CHAPTER-II

Review of Literature

The review of literature is presented under the following sub heads.

2.1 Mental Retardation-Concepts and meaning
2.2 Classifications of Mental Retardation
2.3 Associated Conditions
2.4 Characteristics of Persons with Mental Retardation
2.5 Causes of Mental Retardation
2.6 International Policies and Programmes for Persons With Mental Retardation
2.7 National Policies and Programmes for Persons With Mental Retardation
2.8 Legislations for Persons With Mental Retardation
2.9 Related Research Studies

2.1. Mental Retardation- Concepts and Meaning

For the present study the concepts and meaning of mental retardation is viewed as follows.

Mental Deficiency, Mental Subnormality and Mental Retardation are synonymous terms used by different authors and reputed organizations to denote children with mental handicaps or disabilities. Mental Deficiency is the term used by British professionals like Tredgold (1937) and American
Psychiatric Association. “Mental Subnormality” is the term adopted by World Health Organisation (WHO) and ‘Mental Retardation’ by American Association on Mental Retardation (1992).

“Mental Deficiency” according to Tredgold (1937), is a state of incomplete mental development of such a kind and degree that the individual is incapable of adopting himself to the normal environment of his fellows in such a way as to maintain an existence independently of supervision, control or external support.

Mental Subnormality the term recommended by WHO (1981) denotes “incomplete or insufficient general development of mental capacities”.

Heber (1961) defined Mental Retardation as the subaverage general intellectual functioning which originates during the developmental period and is associated with impairment in adaptive behaviour”.

‘Mental Retardation’ refers to significantly subaverage general intellectual functioning resulting in or associated with concurrent impairments in adaptive behaviour and manifested during the developmental period (Grossman, 1983).

‘Significantly subaverage’ refers to two standard deviations below the mean obtained from standard intelligence tests.

‘The degree with which the individual meets the standards of personal independence and social responsibility expected of one’s age and cultural group referred to as adaptive behaviour.'
‘Developmental Period’ is the period of time between conception and
the eighteenth birthday of the person.

According to the Persons With Disabilities (Equal Opportunities,
Protection of Rights And Full Participation) Act, 1995, "mental retardation"
means a condition of arrested or incomplete development of mind of a person
which is specially characterized by sub normality of intelligence.

The American Association on Mental Retardation (2002) defines
mental retardation as a disability characterized by significant limitations both
in intellectual functioning and in adaptive behaviour as expressed in
conceptual, social, and practical adaptive skills. The disability originates
before 18 years of age.

Five assumptions essential to the application of the definition are:

• Limitations in present functioning must be considered within the context
  of community environment.

• Valid assessment considers cultural and linguistic diversity as well as
differences in communication, sensory, motor and behavioral factors.

• Within an individual, sensory, motor and behavioural factors.

• An important purpose of describing limitations is to develop a profile of
  needed supports.

• With appropriate personalized supports over a sustained period, the life
  functioning of the person with mental retardation generally will
  improve.
In India majority of the service providers consider this definition is holistic and clear and depicts the traits of a Person with Mental Retardation.

American Association on Intellectual and Developmental Disabilities (AAIDD), formerly known as American Association on Mental Retardation (AAMR) have recently changed the term Mental Retardation into Intellectual and Developmental Disabilities to address the people with cognitive disabilities (Prabhala, 2007).

2.2. Classification

Psychological classification: Mental retardation has been categorized as mild, moderate, severe and profound by employing medical, psychological, and behavioural systems. The classification recommended by various experts has been presented in Table No. 2.01.

Table 2.01
Classification of Mental Retardation

<table>
<thead>
<tr>
<th>Category</th>
<th>Binet</th>
<th>Weshler</th>
<th>DSM-IV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild</td>
<td>52-67</td>
<td>55-69</td>
<td>50-55 to 70</td>
</tr>
<tr>
<td>Moderate</td>
<td>36-51</td>
<td>40-54</td>
<td>35-40 to 50-55</td>
</tr>
<tr>
<td>Severe</td>
<td>20-35</td>
<td>25-39</td>
<td>20-25 to 35-40</td>
</tr>
<tr>
<td>Profound</td>
<td>0-19</td>
<td>0-24</td>
<td>20 or 25</td>
</tr>
</tbody>
</table>


Mild mental retardation: The IQ of individuals in this category ranges from 50-75. About 89 percent of the persons with mental retardation belong to this
category (Jeyachandran and Vimala, 2004). Persons in this group are considered educable. Their intellectual ability and efficiency remain below that of normal children. They show no organic pathology and require little supervision. With parental assistance and special training, they can be trained to be self supportive, adjust socially and gain ability to do any work independently during the adolescent period.

Moderate **mental retardation**: The IQ of these children ranges between 35 and 55. About seven percent of the persons with mental retardation are found to belong to this category (Jeyachandran and Vimala 2004). They are considered trainable. Their retardation becomes visible during their schooling. Though some of them need special attention, they can manage to live safely under the protection of their family members. With parental help and adequate opportunities for training, they can manage to earn their own livelihood.

**Severe mental retardation**: Persons with severe retardation represent around three percent of the total persons with mental retardation (Jeyachandran and Vimala, 2004). Motor and language development occurs very late in their infancy and childhood. They are referred to as ‘dependants’ and are subjected to suffer from motor and sensory defects. Under supervision they can learn to perform simple tasks (Kar, 2004).

**Profound mental retardation**: This group represents one percent of the mentally retarded. Their IQ level has been reported to be ranging from 20 -25 to 35-40 (APA, 1994). They are severely deficient in adaptive behaviour and are unable to do simple tasks and fulfill their basic
physical needs. Major deformities of brain and body are often observed with these individuals and great percent of the profoundly retarded die at a very early age. They require constant supervision throughout their life.

**Educational classification**

Table 2.02

<table>
<thead>
<tr>
<th>S.No</th>
<th>Levels of education</th>
<th>Chronological age (in years)</th>
<th>Mental Age (in years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Pre primary (A) Level</td>
<td>3-6</td>
<td>Up to 3</td>
</tr>
<tr>
<td>II</td>
<td>Pre primary (B) Level</td>
<td>over 6</td>
<td>Around 4 1/2</td>
</tr>
<tr>
<td>III</td>
<td>Primary Level</td>
<td>7-10</td>
<td>5-7&quot;</td>
</tr>
<tr>
<td>IV</td>
<td>Secondary Level</td>
<td>10-13</td>
<td>7-9</td>
</tr>
<tr>
<td>V</td>
<td>Pre-Vocational Level</td>
<td>14-16</td>
<td>8 + years</td>
</tr>
</tbody>
</table>

The educational classification of children with mental retardation given by Narayan and Thressiakutty (1989) is given in table 2.02. The mental age of the children with mental retardation lagged behind their chronological age, thus denoting their learning disability.

2.3. **Associated conditions of mental retardation**

The commonest medical illness accompanying mental retardation is **Epilepsy** (Khers et al, 1998). Epilepsy can directly leave an impact on a person’s cognitive ability, life expectancy and physical health. The prevalence of epilepsy among the children with mental retardation ranges from 10 to 44
per cent (Bowley and Ker 2000, Kundu 2000 and Morgan et al 2003). Batshaw, (1993) is of the view that approximately 20 percent of children with severe retardation have cerebral palsy. Seizure disorders develop in about 20 percent of children with severe retardation. Psychiatric and behavior disorders occur in half of this population. Epidemiological studies indicate that a high rate of mental retardation will have a common cause such as metabolic disorder or brain trauma (Besag, 2001).

Sensory impairments are more prevalent in persons with mental retardation. Nearly four percent of all children with mental retardation have multiple handicaps (Kundu, 2000). Kelleher and Mulcahy (1986) reported from their study that among a total of 23,000 persons with mental retardation three in ten had an additional physical disability, and one in twelve had a combination of two disabilities.

It can be concluded that epilepsy is the most common associated disability with mental retardation followed by sensory impairments and multiple disability. Associated conditions add to the severity and burden of mental retardation and vice-versa.

2.4. Characteristics of Persons with Mental Retardation

Persons with mental retardation, in the opinion of Bhargava (1994) are, either stable and apathetic or unstable or excitable. They differ from their non-disabled peers in their physical, cognitive, communicative, academic and social characteristics.
Most of the persons with mental retardation exhibit differences in appearance, from that of their non-disabled peers. Burack et al (1988) point out that the persons with mental retardation experience problems in motor skill development, body image and action and language skills.

The persons with mental retardation according to Burack et al (1988) are characterized by limited cognitive functioning. They exhibit poor general conceptualization, perception, discrimination and comprehensive skills. They experience qualitative deficits in memory, attention, problem solving, and logical thought and are unable to understand abstract concepts. They lack in concentration, response, coordination and expressing needs and feelings. They exhibit inability in decision making and face difficulty to switch over from one activity to another. Those with mental retardation may demonstrate delayed comprehension and communication. Severely retarded children have difficulty in expressive and receptive language. Children’s low level of receptive language limits their expressive abilities (Cric and Dodge, 1994).

The children with mental retardation perform poorly in most of the academic areas. They have inadequate acquisition and application of basic academic skills in daily life, application of appropriate reasoning and judgment (Jeyachandran and Vimala, 2004) and are incapable of adequate self-care, self-support or self-management in society (Kar, 2004). They often occupy a marginal position in social network (Sabomie and Kauffman, 1987) due to inappropriate social behaviour (Cric and Dodge, 1994).
Thus the children with mental retardation differ from the non-disabled children in their cognitive, communicative, academic and social characteristics. These traits are inter-related and they limit their functioning capability in daily life.

2.5. Etiological factors of mental retardation

The causes of mental retardation are multiple, complex and diverse and deeply embedded in disadvantaged social, economic and family living conditions (Clarke et al 1978). The causes observed were in conformity with the studies presented. Ratnayake, (1998) has reported in his study consanguinity and birth asphyxia as the commonest causes of mental retardation, while Prasad et al (1995) have highlighted the non-genetic causes as most common among children with mental retardation. Various factors causing mental retardation can be broadly classified under Pre, Peri and Postnatal stages.

Prenatal stage: The prenatal causes according to Prasad et al (1995) constitute nearly twice that of birth and neonatal causes. These causes include prematurity, Intra Uterine Growth Retardation (IUGR) such as congenital anomalies, Meconium aspiration and the like.

Chromosomal disorders: Turner’s syndrome, Klinefelter’s Syndrome, Fragile X Syndrome, Rett Syndrome and Down Syndrome were chromosomal disorders. The study conducted by Rajangam et al, (2004) reports that the suspected percentage of chromosomal disorders were 34 percent.
**Genetic Disorder:** Genetic disorders are estimated to account for more than half of severe mental retardation in developed countries. Mathew, (2002) has estimated the percentage of defective gene cause of mental retardation as 12 percent. The affected persons may acquire certain conditions with mental retardation like Phenylketonuria, Galactosaemia, Hurler’ Disease, Tay - Sachs Disease, Microcephalus and Tuberous Sclerosis.

**Infections:** Certain infections of the mother like German measles, Syphilis, Cytomegalovirus and Toxoplasmosis may damage the foetus. Certain drugs can act as teratogenic agents when given during pregnancy.

Maternal disease such as diabetes mellitus, high blood pressure, chronic problems in the kidneys, malnutrition in the mother, deficiency of iodine develops mental retardation in infants. Exposure to X-rays during early pregnancy, using harmful drugs, heavy alcohol consumption by pregnant women results in low birth weights of infants with facial anomalies, poor brain growth and mental deficiencies ((Reddy and Sujathamalini, 2004 and Clarren and Smith, 1978).

**Perinatal Stage:** Premature birth may lead to mental retardation. Low birth weight babies, prolonged labour or birth difficulty, instrumental delivery, twist or excessive coiling in umbilical cord, etc, will give rise to anoxia (lack of oxygen), abnormal position of the foetus, hemorrhage or bleeding in the brain of the new born can develop mental retardation.

**Postnatal stage:** Malnutrition in the child during first two years, infections such as meningitis or encephalitis (brain fever), repeated epileptic convulsions,
any injury to the brain from accidents or falls, lead poisoning can also cause mental retardation.

2.6. International Policies and programmes for the children with mental retardation

There have been a number of encouraging pronouncements on the international platform for the education of children with disabilities as a matter of human rights and social justice. These pronouncements helped the service providers to imitate an array of services for persons with mental retardation including CBR services. They are,

**International Year for Disabled Persons-IYDP- (1981)** The United Nations declared 1981 as the International Year of Disabled Persons. ‘Full participation with Equality’ was the underlying theme of this program. India’s response to the UN’s declaration was the development of a National Plan of Action (NPA) to provide comprehensive services for persons with disabilities.

**UN Convention on the Rights of the Child (1989)** The 1989 UN Convention on the Rights of the Child has been ratified by 177 countries worldwide. The Convention includes statement such as: *all rights shall apply to all children, without discrimination on any ground including disability. In all actions the child’s best interests shall be a primary consideration and they should develop to *the maximum extent possible* Article 23 of the convention states that, the child’s education shall lead to the fullest possible social integration and individual development. It also states the right of the disabled child to special care, education, health care, training, rehabilitation, employment preparation

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and recreation opportunities. Article 29 states that, Education should prepare a child to become an ‘active and responsible’ adult.

Asian and Pacific Decade of Disabled Persons (1992) The Economic and Social Commission for Asia Pacific (ESCAP), at its forty-eighth session held in Beijing, declared 1993-2002 as the Asian and Pacific Decade for Disabled Persons. The commission, while evaluating the situation of people with disabilities, in member countries, state that, “the opportunities for full participation and equality of people with disabilities, especially in the fields of rehabilitation, education and employment, continue to be far less than those for their non-disabled peers”

The ESCAP committee strongly urged member nations, when formulating their national policies and legislation, to promote the greater integration of children and adults with disabilities in their formal and nonformal educational programmes. India, along with other signatories of the Commission, pledged to implement the conference’s agenda on ‘Full Participation and Equality of People with Disabilities’. The most significant action by the government of India, following its attendance at the ESCAP meeting, was the formalization of efforts to develop legislation based on the Commission’s guidelines.

support for the development of inclusive education for disabled pupil world wide. In order to implement inclusive education, countries should have a ‘clearly stated policy’ that is understood at a school level and in the wider community. Rule 6 covering education, says that states should ensure that the education of disabled people is an integral part of the education system and it calls for buildings to be accessible and other support services, parents and organizations of disabled people to be involved in the education process, a flexible curriculum plus additions and adaptations for disabled pupils, and ongoing teacher training. Where ordinary schools cannot yet make provision to include disabled children, Rule 6 calls for ‘special school education aimed at preparing the students for inclusion in the mainstream’.

UNESCO Salamanca Statement (1994) In 1994, UNESCO, the UN’s Education Agency published the Salamanca Statement, a declaration on the education of disabled children, which called for inclusion to be the norm. Representatives of 92 governments and 25 international organizations agreed on it. It states that ‘We call upon all Governments, and urge them to adopt as a matter of law or policy the principle of inclusive education, enrolling all children in regular schools, unless there are compelling reasons for doing otherwise.

The Salamanca statement asks all governments to give highest policy and budgetary priority to improve education so that all children can be included, regardless of individual differences or difficulties; to develop demonstration projects and encourage exchanges with countries which have
inclusive schools; to ensure organizations of disabled people, along with parents and community bodies, are involved in planning and decision making; and to make early identification and intervention strategies a priority as well as vocational aspects of inclusive education and to ensure that both initial and in-service teacher training addresses the provision of inclusive education. It calls for action from UNESCO UNICEF, the UN development programme, and from the World Bank.

Dakar Framework for Action (2000) The Dakar Framework for Action is accompanied by the ‘notes on the Dakar Framework for Action’ which provide details on each goal and suggest strategies for pursuing the goals. These ‘explanatory’ notes are based on the suggestions provided before and during the World Education Forum, and from the strategy sessions carried out in Dakar.

Biwako Millennium Framework for Action (2002) The Biwako Millennium Framework for Action aims to promote an inclusive, barrier free and rights-based society for persons with disabilities in the Asia Pacific region. To focus on priority areas where progress was found inadequate and action was lagging behind during the implementation of the Asian and Pacific Decade of Disabled Persons, 1993-2002. By resolution 58/4, Governments in the region defined the priority policy area as: Self-help organizations of persons with disabilities and related family and parent associations, women with disabilities, early detection, early intervention and education, training and employment, including self employment, access to built environments and public transport, access to
information and communications, including assistive technologies and poverty alleviation through capacity-building, social security and sustainable livelihood programmes (UNESCAP, 2002).

The Montreal Declaration on Intellectual Disabilities-MDID (2004) The Montreal Declaration on Intellectual Disabilities (2004) call upon the states to recognize that persons with intellectual disabilities are full citizens in society. They have to fulfill their obligations given by national and international laws, develop, establish and take the legislative, judicial, administrative and educational means to achieve the foil social inclusion, provide support to the communities, to the persons with disabilities and to their families for their rights and to strengthen the organizations. Further the states have to develop and implement human rights education and training and information programmes to persons with intellectual disabilities (MDID, 2004).

2.7. National Policies and Programmes for the Persons with Mental Retardation

India has witnessed a phenomenal expansion of educational opportunities in the post-independence period. The special education system has done pioneering work in the field of educating children with disabilities. The policies and programmes for the development of children with disabilities are discussed below:

Indian Constitution: Article 41 of the Indian constitution states that the states shall within the limits of its economic capacity and development make
effective provision for securing the right to work, to education and to public assistance in case of unemployment, old-age, sickness and disablement.

Indian Education Commission (1964-66): The Indian Education Commission was the first statutory body to suggest that ‘the education of handicapped children has to be organized not merely on humanitarian grounds but also on the grounds of utility’. The commission felt that services for children with disabilities were extremely inadequate and recommended the adoption of two approaches namely, the provision of special education and integrated education to improve the situation.

The commission set up Education for about 15 percent of the blind, the deaf and orthopaedically handicapped and five percent of the mentally retarded as the targets to be achieved by 1986: The Commission also specifically emphasized the importance of integrated education in meeting this target as it considered integrated education to be cost effective and useful in developing mutual understanding between children with and without disabilities.

Integrated Education for Disabled Children IEDC (1974) In 1974, Ministry of Welfare, the Central Government of India, initiated the IEDC programme to promote the integration of students with mild to moderate disabilities into regular schools. Children were to be provided financial support for books, stationery, school uniforms, transport, special equipment, and aids. The state governments were, provided 50 percent financial assistance to implement this programme in regular schools. However, the program met with little success.
Due to the failure of the IEDC scheme, it was revised in 1992, incorporating various recommendations of Project Integrated Education for the Disabled (PIED). Various non government organizations are now entitled to implement the scheme.

National Plan of Action against Avoidable Disablement (1983): National Plan of Action against Avoidable Disablement under the Impact India aims to initiate, augment and intensify action against massively prevalent disablement and to treat an estimated 15 million people who are disabled by curable blindness, deafness and physical handicaps. The main thrust areas at the primary health care level are elimination of poliomyelitis by immunization, prevention of blinding malnutrition by Vitamin A supplementation, prevention of childhood disability through improved system for the delivery of community health, nutrition and maternal and child care including family welfare, prevention of accidents through intensified community-level education on safety procedures, effective enforcement of legislative measures and organization of facilities for emergency management.

education component in pre-service training of general teachers, provision of vocational training of the disabled’ and involvement of NGOs in this work.

The Programme of Action (POA) states the placement principle: a child with disability who can be educated in the general school should not be in the special school. Even those children who are initially admitted to special schools for training in daily living skills plus curriculum skills should be integrated in general schools, once they acquire daily living skills, communication skills and basic academic skills.

**Project Integrated Education for the Disabled (PIED), 1987:** In 1987, the Ministry of Human Resource Development (MHRD) in association with UNICEF and the National Council for Educational Research and Training (NCERT) undertook “Project Integrated Education for the Disabled” (PIED). The aim of the project was to strengthen the implementation of the IEDC Scheme. Instead of confining this programme to a particular institution or school, PIED adopted a “Composite Area Approach”. Schools in a particular area have to share resources such as specialized equipments, instructional materials, and special education teachers.

The key aspect of the project was the teacher training programme. Selected teachers undertook six week intensive training in special education and were provided hands on experience in integrated and special school settings. This project produced several positive results.

**District Primary Education Programme-DPEP-(1994)** District Primary Education Programme (DPEP) is a centrally sponsored scheme and it aims to
reduce the overall dropout rates of all students enrolled in primary classes, to raise their achievement levels and to provide primary education for all children, including children with disabilities. A significant feature of DPEP is its emphasis on integrated education. The programme specifically emphasizes in-service training of primary school teachers in areas such as early detection of disabilities, functional assessment, use of aids and appliances and implementation of individualized education plans. In order to successfully carry out an integrated education in primary schools, DPEP also has made provisions for a resource room at block or district level. The programme also has provisions to finance for the use of various educational aids and appliances and the removal of architectural barriers.

**Sarva Shiksha Abhiyan-SSA-(2000)** SSA ensures that every child with special needs, irrespective of the kind, category, and degree of disability, is provided education in an appropriate environment. SSA adopts ‘Zero Rejection Policy’ through which no child is left out of the education system. The thrust of SSA will be on providing integrated and inclusive education to all children with special needs in general schools. It supports a wide range of approaches, options and strategies for education of children with special needs. This includes education through open learning system and open schools, nonformal and alternative schooling, distance education and learning, special schools where ever necessary, home based education, itinerant teacher model, remedial teaching, part time classes, Community Based Rehabilitation (CBR), vocational education and cooperative programmes.
2.8. Legislations for the children with mental retardation in India

Progressive legislations helped persons with disability to get quality services, their rights, range of services and social security. They are, The Rehabilitation Council of India Act, 1992; This is an act to provide for the constitution of Rehabilitation Council of India for regulating the training of rehabilitation professionals and the training of Central Rehabilitation Register and for matters connected therewith or incidental thereto. The functions of the council are, recognition of qualifications granted by University etc, in India and abroad, for rehabilitation professionals, withdrawals of recognition, setting minimum standards of education, maintenance of central rehabilitation register and laying rules and regulations.

Persons With Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995: This Act gives effect to proclamation on the Full Participation and Equality of the people with Disabilities in the Asian and Pacific region. The main functions of the Act are constitution of Central Coordination Committee and State Coordination Committee to exercise the powers conferred on, and to perform the functions assigned to it.

The other major functions are prevention and early detection of disabilities, education by ensuring access to free education and promoting integration and vocational training facilities, employment through reservation, affirmative action to provide aids and appliances to persons with disabilities,
ensuring non-discrimination by adapting rail compartments, vehicles, and 
aircrafts to permit easy access, adapting toilets in transport vehicles and public 
places, etc., Research and manpower development activities are encouraged to 
prevent disability, promote rehabilitation, development of assistive devices, job 
identification and on-site modification in offices and factories.

**National Trust for Welfare of Persons With Autism, Cerebral Palsy, 
Mental Retardation, and Multiple Disabilities Act, 1999:** This legislation 
was enacted to provide a body at the national level for the welfare of the 
persons with autism, cerebral palsy, mental retardation and multiple disabilities 
and for matters connected therewith or incidental thereto. The objectives of the 
trust shall be to enable and empower persons with disability to live as 
independently as possible within and as close to the community to which they 
belong to and to strengthen facilities to provide support to persons with 
disability to live within their own families. The other functions are to extend 
support to registered organizations to provide need based services during the 
period of crisis in the family of persons with disability. It also promises to 
promote care and protection of the persons with disabilities in the event of 
death of their parent or guardian and to evolve procedure for the appointment 
of guardians and trustees for persons with disabilities.

**2.9. Related Research Studies**

Community Based Rehabilitation (CBR): Community Based Rehabilitation 
(CBR) is defined as “a strategy within the community for the rehabilitation, 
equalization of opportunities and social integration of all children and adults
with disabilities. CBR is implemented through the combined efforts of disabled people themselves their families and communities and the appropriate health, education, vocational and social services (ILO, UNESCO, WHO, Joint Position Paper, 1994).

The process of Community Based Rehabilitation emphasizes integration and provides an opportunity for people with disability to have full participation and equalization of opportunity within their society (WHO, 1989). During this process, the people with disability are exposed to day-to-day risks. This insists on them with confidence and teaches them skills to negotiate and overcome problems and achieve their own rehabilitation through self-help (Myezwa and Kumbuzi, 2003).

The programme components of CBR are a) Restorative-health, medical, education, economic, b) Preventive-immunization, awareness, nutrition, and c) Empowerment-access, group saving, credit programme, awareness and rights issues. (SPASTN, 2000). There are different approaches for CBR, but their programme components are largely same. DRC model, SPASTN model, Seva in Action model and ADD-India model are some of the approaches for CBR in India.

The **DRC model** was launched by Government of India in 1985. The District Rehabilitation Centre Scheme had a three tier structure-village level, PHC (Primary Health Centre) level and District level. This is a bureaucratic approach in which major success was achieved in health aspects. In this model the persons with disabilities have to travel a long distance to the District
Rehabilitation Centres, But the flip side of this model is that it has given an impetus to national level planning for implementing CBR.

The project called DARC (Disability Awareness and Rehabilitation in the Community) was initiated by SPASTN in 1992 and developed in response to the felt and expressed needs of families of children with disabilities. The house of DARC is built on six pillars with the community as the foundation. They are, Awareness creation, Screening and Detection in hospitals in Balwadi’s and schools and through camps, Early Intervention on a multi-site basis, Training of Grass root workers, Referral Chain, and Cross-Sectoral networking. This model is based on lessons learnt from David Werner in Mexico and Tjandrakusuma in Indonesia.

The SEVA in Action model had CBR committees at the grassroots level managed by key local persons. A community member is trained at the grassroots level and the cost is paid by CBR Committee through local resources, local government, and donors. All the management committees are actually community based in deed and action, where ownership of rehabilitation is with the community. Community handles planning, managing and evaluation. In this model of approach, very nominal salaries are paid to very committed workers and so they are few and far between. CBR committees disintegrate after the initial euphoria, as there is nothing for them in terms of benefits. Local politics, personal egos also come into play. This model was often operational in small towns rather than in villages.
The **ADD-India Model** is otherwise known as empowerment model. Community and disabled people are empowered, as it is a bottom up approach. In this method single disabled person is trained in all aspects of rehabilitation and community organization. This person will work with the community at one end and disabled persons at the other end. Persons with disabilities are motivated to form self help groups for advocacy and rights issues to be tackled at all levels of government to gain access to existing health facilities, education, training, and employment. The only limitation is that there are no quick solutions and benefits.

Various countries have adopted CBR approach to provide maximum rehabilitation measures. There was a very strong movement towards Community Based Services in Canada, Australia and New Zealand. In United Kingdom, majority of the persons with mental retardation live in their ordinary households and the changes towards CBR tend to give reasonable confidence. In Eastern Europe efforts were taken to promote community-based services. In France and Italy the community based services were working relatively in a slow pace as compared alacrity of other European countries (Ross, 1998).

O’Toole (1991) is of the view that CBR was viewed as a philosophy of care which inevitably embraces many forms of services and according to Tjandrakusuma, (1998) it is directed towards the whole community as well as the individual members who happen to have a disability. It is not to normalize
disabled people to fit into a restrictive unjust and disempowering society but it is to join the struggle of other marginalized people to transform our social order into one that every one weak and strong, rich and poor, disabled and non-disabled enjoy equal opportunities and respect.

In the CBR frame work which relies on family and community members providing aspects of support or assistance for people with disabilities, such demands may be seen as unrealistic. The potential within CBR forever burdening parents, family members the local health worker or the local community (Momm and Konig, 1989) has been recognized as an issue of concern. Specifically, it is felt that such an approach is unsustainable. CBR services attempt to find ways to synchronize services in order to maximize the benefits to the child and to minimize their potential for stress (Gebre-Mehdin, 1998). McConkey (1998) is of the view that the CBR services aim at enabling the persons with mental retardation to reduce their dependency, level irrespective of their age group and further to mobilize the family members.

These programmes have helped people with disabilities to become more visible and shown that they can contribute to family and community life. They have also had a positive impact on the self reliance of many children and adults with disabilities especially through training in daily living skills (Shukshin, 2005). Miles (1996) found that the dignity of disabled people was promoted through enabling them to play a decisive role in any service that is created.
In 1970s a number of policy documents were drawn up highlighting the rights of persons to be part of the society. As a consequence the concept of CBR was formed during the decade. The international year of the disabled in 1981 was the occasion when this position became public. During the decade of Disabled persons in 1992-2002, United Nations prepared the Standard Rules for Equalization of opportunities, which offered global strategy to the international community. Community Based Rehabilitation intervention were shifted from institutions to the home and communities and carried out by minimally trained people such as families and other community members (WHO, 1989). CBR has been promoted internationally for more than twenty years as the core strategy for improvement of the quality of life of persons with disabilities (Annika and Nilsson, 2002).

During eighties and nineties there was a substantial growth in the number of CBR programmes in different developing countries. Along with the quantitative growth, there were also major changes in the way it was conceptualized (Thomas and Thomas, 1999a). In the 1990s CBR evolved to include comprehensive intervention in education, prevention, social rehabilitation and vocational training, along with a shift to changing community attitudes and other contextual factors acknowledging that disabled individuals do not live in isolation but are influenced by community factors such as attitudes and acceptance, promotion of social integration, opportunities in education and employment and community ownership of CBR programmes.
This was reflected in the joint position paper of WHO, International Labour Organisation (ILO) and UNESCO (1994).

It was estimated that by 2000 AD the number of disabled in the world would be doubled. Various studies have estimated that majority of the persons with disabilities are living in rural and semi urban areas where rehabilitation services are limited or sparse and that have very less possibility to be included in welfare schemes and programmes provided both by the government and nongovernmental agencies. The developing countries had no access to services and had limited resources to provide uniform services to all the persons with disabilities.

Accurate statistics are difficult to obtain since many families are reluctant to report disability because of the negative attitudes towards disabled people in most communities, but village surveys in different parts of India indicate that up to 10 percent of the population are persons with disabilities (Thomas and Thomas, 2002 and Janet Seeley, 2001).

To reach out to the rural population especially the persons with mental retardation through CBR programme becomes not only a priority but also a matter of urgency (Jeyachandran, 2001). India is a country with most of its population located in rural areas, which are often unapproachable having poor health and rehabilitation services, having uneven development in the indicators of health education employment and per capita income (Thomas and Thomas, 2002). It is fact that India continues to have substantially higher population living below the poverty line. Most of the areas in rural India are still
inaccessible to the health and other services. People with disabilities are a heterogeneous group made up of people born with disability those who acquire a disability because of diet or disease and those disabled in accident or disasters (Janet-Seeley, 2001).

Associations of people with disabilities have been very active in India for some years. They have been moderately successful in areas of service provision, awareness building, information dissemination and vocational training. Of late, they have become active in promoting rights of disabled persons. They include people with different disabilities. Due to variety of circumstances people in developing countries, particularly in rural contexts may have little time or energy to devote to helping people with disabilities (O’Toole, 1991). Guzman and Luza et al (1988) report that achieving integration was easier in rural areas than in urban areas.

The last few years have witnessed attempts to integrate disability into community development projects that has shown some tangible benefits for disabled people from integration (Scott, 1994, Litton, 2000, Thomas and Thomas, 2000). Structural elements such as management skills, infrastructures monitoring and evaluation procedures (Rehabilitation International, 1995). Programme and national policies (Yeadon, 1990) have also been seen as factors influencing sustainability of a CBR project.

According to a study conducted by Gershon and Srinivasan (1992) there was a dramatic improvement in employment and occupational status, increased level of income and earning capacity- and marked improvement in housing
standard due to the interventions from CBR programmes. Impact of CBR in Nepal has improved the self reliance of disabled persons including mobility, personal hygiene and economic independence through self help groups (Annika and Nilsson, 2002).

Venkatesh (1993) is of the view that the people with disabilities become increasingly empowered through CBR programmes. They begin to generalize their focus and seek to address issues such as income generation and broader socio-economic issues. General poverty alleviation was emphasized by a number of CBR programmes in South Asia (Miles, 1996). Zaman (2003) observed that micro credit programme of Bangladesh Protibondh Foundation helps the poor families of disabled children to improve their financial conditions.

O’Toole (1996) observed that the child is allowed and encouraged to be a more active participant in the life of households through CBR programme. Thorburn (1992) in his evaluation study in Jamaica reported that the knowledge of parents regarding their child’s disability has improved after the initiation of CBR programme. There was a remarkable increase in the positive attitude of the parents towards their child’s disability. Saunders and Zinkin (1990) have reported that there are effective community solutions to the significant proportion of the problems. For many children it is possible to provide medical rehabilitation and ensure full educational and social integration.

Parents have demonstrated a readiness to be involved in Home Based programmes. Local teachers encouraged integration in the ordinary primary
schools. All these have led to increase in community awareness of disability. The CBR programme in Jordan have positive and developing roles in creative awareness and identifying the rights of persons with disabilities and their families. The programme has offered relatively limited medical, social and educational services (Raad, 1998). The CBR services in Jordan have dramatically changed the lives of the Persons With Disabilities. But the persons with mental retardation were in need of support (Ericsson, 1998).

Thorbum (1992) is of the view that the parents who are working in CBR projects have shown rewarding involvement. Venkatesh (1993) described about CBR programme in India, in which persons with disabilities collectively started to address broader political and social issues such as income generations primary education, rehabilitation, housing, transportation and even land distribution.

According to Spreat and Conroy (2001) the community groups of persons with disabilities have exceeded or matched the institution groups with respect to community integration and adaptive behaviour. Through CBR programmes the persons with disabilities have participated in decision making (Ginsberg, 1993) become more vocal and demanding their rights (Myezwa, 1995) demonstrated greater degrees of self advocacy (Frey and Hoff, 1994) and initiated their own organizations.

Lagerkvist (1992) reported about the magnitude of improvements in activities of daily living across disability and found that majority of the persons
with disability has shown an increase in independence in activities of daily living. Social integration, placement in jobs (Lagerkvist, 1992) and ongoing improvement in function (Finnstam et al 1988). Through CBR efforts are made to address collectively broader political and social issues such as income generation, primary education, rehabilitation, housing, transportation and even land distribution for the benefit of persons with disabilities (Venkatesh, 1993). Helander (1993a) stated from his experience of CBR that it promotes the dignity of people with disabilities. Mitchell et al (1993) reported that people with disabilities were increasingly treated as valued resources of the community.

Gershon and Srinivasan (1992) found that CBR resulted in increased respect and recognition for participants with their families, increased social and occupational status for people with disabilities and increased the level of income and earning capacity and improved housing standards. Mendis (1993) reported that the children under CBR programme have shown a significant improvement in independence in mobility, self care, socialisation within the family and community and communication. The obstacles of CBR are enumerated by Myezwa and Kumbuzi, (2003) such as the poor knowledge of CBR among the public, the cultural beliefs that discourage a positive outlook regarding disability, charity expectations of the community, poverty within the communities, poor health and social environments, authoritative attitude of the health workers and centralized health organisation.
In Guyana the community resource units are appreciated for their social support and skills training activities for parents. Some units also have classes, for children who do not cope with ordinary school education. Skills of CBR workers are reported to be quite limited in Ghana. The efficiency of the home visits by volunteers has declined as no new volunteers have been trained and old ones have lost motivation (Annika and Nilsson, 2002).

It has been argued that the limited training offered to community level workers may lead to superficial service delivery (O’Toole, 1991) and potential danger to people with disabilities. Momm and König (1989) and Rottier et al (1993) cited that the poor success, difficulties and reduced follow up by trained community level workers, as highly localized. Community based approach using minimally trained workers and effective quality control of service delivery is highly problematic with CBR. Krefting and Krefting, (1998) report that it is difficult to find out local female social workers who can leave their household confines and participate actively in CBR programmes.

The National Union of Disabled Persons of Uganda realized that using volunteers as service delivers was not a workable solution (Rifkin and Kanger, 2001). Rao, Venkatesan and Vepuri, 1991), conducted a study in rural areas of Andhra Pradesh, India and revealed that experience in using parents of disabled children as workers has been very rewarding though their quality of work is not yet compared with non-parents (Thorbum, 1992). Tjandrakusuma (1998) is of the view that the challenges of CBR include the need of improved strategies
and methods to implement CBR programmes, human resource development, funding and dissemination of information about CBR services.

Various models and aspects of CBR have been discussed in these reviews and all have their own strengths, positive and negative dimensions. CBR has no readymade formula for successful implementation and each programme will have to evolve its own modalities that best suit the locale.

**Background of the families having children with mental retardation:**

Various research studies (Ehlers et al. 1977 and Pakrasi et al. 1987) indicate an association between socio economic status of the families and prevalence of mental retardation. It was noticed that the persons with disabilities are actually affected by a shortage of basic necessities like water, food and housing apart from bad or nonexistent public transportation, health care, employment or other income opportunities. The disabled find it difficult to access them due to various inhibiting factors like handicapping physical environment, lack of assistive devices, tools that cannot be used by the disabled persons etc. There is strong and definite vicious cycle of poverty and disability because the aggravating factors such as malnutrition and filthy housing, hazardous occupations and so on. Conversely persons with disability tend to become poorer because of lack of access to income, jobs, basic medical services and rehabilitation (Arora, 2003). According to Arasi, (2004) three fourths of the families having children with disability in Ramanathapuram district were below the poverty line. Persons with low income are at a disadvantage in preventing the onset of disability and in
ameliorating its effects after acquiring the disability (Alston and Mngadi, 1992).

Seltzer et al (2001) stated that the parents of the developmentally disabled children had lower rates of employment, larger families. They had normative patterns of educational and occupational attainment and marriage but elevated levels of physical symptoms, depression and alcohol symptoms at midlife.

These research findings already state that the prevalence of mental retardation is higher among families in the low socio economic strata. Rural households are mostly from the socio economic strata without, basic physical amenities and education is more prone to have children with mental retardation compared to their urban counterparts with improved livelihood facilities and health care amenities.

**Problems of Mental Retardation on Families:**

The vast majority of the children with mental retardation lives in their family units either with their biological or substitute parents (Fujiuria, 1998). These parents of children with even mild disabilities undergo a process of adjustment and accommodation in relation to their child’s retardation (Gallimore et al 1996).

Non adaptive family pattern may result in upset in optimal parent child interaction (Guralnick, 1999) and the parents face challenges in family adaptations (Cahill and Glidden, 1996). This may pose a threat to the parental
feeling of adequacy and interrupt the normal family life cycle and leads to crisis (Nadler et al, 1991). Jena is of the view that the parents love retarded children, even though they face problems. Although they identify lack of proper facilities many of the parents used to keep their retarded children with their family, rather than letting them in the functionary world (Katz and Yakateil, 1974).

A number of investigators (Bailey et al 1999, Dyson, 1991, Scott et al 1997 Beckman, 1983 and Holroyd and McArthur, 1976) have reported that the parents of children with disabilities appear to experience higher level of stress and depression than the other parents. As the severity increases the level of stress also increases (Jena, 2000). According to Scott et al (1997) and Beckman (1991), care giving stress is more common among the members who provide homecare for children with severe handicaps. Higher stress in care giving difficulties, incompetence, depression, health problem, role restriction etc., were observed among parents of children with severe disabilities (Roach et al 1999).

The presence of a retarded child may disturb the parents’ life in several spheres such as participation in social and household functions, less attention towards their personal health problems and non-availability of time for the care of other children etc. Shin (2002), Llewllyn et al (1998) and Dunst et al (1986) reported that the parents were revealed to be making tiresome efforts to organise the environment and to obtain resources which are essential to cope
with the challenges and everyday demands in caring for a child with mental retardation. The lack of rest, sleep and feeding problems are the most serious difficulties for the parents having children with mental retardation. (Brinchman, 1999).

From the above review, it may be concluded that the families having children with mental retardation experience a high level of stress in care-giving and personal and home management. They face the crunch of family burdens, family conflicts and loss of supports.

**Perceived problems of caregivers of Children with Mental Retardation on caregivers-Mothers:**

The primary caregivers of most of the children with mental retardation are the mothers in the middle and old age (Heller and Fractor 1993 and Bailey et al 1992). They spend extra time compared to any other members in the family for their care (Austin, 1991). The greater the retardation of the child, the greater the perceived burden and distress of the mother. (Hoare, Harris and Jackson 1994). For single mothers the presence of a retarded child is a big challenge. (Costigan, Floyd and Harter, 1997) and they become particularly vulnerable to financial problems (Dunst, Trivette and Cross, 1986).

Mothers who have reported more responsibility for childcare perceived more difficulties in finding suitable care according to the child’s special needs (Hauser-Cram, 1996), personal health, role restrictions and spousal support (Roach et al 1999). Coffman et al (1995) specified that the mother receive the
limited satisfaction from her disabled child and the need to be cautious in protecting his/her health condition.

The mothers having children with mental retardation experienced inadequate family encouragement in terms of expressiveness or personal growth like independence, recreation etc., (Margalit and Raviv, 1983). The mental retardation of children posed greater social and psychological problems to the mothers (Emerson 2003). The mothers of children with mental retardation were highly vulnerable to psycho social challenges and did not have any resource or support to buffer depression (Blacher et al, 1997). Mothers expressed more needs primarily in family and social support and childcare (Bailey et al, 1992). The care of the adult children with mental retardation may be detrimental to the older mothers than the younger mothers. (Chen et al, 2001)

Chen et al, (2001) reported that Arthritis was found common among mothers having retarded children. The influencing factors of physical health are employment and family income for the younger and older mothers respectively. Mother’s mental health problems were associated with the child’s difficulty, stressful life event, social impact, poverty, receipt of mean-tested welfare benefits and unhealthy family functioning (Emerson, 2003).

Smith et al (1995) and Seltzer and Kruass, (1989) found that family income was positively correlated with mother’s general health. The higher the amount of informal support resources the higher the sense of well being and the
lower the level of stress of the mothers (Duvdevany and Abbound, 2003). Lee and Kang (1997) are of the view that the mothers are doubly trapped because of the society’s negative attitude towards disabilities and the loss of social support network. Even though the formal support services are available, the rural mothers are not utilizing them because of the low level of education (Duvdevany and Abbound, 2003). The mothers, who have received life skill training programme, have reported lower stress, lower depression, improved coping skills greater satisfaction with intimate relationships (Kirkham, 1993).

With these review, one may arrive at a conclusion that as being the primary caregiver, the mothers of the children with mental retardation carry additional responsibilities to meet the extra demands put forth by their retarded children. As a result of this she experiences higher level of constraints than any other persons in the family. Even though the mothers have increased amount of burden, they are able to accept their children’s inadequacies as well as to think positively and act realistically for getting necessary information and available services.

Fathers: The extent of father involvement and responsibility in childcare is likely to increase as the structures and functions of family life are rapidly changing (Cabrera, et al, 2000). A consistent pattern of differences between parents has emerged across several studies with mothers reporting higher level of stress (Beckman, 1991 and Kazak, 1987) more depressive symptoms and family disruptions (Bristol, Gallagher and Schopler, 1988), more problems
related to their children and family functioning (McLinden, 1990) expressed more needs (Bailey, Blasco and Simeonsson, 1992) and spending considerably more time (McConachie, 1989). Although fathers are affected by the birth of a child with disability (Cummings, 1976) its impact on fathers differs from that experienced by mothers. Holroyd (1974) found greater problems reported by mothers of children with mental retardation and behaviour disorders than by fathers. Hastings, Beck and Hill (2005) are of the view that mothers generally report more positive contribution than fathers. They are more likely to have more frequent occurrences of intrusive thoughts regarding their children and are more likely to acknowledge realistic concerns than did fathers (Schultz, Kemm and Bruce, 1992). Regarding the child’s disability, fathers were more sensitive to the effects of the family environment, where as mothers were more affected by their personal support networks (Krauss, 1993).

Mothers of children with disabilities are more inclined to deal with the emotional issues involved in caring for a child with a disability, while fathers are more concerned with financial and other practical issues (Gumz and Gubrium, 1972). Trute, (1995) is of the view that mothers with younger children and fathers with male children appeared to be at higher risk for depression.

Bristol, Gallagher and Schopler (1988) studied the relation between spousal support and measures of parental adaptation, such as depression, marital satisfaction and observed parenting interactions. The fathers of the children with disabilities participated significantly less in caring
for their children than did the fathers of children without disabilities, regardless of whether or not the mothers worked outside the home. These findings give a clear picture that, even though the fathers are influenced by the retardation of the child, their contribution is much less towards the child care responsibilities. However their roles cannot be ignored.

Siblings: There has been sharp increase in knowledge about sibling of children with disabilities from the past decade. Sibling relationships according to Seltzer et al (1991) and Geothings, (1986) are highly independent and the sibling role remains part of the individual’s identity regardless of changes in life events. These unique attributes contribute to the emotional and reciprocal influences among siblings.

There have been efforts to discover whether the relationship between children with disabilities and their siblings are similar in warmth and are positive to relationships between typically developing siblings (Stoneman, 2001). They are forced to change their affective and instrumental role towards their brothers and sisters with mental retardation. Some commit themselves towards the new role but others may be ambivalent or frustrated with the new, added responsibilities (Seltzer, 1993). Sibling care responsibilities are greater when the sibling with mental retardation had fewer adaptive and self help skills (Stoneman etal, 1991).

Younger siblings of children with mental retardation provided more care giving, with the extent of care giving depending on the severity of the
sibling’s disability (Stoneman et al, 1991), where as Stoneman, (2001) reported that younger siblings do not help feed or baby-sit their older siblings.

The extent of sibling participation in domestic chores and care giving may be depending on the competence of the child with disabilities (Stoneman et al 1991). Older children assumed more household responsibility. The number of domestic core done by the siblings is strongly associated with positive interactions with parents (Cuskelly and Gunn, 2003). Older siblings of children with mental retardation seemed to compensate for their siblings’ limited skills by selecting activities in which they could easily participate (Stoneman et al, 1987).

Siblings who have greater opportunities for interaction are more likely to experience greater intensity of both positive and negative effect. Even though the siblings of children with mental retardation have a lot of problems, Saxena and Sharma (2000) have reported that a majority of them have medium level of self-esteem. Their sense of identity, was not negatively influenced by the presence of a disabled sibling (Brody et al, 1991).

Siblings of disabled children are at greater risk for developing psychological adjustment problems (Arya, 2002). Siblings of children with severe disabilities have reported that they have fun playing with their siblings, feel strong loyalty, interact with their siblings on a daily basis and are aware of the children’s’ activities and development gains (Stoneman, 2001). Kaminsky and Dewey, (2002) reported that the siblings of children with autism were well adjusted and reported low levels of loneliness and high levels of
societal support. The extent of current and future involvement by siblings of adults with disabilities depends on the degree of closeness with the family of origin (Greenberg et al, 1999). The sisters of the siblings with mental retardation represent more of continuity in lifelong role and expectations in care giving responsibility after parental illness or death. They provide more care and companionship than did brothers to their sibling with mental retardation (Orsmond and Seltzer, 2000).

According to Cuskelly and Gunn, (1993) mothers reported that girls who had a sibling with Down syndrome had shown more conduct problems. Sisters not only provided more care but felt closer to their sibling than brothers did (Stoneman, 1989). Sisters were significantly more likely than brothers, to have frequent contact with their sibling with mental retardation, to do more things together, to have knowledge about their siblings’ current skills and needs, to have had discussions with parent about their sibling’s future, and to feel closer in the sibling relationship (Orsmond and Seltzer, 2000).

Grandparents: Family studies and special education literature occasionally have presented information related to the support provided by the grandparents and not focused on their experiences or needs. Vadasy (1987) revealed that the grand parents are the first people contacted by the parents their child’s disability and therefore may become a key element of the mothers’ support network.
Grandparents are not merely passive bystanders or observers of their grandchildren with disabilities. They support their sons and daughters and the grandchild in a variety of ways. The most frequently reported types of support are emotional-unconditional acceptance of the grandchild regardless of its behaviour and instrumental- financial, care for the grandchild and leisure time activities (Schilmoeller and Baranowski, 1998).

The sparse literature on grandparent’s social support of parents, in situations of childhood developmental disability, has only offered generalizations in regard to the facilitative or hindering involvement of grandparents in family life. Annapurna (1997) is of the view that the grandparents of the mentally retarded children often experience a dual grief such as loss of an expected grandchild, life long burden and reduced opportunities. According to Schilmoeller and Baranowski, (1998) initial feeling of worry, sadness, helplessness and fright give way to more positive feelings of acceptance, hopefulness, involvement and confidence for many of these grandparents.

Vadasy et al (1986) found that grandparents often attempt to find out more information about the disability as well as their possible roles in helping by talking with their grandchild’s parents, attending educational programme and participating in support groups. According to Gardner et al (1994) the most common grandparent support activities were baby-sitting, transporting the grandchildren to schools, taking grand children to medical appointments and to support services, assisting with medical and therapeutic interventions and providing financial assistance. Hornby and Ashworth, (1994) found that more
support were provided by the maternal than the paternal grand parents in situations of childhood disability. Most of the grand parents extend support to the family both in emotional and instrumental aspects. The maternal grandparent were more supportive than the paternal grandparents. These studies highlight the importance and need of the grand parent’s support as caregivers of children with mental retardation.

**Positive Impact of Mental Retardation in Families;**

A positive perception and feelings are the important goals for working with families. Parents with few children, high socio economic status, adequate crisis meeting resources, community support, strong marital relationship, well adjusted personality, positive view and realistic expectation seem to be successful in adjusting with their child with disability (Szymanski, 2000).

Minnes (1988) in his study has reported that the families with a mentally retarded child have less stress, greater family harmony and a strong feeling of personal reward associated with parenting. Presence of a child with mental retardation may strengthen the entire family unit and bring positive impact in the quality of life and in the process of adapting to the child with disability.

The family who has adopted a child with mental retardation demonstrated positive outcomes early in the process and that these effects have been maintained over 10 years after the adoption took place (Glidden and Pursley, 1989).

These studies on the whole have elaborated the impact of mental retardation of children on their family members. The families undergo a
drastic change in their routine life. They experience difficulties in smooth functioning, harmonious life style and face problems in coping, interaction, leisure activities etc. Consequently understanding relationship in the family and identification of potential supporting agent within the family may throw some light on possible solutions to minimize the burden of the caregiver and maximize the functional support system within the family.

**Conclusion**

The literature reveals that the policies and programmes were inadequate to solve the problems of the persons with disabilities and their families in real life situation Integration of programmes and empowerment of the family and community as partners of development attempted under the innovative CBR approach is a real challenge. The Pilot efforts in this line needs periodical review and perfection then and there to ensure its replicability.