitly included in the legal codes perhaps as long ago as 2500 B.C. (Scheerenberger, 1983). If people have been paying attention to it for so long, why do confusion and vagueness about the classification and definition still remain.

Many different factors contribute to this lack of precision and definition. Mental retardation always implies a reduced level of intelligence, and the concept of intelligence has played a central role in the definition of mental retardation. Every controversy about the nature of intelligence has a direct impact on the field of mental retardation. Hence, part of the difficulty in defining mental retardation relates to the notion of permanence and measurement of intelligence.

Mental retardation has always been an area of interest and study for many disciplines, a fact that has contributed significantly to the problems of definitional and conceptual clarity. There has never been a legitimate science of mental retardation independent of other disciplines. Psychiatrists, sociologists, psychologists, educators, anthropologists and many others, each with a different perspective and language have all addressed the problem of mental retardation. The many different definitions and classification systems of these disciplines often tend to focus on the constructs of a particular profession rather than on the individual with the problem; sociologists set out to study retardation as a social problem, psychologists examine it as a psychological problem, physicians treat it as a medical problem, and so on. There are even wide variations evident within professional areas such as clinical, developmental and experimental psychology (Koop & Krakow, 1983). The absence of a single core
conceptualisation of mental retardation that is both logically and theoretically sound and still functional has seriously detracted from the preparation of professionals who work with those with mental retardation. Although a high degree of sophistication has been developed in certain technical aspects of programming for children (for example, diagnosis, behavioural control), the lack of an effective generic concept of mental retardation has impeded the overall progress of service delivery to these people. Professional expertise often consists of a great deal of technical skill in certain areas but a limited amount of knowledge about mentally retarded individuals in their total environment. Efforts are now under way to formulate conceptual frameworks that will facilitate more effective professional preparation. Individuals with mental retardation must be viewed as developing human beings with varying needs and characteristics living in a society with fluid and complex performance standards.

II. Definitions

There is a plethora of definitions explaining mental retardation. Definitions and classifications of mental retardation have varied greatly over the years according to the factors receiving attention and the age groups of primary concern.

Early definitions of Mental Retardation varied to some degree with respect to age focus. Tredgold (1937) defined mental retardation in the following manner.

"A state of incomplete mental development of such a kind and degree that the individual is incapable of adapting himself to the normal environment of his fellows in such a way as to maintain existence independent of supervision, control or external
Nearly 20 years later Benda (1954) gave the following definition.

"Mentally defective person is a person who is incapable of managing himself and his affairs, or being taught to do so and who requires supervision, control and care for his own welfare and that of the community."

Wallin (1949) indicated that the mentally retarded individual is "one who on standardized tests fail to attain an I. Q. or M.A. of a particular level."

Bijou (1963) offered a natural science definition for mental retardation. He defined mental retardation in terms of the operant conditioning model: a person who is mentally retarded is one, "who has a limited repertory of behaviour evolving from interactions of the individual with his environmental contacts which constitute his history."

According to Spitz (1963) mental retardation is a condition of retarded mental development as determined by an I.Q. below 70 on a standardized individual intelligence test - a condition which, to the best of our knowledge, has existed from before the age of three.

Corbett (1977) defined mental handicap as 'that condition where intellectual deficit is associated with social, physical or psychiatric handicap, and requires special
The American psychiatric Association's definition stated that "mental retardation refers to subnormal general intellectual functioning that originates during the developmental period and is associated with impairment of learning, social adjustment, or maturation or both."

The most widely accepted current definition of mental retardation is that offered by the "Manual on Terminology and Classification in Mental Retardation," published by the American Association on Mental Deficiency (A.A.M.D).

"Mental Retardation refers to significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behaviour; and manifested during the developmental period."

Of all the definitions, AAMD definition is more satisfying for so many reasons

(1) The diagnosis is based on current functioning.

(2) The definition requires that the person diagnosed as mentally retarded show serious deficits in both intellectual and adaptive functioning.

(3) The definition emphasizes the developmental period. In earlier decades, diagnosis was frequently based on adult functioning, with diagnosticians once again predicting how this or that child would fare as an adult. Today, instead the child's progress is judged normal or delayed by comparing it with norms for his or her
(4) Finally, the AAMD definition says nothing about the cause. Earlier diagnostic criteria often stated that mental retardation was organically based and incurable. Today, therefore diagnosis does not depend on cause or prognosis.

Despite advances, definitions of mental retardation still face philosophical problem that affect research diagnosis and decisions about services (Bau meister ; 1987). It does not seem efficacious to spend time and effort defining mental retardation without asking "what is the purpose of this definition?" The purpose of definition, of course was not completely ignored. Each of the early workers to define mental retardation was progressing in a given area of interest, probably with objectives clearly in mind. These purposes were, however, most likely in line with the definer's effort and not necessarily attentive to the broader problem of mental retardation. We believe that the confusion evident in the historical development of an encompassing definition of mental retardation is characteristic of an effort proceeding without overall purpose or direction. Absence of overall purpose is perhaps most obvious in educational programming. A definition should be useful, or there is little reason to have it. Yet we often find that the definition of mental retardation is of questionable use for educational programming, a facet of services that touches a major proportion of the population diagnosed as having retardation.

III. Classification

The historical evolution of classification schemes for mental retardation has
shown confusion in concept and direction nearly parallel to that of efforts at definition. Perhaps the most serious difficulty with all classification schemes relates to the choice of parameters for classification. This problem has been particularly troublesome in the mental retardation field, partly because of the wide variety of disciplines interested in the phenomenon. The purpose or objective underlying the classification process in different disciplines has generated other difficulties. For example, a given difference in purpose between the school administrators and physicians does not necessarily mean that their classification schemes are mutually exclusive or in conflict. But compatibility and joint focus is rare.

Problems also arise when a system's parameters of classification are unclear or incompletely described. Categorization frequently emphasizes one parameter while simultaneously employing one or two others that seem to be added informally and imprecisely. The difficulty does not arise from using multiple parameters for classification, for mental retardation is a multi-faceted problem.

(a) Parameters of Classification

Parameters of classification are often fluid and in some cases implicit, rather than explicit and well thought out. The literature reveals that a wide variety of parameters has been used in different classification schemes. Parameters represent the bases or basis for classifying a condition or behaviour. Although used with varying frequency, six general parameters seem to persist.

(1) Symptom severity
Figure 1 presents parameters of classification and illustrates how they may converge in a particular case of mental retardation. This conceptualization is a flexible model, different parameters could be used in varying types of parameter intersections depending on the case and the system employed.

Figure 1    Parameters of classification
(a) Symptom Severity

The most common criterion of symptom severity has been measured intelligence. Classification on this basis necessitates grouping individuals by I.Q. and then labeling the groups. Table I summarizes selected symptom severity classifications based on measured I.Q. for comparison purpose.

<table>
<thead>
<tr>
<th>Source</th>
<th>Measured Intelligence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Terman (1916)</td>
<td>Borderline — IQ 70 to 79</td>
</tr>
<tr>
<td>Wechsler (1958)</td>
<td>Borderline — IQ 70 to 79</td>
</tr>
<tr>
<td>American Association on Mental Deficiency (1961)</td>
<td>Borderline intelligence — 1 S.D., IQ 68 to 83</td>
</tr>
<tr>
<td>American Association on Mental Deficiency (1973, 1977, 1983)</td>
<td></td>
</tr>
<tr>
<td>American Psychiatric Association (1987)</td>
<td>Mildly mentally retarded — IQ 50 to 70</td>
</tr>
</tbody>
</table>

*IQ ranges from Stanford-Binet standard deviations (S.D.).
*The 1983 AAMA classifications placed a narrow band of IQ scores at each end of each level but are essentially the same as those in the table.
Symptom etiology the second general parameter, has primarily involved the biomedical aspects of mental retardation. It is most often viewed in a medical context and has often been called the medical classification. Three major systems have been instrumental in constructing the current view of etiological classification in Mental Retardation: the World Health Organizations' (W.H.O). International classification of Diseases (ICD-9, 1978), the American Psychiatric Associations revised third edition of the Diagnostic and statistical Manual DSM (III R ; 1987) and the AAMR Manual classification in Mental Retardation (Grossman ; 1983). Although not identical the three systems are compatible with respect to etiology of classification. The AAMR includes the following 10 categories in its etiological classification.

1. Following infection and intoxication (e.g ; congenital rubella, syphilis).
2. Following trauma or physical agent (e.g ; mechanical injury at birth)
3. With disorders of metabolism or nutrition (e.g ; phenyl ketonuria (P.K.U)
galactosemia)
4. Associated with gross brain disease, post natal (e.g ; nurolibro matics, intracranial neoplasm)
5. Associated with diseases and conditions resulting from unknown pre-natal influence (e.g. hydrocephalus, microcephaly)
6. Associated with chromosomal abnormality
7. Associated with other perinatal (gestational) conditions (e.g ; prematurity)
8. Following psychiatric disorder (e.g ; autism)
9. Associated with environmental influences (e.g.; cultural, familial retardation)

10. Associated with other conditions

(c) Syndrome Description

Another approach to classification involves the description of syndromes by symptom grouping, like etiology, the syndrome description scheme is largely the province of medical workers. Observation of a pattern of both physical and behavioural characteristics usually results in identification of a syndrome, although physical descriptions have predominated.

The syndromes (for example, Down syndrome or mongolism, microcephaly and hydrocephaly) are the stereotypes of mental retardation often held by people not working in the field. Many people think of Down Syndrome when mental retardation is mentioned in a lay context. This may be because the defining characteristics for syndromes are often visible or because the Syndrome approach to classification has a long history. Syndrome names usually include either the name of the pioneering worker discovering the syndrome or the technical clinical terminology involved in diagnosis (for example, neurofibromatosis). Carter’s (1978, 1979) volumes on medical aspects of mental retardation and the syndrome atlas by Gellis and Feingold (1968) contain detailed treatments of particular syndromes.

(d) Adaptive Behaviour.

Adaptive behaviour and concepts related to it have been involved in definition and classification for most of the history of effort in mental retardation. Only for the
past 35 years, however, have conceptualizations progressed far enough for adaptive behaviour to be viewed by many as a parameter of classification, and even today there are a number of difficulties in using adaptive behaviour to categorize individuals.

Much of the impetus for the current view of adaptive behaviour came from the work of Sloan and Birch (1955). Their material was adapted for the AAMR Manual on Terminology and Classification in 1961 (Heber, 1961). Later revisions of this manual (Grossman, 1973, 1977, 1983) developed it further. One of the important factors in adaptive behaviour as a classification parameter is that it attends to human development. Table - 2 summarizes the illustrations of adaptive behaviour levels by ages presented in Grossman (1983).
<table>
<thead>
<tr>
<th>Age and level indicator</th>
<th>Illustrations of highest level of adaptive behaviour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 3 and above: Profound</td>
<td><strong>Independent functioning</strong>: Drinks from a cup with help; &quot;cooperates&quot; by opening mouth for feeding. <strong>Physical</strong>: Sits unsupported or pulls self upright momentarily, reaches for objects, has good thumb-finger grasp, manipulates objects (plays with shoes or toy). <strong>Communication</strong>: Imitates sounds, laughs or smiles back (says &quot;Da-da,&quot; &quot;Bu-bu-bu&quot; responsively, no effective speech; may communicate in sounds, gestures, or signs. <strong>Social</strong>: Indicates knowing familiar persons and interacts non-verbally with them.</td>
</tr>
<tr>
<td>Age 3 years: Severe</td>
<td><strong>Independent functioning</strong>: Attempts finger feeding; &quot;cooperates&quot; with dressing, bathing, and toilet training; may remove clothing (socks) but not as an act of undressing as for bath or bed. <strong>Physical</strong>: Stands alone or may walk unsteadily or with help; coordinates eye-hand movements. <strong>Communication</strong>: One or two words (Mama, ball), but predominantly vocalization. <strong>Social</strong>: May respond to others in predictable fashion; communicates needs by gestures and noises or pointing; plays &quot;patty-cake&quot;; plays imitatively with little interaction; occupies self alone with &quot;toys for a few minutes&quot;.</td>
</tr>
<tr>
<td>Age 6 years and above: Profound</td>
<td><strong>Independent functioning</strong>: Tries to feed self with a spoon with considerable spilling; removes socks, pants; &quot;cooperates&quot; in bathing, may indicate wet pants, &quot;cooperates&quot; at toilet. <strong>Physical</strong>: Walks alone steadily, can pass ball or objects to others; may run and climb steps with help. <strong>Communication</strong>: May use four to six words; may communicate many needs with gestures (pointing). <strong>Social</strong>: Plays with others for short periods, often as parallel play or under direction; recognizes others and may show preference for some persons over others.</td>
</tr>
</tbody>
</table>

(Note: All behaviours at greater degree of impairment would also indicate profound deficit in adaptive behaviour for persons 3 years of age or above.)
<table>
<thead>
<tr>
<th>Age and level indicator</th>
<th>Illustrations of highest level of adaptive behaviour</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 years: mild</td>
<td>Independent functioning: Feeds self with spoon (cereals, soft foods) with considerable spilling or messiness; drinks unassisted; can pull off clothing and put on some (socks, under-clothes, boxer pants, dress); tries to help with bath or hand washing but still needs considerable help; indicates toilet accident and may indicate toilet need.</td>
</tr>
<tr>
<td>6 years: moderate</td>
<td>Physical: May climb up and down stairs but not alternating feet; may run and jump; may balance briefly on one foot; can pass a ball to others; transfers objects; may do simple form-board puzzles without aid.</td>
</tr>
<tr>
<td>9 years: severe</td>
<td>Communication: May speak in two or three word sentences (Daddy go work); names simple common objects (boy, car, ice cream, hat); understands simple directions (put the shoe on your foot, sit here, get your coat); knows people by name. If nonverbal, may use many gestures to convey needs or other information.</td>
</tr>
<tr>
<td>12 years and above: profound</td>
<td>Social: May interact with others in simple play activities, usually with only one or two others unless guided into group activity; has preference for some persons over others.</td>
</tr>
<tr>
<td>6 years: mild</td>
<td>Independent functioning: Feeds self with spoon or fork, may spill some; puts on clothing but needs help with small buttons and jacket zippers; tries to bathe self but needs help; can wash and dry hands but not very efficiently; partially toilet trained but may have accidents.</td>
</tr>
<tr>
<td>9 years: moderate</td>
<td>Physical: May hop or skip; may climb steps with alternating feet; rides tricycle (or bicycle over 8 years); may climb trees or jungle gym; play dance games, may throw ball and hit target.</td>
</tr>
<tr>
<td>12 years and above: severe</td>
<td>Communication: May have speaking vocabulary of over 300 words and use grammatically correct sentences. If nonverbal, may use many gestures to communicate needs. Understands simple verbal communications including directions and questions (&quot;Put it on the shelf,&quot; &quot;Where do you live?&quot;) (Speech may be indistinct sometimes); may recognize advertising words and signs (ice cream, stop, exit, men, ladies); relates experiences in simple language.</td>
</tr>
<tr>
<td>15 years and above: profound</td>
<td>Social: Participates in group activities and simple group games; interacts with others in simple play (&quot;store,&quot; &quot;house&quot;) and expressive activities (art and dance).</td>
</tr>
</tbody>
</table>
Table 2 Continued

Illustrations of highest level of adaptive behavior

9 years: mild
12 years: moderate
15 years and older: severe

Independent functioning: Feeds self adequately with spoon and fork; can butter bread; needs help with cutting meat; can put on clothes and can button and zipper clothes; may tie shoes; bakes self with supervision; is toilet trained; washes face and hands without help

Physical: Can run, skip, hop, dance, uses skates, sled, and jump rope; can go up and down stairs alternating feet; can throw ball to hit target

Communication: May communicate in complex sentences; speech is generally clear and distinct; understands complex verbal communication, including words such as "because" and "but". Recognizes signs, and words, but does not read prose material with comprehension.

Social: May participate in group activities spontaneously; may engage in simple competitive exercise games (dodge ball, tag, races). May have friendship choices that are maintained over weeks or months.

Economic activity: May be sent on simple errands and make simple purchase with notes; realizes money has value but does not know how to use it (except for coin machines)

Occupation: May prepare simple foods (sandwiches); can help with simple household tasks (bed making, sweeping, vacuuming); can set and clear table

Self-direction: May ask if there is "work" for him to do; may pay attention to task for 10 minutes or more; makes efforts to be dependable and carry out responsibility.

Independent Functioning: Feeds, bathes, dresses self; may select daily clothing; may prepare easy foods (sandwiches) for self or others; combs and brushes hair; may shampoo and curl hair; may wash, iron, and store own clothes.

Physical: Good body control; good gross and fine motor coordination

Communication: May carry on simple conversation; uses complex sentences. Recognizes words, may read sentences, adds signs and simple prose material with some comprehension.

Social: May interact cooperatively and competitively with others.

Economic Activity: May be sent on shopping errands for several items without notes; makes minor purchases; adds coins to dollar with fair accuracy

Occupation: May do simple routine household chores (dusting, garbage removal, dishwashing; preparing simple foods that require mixing)

Self-direction: May initiate most of own activities; attends to task 15 to 20 minutes (or more); may be conscientious in assuming much responsibility.

12 years: mild
15 years and over: moderate
Age and level indicator

Adaptive behaviour

15 years and adult: mild (NOTE: Individuals who routinely perform at higher levels of competence in adaptive behaviour than illustrated in this pattern should not be considered as deficient in adaptive behaviour. Since by definition an individual is not retarded unless he shows significant deficit in both measured intelligence and in adaptive behaviour, those individuals who function at higher levels than illustrated here cannot be considered to be retarded.)

Illustrations of highest level of independent functioning: Exercises care for personal grooming, feeding, bathing, toilet; may need health or personal care reminders; may need help in selection and purchase of clothing.

Physical: Good about home town (local neighbourhood in city, campus at institution) with ease, but cannot go to other towns alone without aid; can use bicycle, skis, ice skates, trampoline, or other equipment requiring good coordination.

Communication: Communicate complex verbal concepts and understands them; carries on everyday conversation, but cannot discuss abstract or philosophical concepts; uses telephone and communicates in writing for simple letter writing or orders but does not write about abstractions or important current events.

Social: Interacts cooperatively or competitively with others and initiates some group activities, primarily for social or recreational group or church group, but not in civic organizations or groups of skilled persons (photography club, golf, books club, or kennel club); enjoys recreation (bowling, dancing, TV, checkers, but either does not enjoy or is not competent at such activities as tennis, sailing, bridge, piano playing, or other hobbies requiring rapid, involved, or complex planning and implementation).

Economic activity: Can be sent or can go to several shops to make purchases of several items without a note to shopkeepers; can make change correctly, but does not use banking facilities; may earn living but has difficulty handling money without guidance.

Occupation: Can cook simple foods, prepare simple meals, and perform everyday household tasks (cleaning, dusting, dishes, laundry); as adult can engage in semiskilled or simple skilled job.

Self-direction: Initiates most of own activity; will pay attention to task for at least 15 to 20 minutes; conscientious about work and assumes such responsibility but needs guidance for tasks with responsibility for major tasks (health care, care of others, complicated occupational activity).
(c) Educability Expectations

Educability expectations have been viewed as a parameter of classification in the field of education for many years. This approach to classification is also known as the educational classification. Preference for including the term expectation is based on the form of this parameter, which is a statement or prediction of expected achievement. Generally there are three categories - educable, trainable and custodial or severely multiply handicapped (S.M.H.) - although some professionals have included a fourth classification known as dull normal, which ranges just above educable in terms of measured I.Q. (approximately 75 or 80 to 90). Measured I.Q. ranges associated with the other categories include 50 - 75 or 80 for educable, 20 - 49 for trainable and below 20 for S.M.H or custodial.

(1) Behavioural Manifestations

The final classification parameter mentioned was termed as Behavioural Manifestations. This approach has been very popular in a number of areas of psychology as well as in several educational applications. It derives from applied behaviour analysis and evaluation on individual based on observation of task performance. The behavioural description perspective differs conceptually from previously discussed classification schemes because it is not primarily concerned with grouping but focuses on the skills a person has or does not have (more precisely, to what degree a task can be performed).
IV. Incidence and Prevalance

It is important to distinguish between incidence and prevalence and to consider other factors, such as Socio Economic Status, Severity and age, when determining how frequently mental retardation occurs. The difference between incidence rate and prevalence rate in defined populations is between the new cases in a given time period and the number of cases existing at a specified time (Alberman, 1984)

The calculation of the incidence rate of mental retardation varies in terms of etiological factors and also with the degree of mental retardation. (Carfield and Wilson (1960) were opposed to the criteria of the standard deviation cut off point (I.Q. below 84) for defining mental retardation (AAMID Manual, Heber 1961). They pointed out psychometrically defined intellectual level as between 68 and 83 I.Q. would include almost four times the number of mentally retarded as all other levels combined.

The prevalence of mental retardation also varies a great deal as a function of age. Chinn et al (1975) pointed out “Research has consistently indicated the highest incidence of retardation occurs during the years of formal schooling, with rather dramatically reduced numbers being identified both at the pre-school and post-school levels.

Another factor influencing the estimates of mental retardation is the environment, whether it is complex or relatively uncomplicated. Although technological advancements have percolated to the rural areas and the environment is
more complex than what it was in 1890, yet it is less complex as compared to large metropolitan cities. In view of strictures, rules and congestion which are characteristic of large cities, a person who is deficient in coping skills would be more readily identified as mentally retarded. In contrast, the lack of academic skills such as reading would be less disastrous in rural areas where the rigours of daily living are less intellectually oriented. The more uncomplicated the society, the greater is the likelihood of acceptance and tolerance of aberrant conditions.

The mentally retarded will always be with us, it is even probable that the total number of such children will increase with the passage of time. However, medical advances, genetic counselling, improved nutrition, education regarding preventable retardation and early intervention can save those who would have died, say 50 or 100 years ago. Research has clearly indicated that biomedical prevention is likely to have a significant impact on the incidence of handicapping conditions (Richardson and Koller, 1985). However, other undesirable forces could increase the number of retarded persons. For example, population explosion, atmospheric mediation levels, increase in alcoholism and substance abuses, increase in syphilis, natural or man made calamities, disasters such as Bhopal gas tragedy of 1984, and Chernobyl disaster in Russia could increase the number of mentally retarded.

Though no national survey on the prevalence of mental retardation has been conducted in India it is clear that socio-cultural deprivation, casteism, prejudice and discrimination, poverty, poor nutrition, inadequate health services, inferior education and unemployment is one of the major causes of mild mental retardation.
Mental Retardation cuts across all socio-economic classes and geographical boundaries as revealed by the WHO report of 1968: all over the world between 1 to 3 percent are mentally retarded (WHO, 1968). According to the WHO estimate, the retarded population in India would be anywhere between 18 and 20 million with an annual increase of 40 lakh retardates (Sen and Sen, 1984). This means that 1 out of every 10 individuals in India is likely to be mentally retarded.

V. Family

In its diverse forms and complex dimensions, mental retardation is probably first and most importantly a family problem. The family is the oldest and most enduring of all human institutions. It has survived empires, wars, famine, plague, depression, recession and the constant change of social values. The family is based on both emotional and hereditary bond between parents and children. The primary family unit consists of parents and their children and their extended unit includes grandparents and more distant relatives. Family system exists for various reasons, including the need for security, belonging and love. The family provides a socially acceptable vehicle for bringing children into the world. Many individuals seem children as an extension of themselves: others perceive their children as a means to attain some degree of immortality.

The birth of a mentally handicapped child definitely is a problem for the family. To some families it is a tragedy of utmost magnitude, and its effects are disillusionment, despair and disruption. To other families, it is a crisis, more serious
than most but capable of resolution in time and without harmful self-sacrifice. To still others, it is not a problem in itself, but it is merely one element among many in the daily struggle for social survival.

(a). Parental Reactions

Research evidence supports the common sense conclusion that a mentally retarded child typically increases family stress. Parental reactions usually reflect reactions to frustrations, stress and crisis. These reactions may include shame, guilt, ambivalence, depression, sorrow, defensiveness, self-sacrifice, denial, reaction formation and mourning. Such reactions are understandable in the view of what having a retarded child is likely to mean to most parents. These emotional patterns become pathological only when they become chronic and unusually intense.

Denial is a common parental reaction, especially during the intial stage of adjustment. Denial provides self-protection against painful realities. Parents may minimize the degree of disability or simply deny that any problem exists. They close their minds to their child's limitations or explain their child's limitations by implying laziness, indifference or lack of motivation. Denial can be both useless and destructive. It is useless because refusal to accept the reality of a child's disability cannot make the problems disappear. It is destructive because it impedes the child's own acceptance of limitations and many prevent necessary education and therapy.

Another common parental reaction is projection of blame. Parents may project blame for the child with mental retardation on the people they believe are responsible
for their suffering. Targets are individuals, frequently physicians, whom parents associate with considerable frustration and agony.

When parents of children with mental retardations are unable to blame someone else, they may blame themselves. They begin to look for and often find something in their lives or their behaviour that may be responsible for why this happened. When they look hard enough, a seemingly logical reason appears, and they feel guilt. Guilt is insidious and debilitating. Assuming blame does not eliminate the disability and intense feelings of guilt can erode parents’ positive self-concept.

The unknown can make every person anxious at one time or another. Anxiety in turn may generate fear. Parents of children who are mentally retarded face so many unknown fears. Fear is a natural and common reaction. Common fears of parents are associated with having other children, loss of friends and impacts on the family unit.

When parents begin to realize what has happened, they may react with grief or mourning. Grief is a natural reaction to situation that bring extreme pain and disappointment. Some parents may choose to isolate themselves because of their feelings of shame and guilt. Some parents may show rejection through strong under expectations of achievement, unrealistic goals, escape and reaction formation.

Not all the feelings and defenses outlined here are experienced by all parents nor are they characterized by the same intensity or duration. For the most part, these reactions are not pathologic, but are normal response to intense ego - frustrating
experiences. In time, many parents are able to acknowledge maturely their child's condition and to adjust satisfactorily. Much depends on their ability to compromise on limited goals, on their emotional and spiritual reserves, and on the help that they get from professional and community resources.

B. Family Environments

A majority of the families have to rely on their own resources to manage their retarded children. In some households the condition may be so appalling that they would be unsatisfactory even for children with normal intelligence. The handicap of the child in such families may therefore be incidental. For instance, all the members of a family may have to share a single room and there may not be any space for a child to play. To have a backward, restless child in such a household may be trying both for the child and for the family. In some cases it is very difficult to isolate the effects of having a retarded child from the cause of backwardness. If the family is well-knit, relations between parents are good, parents are mentally and physically healthy, the physical surroundings are not too harsh, the mother is able to divide her attention and affection between the handicapped child as well as other children in the family, she neither over protects nor rejects the retarded child, she is realistic and ready to accept whatever services are available, the father and other children in the family support the mother in her efforts and accept the retarded child, then the retarded child will neither be resented nor perceives as a burden. Unfortunately, these characteristics are not seen too often in families and in most cases the handicapped child does impose a considerable burden material, financial and emotional - subjecting the family to a stringent test.
The retarded child who has been noticeably different since infancy or early childhood, may arouse such feelings and attitudes in parents and siblings which can adversely affect his personality development. Certain kinds of psychological experiences are essential for healthy personal development. There is a high probability that the mentally handicapped child is not exposed to such experiences. The psychological experience or need for self-esteem is the product of three sub-needs of intimacy, success and autonomy.

The quality of relatedness of the mentally handicapped child to other persons is a function of both the degree of retardation and the extent of acceptance by parents and siblings. Retardation makes the child appear immature, at any given age, the retarded child's overall level of functioning will be far below than that of his/her age group. The immaturity which is built into retardation affects the child's ability to relate to others. Without the assistance of adults the child's immaturity is likely to lead to his/her social isolation by other children and foster dependency on the parents long after other children have begun to develop meaningful, peer relationship.

Family acceptance also affects the quality of the child's interpersonal relationships. The child's early affectional experience with parents and siblings shape his/her attitude towards himself/herself (self concept) and others which determine his/her general responsiveness to people and to task situations. Where the parent or family-child interaction is positive and the child feels wanted and loved, a sense of trust and confidence develops which fosters an attitude of openness and approach to new people and experiences.
Another important determinant of the child's attitude towards himself/herself and towards others, is the degree of success in coping with developmental tasks. Though the behaviour that emerges from the need to feel a sense of adequacy may be more apparent in older children and adults than in younger children, such behaviour is likely to be rooted in the experiences of the child during the formative years. Retarded children anticipate problems rather than success in coping with new tasks. The child's disability makes coping difficulties inevitable. Except when the degree of retardation is severe, the mental handicap, however, does not prevent the child from being aware of his/her limitations. If the child is not aware of his/her limitations during the pre-school years, he/she becomes aware on entering school because in school the retarded child's learning difficulties becomes conspicuous.

It is very easy to make sweeping generalization about the family of a handicapped child. For example, we often hear people say "behind every handicapped child lies a handicapped family". It is also easy for professionals to make assumptions and to develop stereo-typed views from their own limited experience. Assumptions may be made, for example, about high levels of marriage break down, or the high incidence of psychiatric breakdown in the mother of mentally handicapped children, or the high degree of stress placed on the siblings. Such generalizations need constantly to be confronted and examined.

We need to remind ourselves that families of mentally handicapped children probably vary as much in their behaviour, social attitudes and family relationships as families who do not have handicapped children. Having a handicapped child will...
bring added responsibilities and may increase the likelihood of marital tension and family discord, but the seeds of tension and discord may have been present long before the birth of the handicapped child. Indeed, for some families having a handicapped child may be the least of their problems.

There is now a substantial research literature on the family with a handicapped child (Murphy, 1982). Many of the studies carried out in the past were concerned with parental personalities and attitudes. Until recently, relatively little research focussed on stress within the family unit. Because the relationship between a mentally handicapped child and his or her family is reciprocal, it is important to study those relationships within the context of the intact family. The family may have a potent effect on the child's development and the child may in turn, have an impact on the well being of the family and of the family members. The social behaviour of parents and siblings may stimulate and nourish the intellectual growth and social development of the handicapped child or the social discord within the family may be so great that the handicapped child suffers continuing psychological damage as part of the experience of growing up within the family.

Each family carries with it a diversity of experience of feelings and of hope for future which needs to be explored before any judgement can be made about the impact of the handicapped child on that family. In order to give the present day facilities a chance to be effective, the underlying problems of the family must come to light.
Objectives of the study

The objectives of the study are (a) to compare the families of retarded children in family burden, problems of care giver, family climate and child rearing practices, (b) to compare the families with children of different levels of retardation in family burden, problems of care giver, family climate and child rearing practices, (c) to determine if statistically significant differences exist between the average score profiles of the families with children of different levels of retardation, (d) To determine which of the independent variables account most for the differences in the average score profiles of the families with children of different levels of retardation.
REVIEW OF RELATED STUDIES