INTRODUCTION

Mental Retardation (M.R.) is a common problem. No nation can claim to be free from this problem. They may come from any racial stock, any type of family background or creed. Of four billion habitants on our planet about one to three percent are estimated to be mentally retarded (WHO, 1968). This has attracted increasingly attention in 'developed countries' in recent years. Even now despite the great changes that have taken place, M.R. is ill understood and there exists many prejudices and misconception about the problem.

The persons like doctors, psychologists, therapists, special educators, whose work is concerned with assessing the performance of children known or suspected to be suffering from a variety of handicaps are becoming increasingly interested, compared to many of the physical sciences. The study of mental retardation is still in its infancy or early childhood.

In developed countries there has been considerable evaluation of the intervention programmes for environmentally disadvantaged children and the research has been applied to intervention programmes for a few organically impaired or handicapped children. But it has been pointed out that most of the research involves children with delayed development from the disadvantaged economic circumstances. The effect on specific and established handicapped conditions are less clear and uniform. There are numerous difficulties in implementing early intervention for this group. Lack of comparison groups, small sample size, brief
and non-comprehensive intervention and vague treatment procedures are some of the problems.

The problem of mental retardation is quite serious, particularly in an over populated developing country like India. It has been said that of all the babies born at a time, at least 5% would turn out to be retarded. The estimated population of the mentally retarded in India is about 13 to 14 millions (WHO, 1978)29.

In the Indian context, research on mental retardation still lays much emphasis on epidemiological work.

The work done by the past researchers in developed countries urges me to do more extensive and systematic studies on the "EFFECT OF EARLY INTERVENTION ON THE DEVELOPMENT OF MENTALLY RETARDED CHILDREN" under more stringent design condition in Indian environment.

**MENTAL RETARDATION**

**WHAT IS MENTAL RETARDATION?**

Mental Retardation is not a disease. It is a disability, which must be differentiated from other conditions. A mentally retarded person is basically the same as a normal human being but has a lower level of intelligence. In another words, "a person who was possibly behind the door, when the Almighty was handing out intelligence".
Mental Retardation (M.R.) means impaired or incomplete mental development. The child who is retarded is not able to learn as much as other normal child. What he is able to learn, he learns much more slowly.

Mental Retardation thus implies impairment in intelligence from early life and inadequate mental development throughout the growing period. It is manifested by the slow and incomplete maturation, poor social adjustment and deficient learning ability.

To understand subnormal intellectual functioning or impairment in intelligence or low intelligence, one should know some more about intelligence.

MacMillan (1982) summerizes the attempts to define intelligence as having three general themes:

1. Capacity to learn.
2. Totality of knowledge acquired.
3. Adaptability of the individual, particularly to new situations.

Kimble et al. (1984) emphasize the function of intelligence as the "solving of real life tasks". They pointed out that modern definition of intelligence tend to emphasize cognition, i.e. the capacity to think, reason, remember and understand.

Combining the above elements, a general definition of intelligence can thus be composed viz. intelligence consists of the mental operations, the accumulated knowledge and the ability to learn that helps one purposefully to solve real-life tasks. Intellectual
functioning involves cognitive processes as thinking, memory, logical reasoning and the knowledge of general information and vocabulary.

The term "Mental Retardation" is based on the "Intelligence Quotient" (I.Q.).

The I.Q. does not really determine anyone's abilities. The score is fundamentally a measure of the rate of intellectual development. The only independent variables involved in assessing the child's relative intellectual standing are Chronological Age (C.A.) and Mental Age (M.A.). The M.A. is computed by awarding the child a certain number of months for the test items he or she is able to pass. Thus, the intellectual level is decided by the M.A.; I.Q. is a measure of brightness obtained by dividing the individual's mental age by chronological age, multiplied by 100.

\[
\text{I.Q.} = \frac{\text{MENTAL AGE}}{\text{CHRONOLOGICAL AGE}} \times 100
\]

The intelligence quotient has been technically defined as the summary index that indicates a person's relative position. The Table No.1 represents the standard nomenclature used to describe persons having different I.Q. levels.

Traditionally, mental retardation has been viewed almost exclusively in terms of low intelligence, i.e. I.Q. below 70. More recently, however, intelligence has been re-emphasized with more importance given to such factors as social competence, motivation and
learning potential. Low intelligence is still necessary for diagnosis of mental retardation.

TABLE No. 1

<table>
<thead>
<tr>
<th>I.Q. LEVEL</th>
<th>CATEGORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Above 140</td>
<td>Genius</td>
</tr>
<tr>
<td>120 - 140</td>
<td>Very superior intelligence</td>
</tr>
<tr>
<td>110 - 120</td>
<td>Superior intelligence</td>
</tr>
<tr>
<td>90 - 110</td>
<td>Average/Normal intelligence</td>
</tr>
<tr>
<td>80 - 90</td>
<td>Dull normal intelligence</td>
</tr>
<tr>
<td>70 - 80</td>
<td>Borderline deficiency</td>
</tr>
<tr>
<td>50 - 70</td>
<td>Mild retardation</td>
</tr>
<tr>
<td>35 - 50</td>
<td>Moderate retardation</td>
</tr>
<tr>
<td>20 - 35</td>
<td>Severe retardation</td>
</tr>
<tr>
<td>Less than 20</td>
<td>Profound retardation</td>
</tr>
</tbody>
</table>

Number of terms have been used to describe 'Mental Retardation'. In England, the official term used is 'Mental Sub-normality' in Scotland, until recently the term used was 'Mental Deficiency'. In U.S.A. 'Mental Retardation' has been used, although now there is a move towards the use of term 'Developmentally Disabled'.

HISTORY OF MENTAL RETARDATION

The history of mental retardation can be broken down into two periods. The pre-scientific from a primitive man to the nineteenth century, and the scientific from the nineteenth century to the present.
PRESCIENTIFIC PERIOD -

The literature of ancient Greece and Rome revealed few references to the 'mental handicap' and indicated that they were primarily treated with scorn and persecution. Roman parents evidently threw their blind, deaf and mentally retarded children into the Tiber river to relieve themselves of the burden of support.

Kanner (1964) reports that ancient literature revealed only one use of the mentally defective, namely the role of a fool or for the amusement of royalty. References to the retarded can also be found in the Bible, the Talmud and the Koran with indication that they were sometimes treated kindly.

In 16th and 17th centuries the mentally retarded were often viewed as 'possessed'. This resulted in some strange and cruel treatment practices. One treatment involved covering the person with blood sucking leeches, cutting the person's wrists to 'let blood'. Beating was also common method of help. Intention of these cure was to force the 'evil spirit' out of the body. Still another treatment involved was lowering of a person into a pit filled with snakes. This was designed literally to 'scare the hell' out of the person and to force the evil spirits to take up residence elsewhere.

MENTAL RETARDATION AND MENTAL ILLNESS -

In 1690, John Locke made the first attempt to distinguish between mental retardation and mental illness. He also promoted a 'blank slate' conception
of child development. He represented a movement known as 'sense-empricism' that emphasized the role of the environment in shaping our destiny. The 'blank slate' is written on by the environment through the senses.

The French revolution was a harbinger of political and social changes that were to occur throughout the European continent, and eventually the rest of the world. The first glimmering of hope for humane treatment of the handicapped began to appear during the eighteenth century, after the French revolution. Phillip Pinel, a physician, unchained several insane patients who had been confined for years in the Bicetre Hospital. Pinel taught the personnel to treat the patient in a humane manner. This event is usually recognized as a major turning point in the treatment of the mentally handicapped. Also during this era, Dr. Benjamin Rush, an American wrote one of the first comprehensive volumes on psychiatry which recognized the need for the special education of the disturbed.

In summary the history of the handicapped in prescientific period i.e. from antiquity to the 1700, was rather grim and marked by cruelty, but there were some human efforts in eighteenth century.

**SCIENTIFIC ERA**

During the late 18th century and in the 19th century, some of the first attempts to educate retarded persons were made.

Jean Maria Itard (1774-1838), a medieval doctor, greatly influenced the field of "Special
Education" through his work with feral (wild) boy. He was found in the woods near Averyon who exhibited little or no social behaviour when found and was unable to communicate. Itard believed that through systematic training, Victor's mental deficiencies could be eliminated. The programme that Itard developed was based on five objectives addressing the following areas: Social skills, Sensory stimulation, Knowledge of his environment, Communication skills, and General academic skills. Interesting, all five of these areas are found firmly embedded in many of today's curricular efforts for the retarded. Itard, however, after working for five years with Victor, gave up in disgust feeling that his efforts to civilize the boy were unsuccessful. But he failed to realise the great stride that he had made with Victor. He set a precedent in educating severely handicapped individuals and developed one of the first systematic set of instructional procedures for teaching skills such as self-care and communication. The programme objectives and instructional strategies he designed are in use today. Itard's experiment was the first documental systematic attempt to teach a mentally retarded person.

Until 1838, single term idiocy was used to refer to 'mental illness' and 'mental retardation'. Frenchman Jean Esquirol made a clear distinction between idiocy and mental illness. Esquirol observed that although mentally deranged persons have lost the abilities they once possessed, idiots have never had those abilities in the first place. Esquirol's developmental distinction has been incorporated in our current definition of mental retardation.
Another pioneer in mental retardation was 'Edward Seguin', a French physician and student of Itard, known as 'FATHER OF MENTAL RETARDATION'. He focused on the education of the mentally retarded. In 1837, he established the first school specifically intended to educate the mentally retarded in Paris. He later emigrated to the United States, and was instrumental in establishing the first state residential facility for the mentally retarded.

Seguin elaborated the methods of Itard. Seguin (1846)21 developed a detailed and systematic programme for the training of sight, hearing, taste and smell and the co-ordination of hand and eye. Seguin's physiological method was based on five main stages:

1. There was training of muscular system.
2. There was training of nervous system.
3. There was education of the senses.
4. There was acquisition of general ideas, and
5. There was inculcation of the ability to think in the abstract and to understand moral percepts.

The decade 1840-1850 was an important one in the history of the education of the mentally handicapped and the sensationalist theories of Itard and Seguin were undoubtedly responsible for the opening of a number of new establishments during this time.

Dr. Guggenbuhl in 1841, established an institution for cretins near Interlaken in Switzerland. In Germany Dr. Saugert had been experimenting with physiological techniques and in 1842, he set up the first private
school for mentally defected in the country. The first school in America was opened in Massachusetts in 1848.

In 1866, Seguin published the first text book on the treatment of mental retardation. He emphasised individualised instruction, sensory motor training and even behaviour modification which are currently most popular therapies to train the mentally retarded. In 1876, the first professional organisation now called the American Association of Mental Deficiency was started.

In the 1890, Dr. Maria Montessori, influenced by the work of Seguin and other sense empiricists, organized a school for retarded youngsters in the slum sections of Rome. She trained teachers to be supervisors of the students in her 'auto-education' programme, that stressed sensory and motor training. Montessori remarkably successful in teaching the mentally retarded children to read and write, began a training programme for young normal children. Her pre-school techniques still continue to be popular.

Binet in 1905, devised a scale to identify specific ages at which children master particular skills. The scale assessed achievement and not potential according to Binet. The test was brought to the United States by Goddard in 1910, and it was revised at Stanford University by Lewis Terman in 1916. Since that time the scale has gone through a number of revisions and continues to be widely used and is the standard against which newer intelligence measures are compared.
The first world war time, during 1920 was not a better decade for the mentally handicapped. Unfortunately the serious economic depression in the early 1930s meant that the situation remained relatively unchanged until the 1944 Education Act.

After 1950 professionals began to take more interest in mental retardation. Menolascino (1977) identified a number of events that caused this resurgence of interest. First, diagnosis of the cause resulting in mental retardation focused on the differences between the retarded and mentally ill. Second, research efforts in medicine, education and psychology interestingly drew more people into the field who wished to study the behaviour of retarded people. Finally, parent groups such as the "Association for Retarded Children" (known today as the 'National Association for Retarded Citizens'), provided the impetus for increased awareness and programme development.

In the early 1960s president Kennedy made a strong appeal for special education programme development and appointed a panel to study the programme.

In 1971, International League of Societies for the Mentally Handicapped (I.L.S.M.H.) got a declaration on the 'rights of the mentally retarded persons' passed by the United Nations. Similar resolutions were passed in 1975 by other international bodies.

The treatment approach towards the handicapped from 1980 and 1990s is characterized by legislative and judicial actions to promote optimal treatment and social integration.
Historically mentally retarded children have been subjected to extremes of treatment practices which have ranged from killing and abandonment in ancient time, special status within certain religions in the past and to advocation of their individual and collective human rights in present time.

MENTAL RETARDATION - INDIAN SCENARIO

The work in the area of mental retardation in India was started less than 100 years ago. The first institution in the country was started in 1941 in Bombay.

At the time of independence (1947), there were three institutions for the mentally handicapped in India. "The Home For Mentally Deficient Children", which was opened by the Children's Aid Society in 1941 as part of their larger home for destitute children at Chembur, near Bombay. Mrs. Jai Vakil started the "School for Children in Need of Special Care" in 1944 because of her concern as a parent. "The Central Nursing Home" at Ranchi, which was established in 1934, using 'Psycho-Medical Rehabilitation' opened admission to the mentally retarded in 1946.

Recognizing the need for trained teachers for the mentally handicapped, the first training programme for teachers was started in 1955, in Bombay at the 'School for Children and Need of Special Care'. Since then three more institutions have started such teacher-training programmes.

The Federation for the Welfare of the Mentally Retarded in India was formed in 1966 (FWMR). Most
of the members of the Federation were persons from the 'All-India Association on Mental Retardation', which was formed a year earlier in 1965 at Chandigadh, at a seminar organised by the 'Punjab Parent Teacher Association for Mentally Handicapped Children'.

Since the inception of the Federation, the scope of co-ordination and the communication between various training establishment was recognized. Thus, FWMR was entrusted with the responsibility of serving as the platform for co-ordinating activities of all voluntary organizations working for the mentally retarded.

The following decades took the momentum in developing service programmes for the retarded. Total number of institutions in 1966 was 51, which became 91 in 1973.

The necessity for improvement in the protection of retarded's rights was lately recognized in different parts of the world. Contemporary was the period when "Declaration on the rights of the Mentally Retarded Person" was passed by international bodies. In India there is still no comprehensive law meant to provide the care, training, education and rehabilitation to the retarded. The Lunacy Act of 1912 was the only piece of legislation covering the mentally retarded which was modified in 1969, but still being inadequate.

Gupta in (1977) after making an analysis of the adequate legislative provisions for the care, education and rehabilitation for the mentally retarded
in other countries like England and U.S., observed that India was far behind in this respect. In 1977, Pai also pointed out that before any legislation could be introduced, a comprehensive study needed to be made about the condition of the retarded class of citizens as a whole.

The 'International Year for the Disabled Persons' observed in 1981, brought a new impetus and fresh outlook to revitalize different welfare programmes for different categories of the handicapped including the mentally handicapped.

A National Institute for the Mentally Handicapped was started in 1984 at Secunderabad to provide training for an all round development of mentally handicapped and to formulate the appropriate policies for an all round welfare of the mentally handicapped. Some efforts for an appropriate piece of legislation needs to be enacted to protect the retarded from any kind of exploitation was being exerted by the F.W.M.R. in 1987.

In December 1987, the Journal of Disabilities and Impairments which was being published in India has provided a list which includes names of 146 institutions for the mental retardates, situated in different parts of the country (Vohra, 1987). Of these institutions, some are run by the State or the Central Government. Voluntary agencies run about 40 institutions. Some institutions are also run by private organizations. Also some social groups like the Rotary, Lions, etc. have shown much of their concern for the welfare of the retarded, but still the existing facilities are far from adequate.
DEFINITION OF MENTAL RETARDATION

Definitions of mental retardation have changed frequently over the centuries and they continue to change today.

HISTORICAL DEFINITIONS -

"The Mental Deficiency Act" of 1927 in England defined "Mental retardation as a condition in which there is an arrest in the development of the brain before the age of 18 years either congenitally or due to disease or injury". 28

Tredgold, 1937 24, explained mental retardation "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 to maintain existence independently of supervision, control or external support."

One of the most famous early definitions is that of Doll (1941) 3, who listed six basic elements of mental retardation, which was widely used in the 1940s and 1950s. These are -

1. Social incompetence.
2. Due to mental sub-normality.
3. Which has been developmentally arrested.
4. Which obtains at maturity.
5. Is of constitutional origin, and
6. Is essentially incurable.

Haywood and Stedman's (1969) 10 definition focuses on the person's ability to function adequately in
society. They relate the inability to an impaired efficiency of learning. "Mental retardation is a global term encompassing over 200 etiologic conditions with one common manifestation, impaired efficiency of learning, both in academic and social areas, which results in the inability to function adequately in society".

Gunnar Dynwad (1971) defined, "Mental retardation is a condition which originates during the development period and is characterised by markedly average intellectual functioning resulting to some degree in social inadequacy".

MacMillan (1974) has identified three categories of definitions of mental retardation, biological, social and psychometric.

Biological definitions was influenced by the medical profession and included components such as disease affecting the central nervous system and incomplete cerebral development.

Proponents of social definitions viewed mental retardation in terms of societal issues and effects resulting from the interaction of the mentally retarded with their environments.

The psychometric definitions resulted directly from the development of intelligence tests. Their ease of administration and the fact that intelligence tests could compare individuals to the so called normal population made psychometric definitions popular.
I.Q. scores in such definitions became the sole determinant for classifying a person as mentally retarded.

**CURRENT DEFINITION**

The definition adopted by the American Association of Mental Deficiency (AAMD) is the one most used by educators, and at the present time, is the most comprehensive. This definition has evolved through a number of revisions (1959, 1961, 1973, 1977, 1983) which has also been accepted and utilized by the World Health Organization (WHO). In the 1983 revisions of its manual on Terminology and Classification in Mental Retardation, the AAMD defined mental retardation as "Significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behaviour and manifested during the developmental period" (Grossman, 1984).

The manual also presented additional criteria explaining the following four components of the definition:

1. General intellectual functioning is operationally defined as the results obtained by assessment with one or more of the individually administered general intelligence tests developed for the purpose.

2. Significantly subaverage is defined as I.Q. of 70 or below on standardized measures of intelligence.
3. Deficits in adaptive behaviour are defined as a significant limitations in an individual's effectiveness in meeting the standards of maturation, learning, personal independence and/or social responsibility that are expected for his or her age level and cultural group, as determined by clinical assessment and usually, standardized scales.

4. Developmental period is defined as the period of time between birth and the 18th birthday. Developmental deficits may be manifested by slow arrested or incomplete development resulting from brain damage, degenerative processes in the central nervous system or regression from previously normal states due to psychosocial factors.

The current emphasis is both on intellectual functions and adaptive behaviour in defining the level of retardedness.

The American Psychiatric Association (1987)\(^1\) has adopted the same definitional approach for its latest classification DSM-III-R, listing mental retardation as an Axis II developmental disorder beginning before the age of 18.

**CLASSIFICATION OF THE MENTALLY RETARDED**

When Esquirol (1945)\(^5\) made the distinction between mental illness and mental retardation, the field was ready to begin classifying the mentally retarded. Esquirol himself proposed the first classification system which was based on language usage,
e.g. those with no speech, those who could say a few words, and those who could speak in simple sentences.

With new developments in medicine and pathology, it became obvious that there were multiple causes of mental retardation. Accordingly a need for an etiological classification system was felt. Physician Down (1866) described three etiological groups—Congenital idiocy, developmental idiocy and accidental idiocy.

This dual classification system for mental retardation has been maintained over the years, since the advent of the intelligent test, the classification of mental retardation has been based almost exclusively on I.Q. levels.

The Table - 2 presents some of the past and present classification systems. The oldest formal system utilized the categories of 'Idiot, Imbecile and Moron'. The current system employs the terminology of mild, moderate, severe and profound.

MILD MENTAL RETARDATION [ I.Q. 50 TO 70 ]

The individuals in this category can be educated to some extent and with appropriate training they can be made capable of sustaining open employment.

MODERATE MENTAL RETARDATION [ I.Q. 35 TO 50 ]

The individual in this category can acquire a limited range of educational skills and a wider range of social skills by special training and can be made capable of performing a wide range of tasks under supervision.
SEVERE MENTAL RETARDATION [ I.Q. 20 TO 35 ]

This group of children display a higher incidence of physical disabilities than the mildly or moderately retarded and tend to have severely impaired language development. With intense training their level of dependency on others can be significantly reduced.

PROFOUND MENTAL RETARDATION [ I.Q. Less than 20 ]

This group suffers from the gross impairment of language, motor and sensory development and display a higher incidence of physical defects. They can be helped by specialized treatment to slow down the process of deterioration.

CAUSES OF MENTAL RETARDATION

The mentally retarded children suffer some defects of brain cells before or after birth, which hold them back from achieving as much as normal children.

Causes of Mental Retardation may be divided into those cases which are primarily genetic (Hereditary) and those cases which are non-genetic in origin (Environmental) with equivalent terms like primary or secondary; congenital or acquired.

Genetic factors include chromosomal abnormalities, dominant, recessive and polygenic forms of inheritance. Environment factors include prenatal, peri-natal and post-natal condition associated with or probably contributing to intellectual impairment.
GENETIC FACTORS

Genetic factors are transmitted by the parents, through the chromosomes which are microscopic units of protein particles. Genes are constituents of chromosomes and undergo severe distortion of their structure during the process of cell division. This process is known as Mutation.

Consanguineous marriages (marriage between blood relations) increase the risk of mental retardation.

1. The genes can be recessive that is - skipping a few generations or dominant, transmitting directly from the parents to their children generations; and multiple recessive genes are responsible for milder degree of mental retardation, e.g. All single recessive genetic transmissions are found in condition like 'Phenyl Ketonuria', 'Galactosaemia', 'Amaurotic Family Idiocy', Gargoyleism'.

2. The dominant genes are responsible for such condition, such as 'Tuberous Sclerosis', 'Naevoid Amentia'.

3. Abnormal number of chromosomes are seen in condition such as 'Down Syndrome', 'Turner's Syndrome', etc.

4. Anomalies due to unknown genetic mechanism are seen in 'Microcephaly', 'Hydrocephaly', etc.
ENVIRONMENTAL FACTORS -

A] PRE-NATAL PERIOD:
Conditions that occur during mother's pregnancy.

1. Hypoxia - As in maternal anaemia or diabetes or bleeding or placental anomalies.


4. Irradiation - Atom bomb effect, X-ray screening of abdomen of pregnant women.

5. Malnutrition

6. Rh incompatibility

7. Syphilis to mother

8. Hypertension during pregnancy


B] PERI-NATAL PERIOD:
Conditions that occur at the time of birth of a child.

1. Pre-mature birth.

2. Trauma - Abnormal delivery, Prolonged labour can damage the child.

3. Hypoxia - Heavy maternal sedation, blocked airway of neonate.
C] POST-NATAL PERIOD:
Conditions that occur after the birth of the child.

1. Anoxia
2. Hypoxia
3. Trauma - Fall on head, accidents
4. Infections - Meningitis, encephalities
5. Drugs and poisons - Lead, Mercury
6. Metabolic - Hypoglycemia, Dehydration
7. Poor nutrition

In large series of case studies by Sinclair (1972) pre-natal causes accounted for about 40% of causes, perinatal factors for 20% of cases, post-natal factors for 15%, multiple factors for 5%, while the unknown cause is 20%.

SOCIO-CULTURAL FACTORS FOR MENTAL RETARDATION IN INDIA -

1. Consanguineous marriage
2. Malnutrition
3. Poverty, Ignorance and Illiteracy
4. Poor antenatal, natal and postnatal care
5. High incidence of pre-maturity, and low birth weight.
6. Frequent infection and late treatment of a disease.
7. Poor utilization of health service even where freely available.
TABLE - 2
CLASSIFICATION SYSTEMS OF MENTAL RETARDATION

<table>
<thead>
<tr>
<th>SYSTEM</th>
<th>GENERIC TERM</th>
<th>INTELLIGENCE QUOTIENTS</th>
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<tr>
<td></td>
<td></td>
<td>95 90 85 80 75 70 65 60 55 50 45 40 35 30 25 20 15 10 5 0</td>
</tr>
<tr>
<td>Amer.Assoc.for the study of the Feebleminded(1921) (Old name of Amer.Assoc. on Mental Deficiency - AAMD)</td>
<td>Feebleminded</td>
<td>Moron</td>
</tr>
<tr>
<td>Amer.Psychiatric Assoc.(1952)</td>
<td>Mental deficiency</td>
<td>Mild or slightly mild</td>
</tr>
<tr>
<td>World Health Organization (1954)</td>
<td>Mental subnormality</td>
<td>Mild</td>
</tr>
<tr>
<td>Sarason and Gladwin (1958)</td>
<td>Mental subnormality</td>
<td>Mental retardation</td>
</tr>
<tr>
<td>Mental Health Act (1959) Great Britain</td>
<td>Mental subnormality</td>
<td>Subnormality</td>
</tr>
<tr>
<td>Educational Systems (General)</td>
<td>Mental retarded or mentally handicapped</td>
<td>Dull-normal or educationally handicapped(EH)</td>
</tr>
</tbody>
</table>

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