Chapter Three

THE FAMILY OF THE MENTALLY RETARDED:
A REVIEW OF LITERATURE

Family of the mentally retarded child

The fate of the mentally retarded child depends on the type of family in which he is born. The child who is the only inferior member in an average or superior family is from the very beginning, exposed to discrimination as an inferior member of the group. Discouragement, contempt, and neglect fostered by the parents on the retarded child enter into the emotional and mental development of the child from early infancy and the child is unable to respond adequately to his environment and return affection and attention with equal currency, and thus the child finds himself exposed to early isolation and exclusion. Such a child is often a source of embarrassment to the other members of the family who react to his presence with shame and many try to hide the fact of his existence. Parents, and teachers feel that he is 'lazy', dull or lacking in will and the child is usually treated with impatience. Thus, he develops an inferiority feeling and soon slows down in his attempts to cope with his environment.

The birth of the retarded child

The birth of a retarded child heralds a traumatic event within the family. The expectations which people hold
for new born babies hold a faulty conception of normalcy. Parents, according to Kanner (1963) and Farber (1960) tend to equate a normal child with a perfect one.

Clearly then the identification of mental retardation at birth or during the primary developmental years, comes at a time when parents are particularly vulnerable physically and psychologically. The irreversibility and intractability of the syndrome of mental retardation with the combination of handicapping symptoms and parental vulnerability, can create havoc within the family milieu.

The presence of a mentally retarded child in a home presents a variety of complex problems involving all facets of family life and all family members. The nature and level of mental retardation of the child, the emotional climate the parents create in the home, as well as the community tolerance for the mentally retarded, all affect the manner in which the parents plan to meet the needs of their retarded child. Mental retardation thus, should be viewed as a family problem with counseling directed towards the needs and concerns of the total family unit Edwards (1967). It is general knowledge that the level of well being and integration of the family exerts influence on the functioning of its members. In most instances, the family influence is even greater on a retarded member, due to his extended dependency on the family group for care, training and protection. The retardate requires the same
basic nurturance as normal children. Much of this nurture is best provided by the family unit; however, the family needs support from the community to carry out its nurturing responsibilities in an effective manner. How much and what kind of care the retardate needs is dictated partially by the degree of his mental limitation. In greater part, the determination is made by the abilities and capacities of his caretakers to provide the essential ingredients of affection, responsive interaction, care and training. The nature of the environment in which the retardate grows and develops is shaped by the emotional reactions of his family to his problem.

The most normal place for children to live is in their family home, and this is where the majority of mentally retarded children live too. This is where they, just as any other children, learn their fundamental lessons; where they learn to love and to be loved, to be a member of a social group and to master basic social skills. And the people who teach them are not 'professional' workers. They are the parents, their grandparents, their brothers and sisters.

The importance of the family in the rehabilitation of the mentally retarded child

Residential homes or special educative schools are so inadequately few in number and can barely reach out to a handful of these unfortunate victims of either-mental
stress, physical birth trauma, genetic aberrations, accidents etc. Whatever the mental or physical make up may be, if the individual is not thrust into a residential care unit or does not receive the beneficial effects of an educative special school designed to fulfil the needs of the various handicapped persons - it is the family in totality which makes, educates, sensitizes the individual.

However, withdrawn or mentally retarded the individual may be, the delicate thrusts of the family impinges upon the sensitive areas of his mind and though his expression may not be eloquent, his behaviour and mental framework is dynamically affected. The techniques which the parents employ in the treatment of the child, i.e. the incentives they offer, the frustrations they impose, their methods of control, together with the character of their general attitudes toward him serve as formative forces on the child's behaviour.

**Role of Parents in caring for the mentally retarded child**

The family care for the retarded child has been termed the 'ordinary service' by psychologists and doctors and family personnel. Parents all over the world get far too little help to cope with the demands made by a mentally retarded child, or to learn the special skills they may need to help them develop. Far too often find that the professional workers they meet simply do not understand their
problems.

The major approach now-a-days is to realise the importance of the family unit, and a dynamically important fact is that parents should be educated to teach their children themselves in ordinary family settings, with support from professional workers. This family service is an 'integrated' service for the mentally retarded child; it is a constant one, which is not short-staffed and which does not confuse the retarded child by removing him from their ordinary setting to receive it.

**The needs of the mentally retarded child**

The primary needs of the mentally retarded child are physiological, that is, to be fed and kept comfortable. In addition, there may be a primitive contact need, for he usually demonstrates greater contentment if he is handled or held, or, rocked or caressed. These needs are no different from those of the normal infants, but the normal infants needs change with maturation, and in the case of the retarded child the needs remain basic throughout his life. Consequently the burden of such children upon their parents is a life long one and may well prove to be traumatic.

The needs of mentally retarded children tend to become more varied and complex as the extent of retardation decreases. The mildly retarded child has virtually all the needs found in persons with normal intelligence; needs for
acceptance, approval, achievement, love, sex and nurturance, for example. Like the normal child, he goes through all the stages of emotional growth, except that he remains longer in each stage, because of his immaturity, which is a result of the slower development of his nervous system.

The mildly retarded child experiences greater difficulty in giving up present gratification and modes of adjustments for more complex levels of interaction. His perceptions and motor responses remain vague and diffuse longer than those of a normal child; his skills develop slowly and much practice is often necessary to reinforce them, Beck (1966). He remains dependent on his parents long after normal children have begun to take care of their own physical needs, or venture out into the neighbourhood or exhibit other independent behaviour. He develops control over his impulses slowly, and often his tolerance of frustration seems hardly to increase at all. Weaning and toilet training are necessarily delayed (because of biological immaturity and his inability to understand his mother's requests) and may be accomplished in an atmosphere of such pressure and anxiety that he has frequent lapses and is vulnerable to further regression for the rest of his life.
The school going mentally retarded child

As the mildly retarded child approaches school age or is enrolled in the early grades, his limitations become more apparent and the differences between him and other children are more pronounced. If such a child is put into a normal children's school, it is likely to have a totally shattering effect on him. Perception, even in the mentally subnormal, can be sharp, and to interact with individuals totally different from him, and live twenty four hours on the ridicule of others can have a more severely retarding effect on him.

The gap widens between the retarded child and his peers as he reaches puberty; he is not able to converse at their level, is not accepted into their interest group, and is left behind as the others go on to high school. Younger siblings have begun to 'catch up' with or even surpass him. He is expected to make vocational plans, yet has not mastered the rudiments of social adjustment at the grade school level. Because of his dependency and limitations, he is even more the victim of parental and community attitudes than the normal child. He reacts to the retardation as it is interpreted and communicated to him. He often develops a poor self concept and thinks of himself as being a 'bad' person because there is a discrepancy between his level of aspiration and capacity for achievement and because he experiences repeated
failure and few successes and rewards. He feels guilty about his failures and tends to anticipate rejection.

The retardate's role

The retardate's role as a member of the total family system is no less important. He has similar needs to establish satisfying interactions and relationships with his family members. Obviously this presumes the retardate has at least nominal capacity for intellectual and affective behavior. Retardates generally need assistance in forming interpersonal relationships and in learning appropriate role behavior. They frequently suffer from limited social experiences and are further handicapped by the social rejection or negative attitudes expressed to them by other people. The stresses emanating from their mental handicaps make them a more vulnerable group to behavioral and personality disorders. Given a warm, accepting family, the retardate can learn to fill a useful and compatible role. If respected and perceived as an individual with emotional capacity and some ability for learning (though at a slow pace and on a lower level of abstraction), the retardate can be given his own responsibilities which contribute to family functioning. Behaviorally, the retardate can be expected to take on accountability for his actions within the limits of his mental ability. His needs and potentials as a growing,
developing, and maturing individual provide guidelines for his parents and siblings for assessing and assigning tasks to the retarded member. Virtually all parents react with extreme shock and disappointment to the shattering news that their child is mentally retarded. Menolascino (1970) and Wolfensberger (1967) have postulated that there are three kinds of crises that are precipitated by this news.

The initial shock and the novelty crisis

The novelty crisis results from a sudden change in the parents' conception of themselves, their family structure, their psychological and economic resources and their future. All parents look forward with a great deal of fervour and anticipation to watching their child develop in a normal, predictive manner and overcome the maturational milestones one by one. With these expectations, it is not unusual to imagine the acute shock and disappointment that the parents experience when they are informed about their child's handicap and the irreversibility of the handicap. In the words of one parent, 'it's as if like being informed that the child is dead', [Edwards (1967)], all the hopes and dreams of the parents are shattered and the parents have to begin to rebuild their world in the light of this tragic reality.

The severity of the initial emotional reaction varies widely from one set of parents to another as proposed by
Farber's (1968), extensive research with retarded children. Some parents are healthy, well adjusted, and functioning at an effective level, while others may be poorly adjusted, neurotic, or psychotic even prior to the birth of their retarded child, and obviously, their reactions to the pervasive trauma of having a retarded child are going to be colored by their own personality and attitudes.

**Parental reactions at diagnosis period**

One major determinant of the reaction of the parents is the circumstances in which they learn about the child's retardation. The majority of mental retardation cases are diagnosed at birth or very shortly afterward, and hence, most of the severe traumatic reactions occur at this time, as the parents had little prior warning that anything was wrong. Early diagnosis is precipitated by obvious features of retardation being prevalent in the retarded child, Adams (1960). Other forms of retardation are however not diagnosed at birth, and the diagnosis is made on the baseline of retarded language or motor development. This process of gradual discovery, according to the studies conducted by Tizard and Grad (1961) can have the effect of reducing the emotional reaction, although often the thought of mental retardation does not occur to parents until it is suggested by the family doctor of pediatrician.

The way the medical personnel breaks the news to the parents is another crucial determinant of the extent of the
novelty crisis, Kirk (1970). According to Waskowitz (1959), and Adams (1960), a common grievance that parents have is that they have been badly handled by the professionals and most of the complaints cluster around the callous manner in which they were first informed of their child's handicap.

Tizard and Grad (1961), interviewed 80 mothers of children with mental retardation, to determine the circumstances under which they first learned of their child's condition. Only 7 parents were told when the physician first suspected mental retardation. Twenty eight of the medical personnel told the parents at some later time, and 39 physicians never informed the parents at all, leaving them to find out for themselves that their child was retarded. Virtually all the mothers interviewed agreed that the physicians were callous in their attitude towards explaining the nature of the handicap to the anxious parents. The interviews further postulated that the medical personnel ought to tell a parent as soon as mental retardation is suspected, rather than putting it off.

The role of the physician

A major reason for this unfortunate situation is that most physicians feel uncomfortable about the subject of retardation. Most physicians admit little experience with retarded children, and have no idea how to treat them,
Obshanokey (1964): Johnson (1970) and Hewett (1966), in a survey of physicians, found that many regarded a retarded child as totally unchanging and helpless.

As recently as the 1960's, 40 per cent of the physicians surveyed by Kirk (1961), felt that immediate institutionalization was the appropriate recommendation for parents of retarded children, and only a small percentage felt that the decision to institutionalize the child was the responsibility of the parents, rather than the medical personnel. A small percent of the practitioners also reported inaccurate information regarding the nature and details of mental retardation.

In defense of the medical profession, Obshanokey and Johnson (1970), point out, that much of the animosity that parents feel toward professionals is certainly due to the fact that they are the ones who have to inform the parents of the bad news, and messengers of bad news have often been scapegoats. Undoubtedly, many parents blame the doctor because the doctor is unable to help the child, and others blamed the doctor irrationally as a result of their frustration and hostility towards the retardate, Sinches (1963).

The crisis in personal values

The novelty crisis is short lived, but after the parents have overcome the initial shock, they begin to
The values crisis as displayed in studies, by Rothstein (1964), Bammeister (1964), Kirk (1970), comes about because the parents are in a situation of conflicting values. Virtually all parents have been socialized to the idea that they must have, cherish and protect their child no matter how the child turns out. On the other hand, the whole concept of mental retardation is unacceptable to most people. This attitudinal framework has been observed in studies of perceptions of parents of retardates by, Alexander and Selesnick (1966), Bandura (1966), and Farber (1960).

There are several characteristic responses to this ambivalence. Some of these reactions are indications of poor adjustments, such as excessive guilt or sorrow or the overuse of defense mechanisms such as denial or overprotectiveness, Tizard and Grad (1961), Kirk (1960), Rothstein (1964), Farber (1960). On the other hand, many parents are able to resolve their conflict and fully accept their child for what the child is.

**The Effects on the Family**

The syndrome of psychological stress

The impact that the handicapped person has on various aspects of family life has attracted much attention over the past 20 years, Grossman (1973), Farber (1960), (1968), Kirk (1966), Karner (1953), Berkson (1967), Baumeister
References to the psychologically damaging effect of the handicapped person on other family members abound in the literature. Reactions of guilt, over protection, rejection and non-acceptance are predicted for parents. Holt (1963), in a study of the effects of a severely mentally handicapped child on the family, considered the emotions of guilt and shame as very noticeable in most parents, although how these emotions are defined or measured is not very clear.

Where attempts have been made to measure emotional response to the handicapped family member they have largely depended either on subjective evaluations by third parties or the use of attitude inventories or questionnaires, which are difficult to interpret because of limited information about 'normal responses', as postulated by Farber (1968), Leland (1965), and Smith (1966), in spite of this, the lack of the handicapped child on the psychological state of the parents still persist.

Recognizing the syndrome of psychological stress in the parents of the retarded, it might be expected that, if the psychological disruption created by the handicapped child is as great as literature postulates, there would be a higher than average reported level of psychiatric symptoms among parents. Smith (1966) reported that in his studies, 40 per cent of the mothers of retardates interviewed, reported current psychiatric symptoms and 17 per cent had already been hospitalized for psychiatric
treatment in the previous years. Similar findings were reported by Jackson (1978), Farber (1960) and Farber (1968). Holt (1968) postulates that all parents of handicapped children suffer extensive psychological and emotional damage for which they require the services of doctors and social workers.

**Parental coping mechanisms**

Parenthood, as postulated by Gramm (1961), Stoddard (1969), Sheimo (1951) and Kirk (1967), related to handicapped children, is associated with a number of anxieties, defences, distortions and misconceptions. Parenthood is also often selfish and parent centered needs may be satisfied under the guise of child welfare. One of the basic maxims in parent management is that most parents are satisfied if they get an adequate feedback from the retardate in terms of the retardate's psycho-social functioning. Parents, as reported in studies by Fredrick (1967), Tizard (1961) and Rothstein (1964), do not feel free to love their child unconditionally, and often love and attention is contingent upon the child's measuring up to his age mates. A retarded child can deprive parents of the sense of certainty, however unrealistic, that they might have felt with a normal child in regard to the future. On the other hand, the situation may also give them another kind of uncertainty, one of woes, trials and misery, unto their death or that of the child, so that they may look upon either as a welcome
Guilt as a dominant attitude

The parental reaction mentioned by the largest number of writers is guilt, Wolfensberger (1967), Stone and Stang (1952). Guilt, and the accompanying emotion of shame, is the feeling that one experiences when one has done something wrong. These feelings of guilt and shame are quite irrational in the case of giving birth to a retarded child. The guilt reaction may be particularly strong if the retarded child was not wanted, or it can be magnified by the obsolete notion that most retardation results from genetic or hereditary factors, implying that the birth of a retarded child is a sign of 'tainted stock', Rothstein (1964), Baummeister (1966) and Hewett (1966). As displayed by a series of studies conducted by Olshansky (1962), most parents feel guilty not about having a retarded child but about their own reactions toward their retarded child. Olshansky (1962), postulates, that a parent who is having difficulty working out his conflicts in values and occasionally feels resentment toward, or gets angry at the retardate, may feel extremely guilty about experiencing such strong negative emotions towards a helpless individual.

One of the overt symptoms of shame and guilt is that the parents seldom discuss their child's retardation either among themselves or with neighbours and relatives,
Kramm (1963). Maloney (1958), on interviewing parents of children with Down's syndrome, found a number of families where the husband and wife never discussed the child because of the intense emotions involved. As an extreme example of such behavior, as postulated by Kirk (1970), in earlier times, it was customary for families to institutionalise a retarded child and to tell other people that the child had died.

The researchers in the field of mental retardation, imply that parental guilt is usually without a reality basis and leads to maladaptive or nonadaptive behavior. The researchers also feel that a little bit of guilt may go a long way in motivating a parent to provide the extra attention, effort and even love a retarded child needs.

**Denial as a reaction**

Another reaction of parents to the discovery that their child is retarded is the defense mechanism of denial. This denial, as proposed by Farber (1968), takes many forms. One relatively harmless version is referring to one's son or daughter as a slow learner, or even brain damaged or autistic rather than mentally retarded. A more serious type of denial is the refusal to admit that the child's condition is probably incurable and that the child will never be self sufficient, Kirk (1970). A classic manifestation of this is going from one specialist to
another trying to get a more precise diagnosis or searching for some miracle cure. Kirk (1970) described a number of cases where parents of retarded children would simply go on contacting physicians and schools. Maloney (1958) postulates that seeking a second opinion from physicians or educators is reasonable, but continuing to run from pillar to post is clearly an irrational strategy and is a demonstration of the parent's inability to face reality.

**Overprotection as a dominant attitude**

A frequently described pattern of parental behavior is overprotectiveness. Some parents, usually mothers, as reported by Alexander and Selesnick (1966), devote all of their time to retarded child to the exclusion of the other children or the spouse. They consistently treat the child as if the child were less capable than he or she is such parents, as also demonstrated by Solnit and Stark (1961), give up all their social life and all other interests to care for the retardate. One interpretation of this behavior is that it is a type of reaction formation. Reaction formation is a defense mechanism in which one denies an unacceptable impulse by emphasizing its opposite.

Boles (1939) in a well controlled study found mothers of cerebral palsied and retarded children to be highly protective. Kook (1973) found overprotection to be a function of degree of improvement to some extent independent to the
kind of handicap. Many writers construe over-protection as an indicator of underlying rejection, Boles (1939) and Kook (1973). Roos (1963) prefers to interpret this in terms of ambivalence. The retarded child, by virtue of his prolonged dependency demands, may elicit dominant child rearing attitudes almost by necessity. Thus high protective ness may or may not be an adaptive and desirable dynamism in the parent.

The dominance of sorrow

Olshansky (1962) has postulated that almost all parents who have a retarded child suffer chronic sorrow throughout their lives. Olshansky (1962) however emphasized that this sorrow was in no way a neurotic reaction but is a perfectly natural and normal response, although most parents try to hide their depressions and sorrow. Other writers of a psychoanalytic orientation, Solnit and Stark (1961) have reported similar reactions, such as grief and mourning. They suggest, that in a sense the reaction of a parent to the knowledge that their child is retarded is similar to the reaction of a parent who loses a child through death.

Ambivalence as a reaction

Ambivalence is another readily understood reaction a parent may undergo; on one hand, handicap in a child is almost certain to make for disappointment, grief, frustration, and anger in a parent who will occasionally have
these feelings even about a normal child, and on the other hand, the impulse to love and protect the young is deeply rooted in human values or instincts. This has been reported in studies by Grebler (1952), Zuk (1962), Parmalee and Koch (1959). According to Schild (1964) ambivalence is a never completely resolved conflict and is stored up again by each new crises.

Frustration as a principle reaction

In parents of handicapped children, Grebler (1952) saw frustration as a result of social and aesthetic stigmata, lack of services for the retarded, financial demands, slow maturation of the retarded and the inadequate feeling that the stream of the generation is stopped.

According to Zuk (1962) parental reactions fall into three major categories of frustration, anger and guilt. One of the causes of guilt is seen as denial and inward turning of anger.

Gralikar, Parmalee and Koch (1959) interviewed parents in 67 families who had obtained diagnostic services in a clinic. They found 48 per cent to display shame, guilt and frustration as a result of the diagnosis, and 30 per cent to be grossly anxious about the reactions of the relatives and siblings.
Chronic emotionality as an unhealthy parental reaction

The idea that the intense and often chronic emotionality of some parents may be understood as an outcome of grief and mourning has since become widely accepted and elaborated, Roos (1963), Holt (1958) and Tizard (1961). Roos (1963) in his studies on parental attitudes of handicapped children, reported that feelings of guilt, depression, shame and anger may be interwined with chronic sorrow. These reactions often become pathological in nature and interfere with parental coping and unjuvstive mechanisms.

An almost indefinite variety of initial or early reactions have been described or mentioned in the literature and range from alarm, ambivalence, anger, anguish, anxiety, avoidance, bewilderment, bitterness, confusion, depression, despair, disbelief, embarrassment, envy, fear, financial worries, helplessness, mourning, regret, rejection, remorse, self blame, shame, shock or suicidal impulses.

Dunn and Epstein (1963) point out that parents may concurrently be depressed about their disappointment, guilty about their responsibilities and ambivalence, angry about the injury done to them, and anxious about the child's future.

The significance of parental acceptance

A great deal has been written about parental acceptance of retardation or the retarded child. Parmelee and Koch (1959), Zuk (1962) and Gralikar (1959) rated the level of
parental acceptance by judging on three criteria of interview behavior, display of minimal defensiveness about the child limitations, and neither obvious rejection nor fostering of overdependence.

According to Adams (1960), Hersh (1961) and Hewett (1966), the initial rejection of a retarded child may undergo a subtle change in that the baby is physically accepted, but its defectiveness is denied. At the same time, as purported by Hersh (1961) and Hewett (1964), the parent's also manifest an overcompensating love that sustains the denial.

Parental awareness or acceptance of retardation is crucial in the training, management and subsequent improvement in the retarded child's behavioral or adaptive patterns. Writers like Sheimo (1951), Cummings and Stock (1962), report that the advent of a retarded child can induce a high drive state in the parents, that can be channeled and utilized in a constructive fashion.

Many parents are also able to successfully resolve their crisis in values and accept their retarded child for what the child is. This process of acceptance, according to Taylor (1964), Ieland (1965), Berkson (1967) and Bandura (1967), involves a number of characteristics:

a) The accepting parent is able to accurately assess the retardate's abilities, weaknesses and growth potentials.
b) The accepting parent is able to view the child's retardation realistically, and not being overwhelmed with self pity, guilt or chronic emotionality.

c) The accepting parent should attempt to provide the best possible medical, educational and recreational services available within their means, without neurotically searching for a miracle cure.

d) The accepting parent should attempt to provide nurturant care to the retarding, neither rejecting, nor overloving the retardate. Other children, on the spouse should not be neglected and the retardeate's developmental process should not be shunted by overwhelming pity or love.

This concept of acceptance involves striking a balance between recognizing the retardate's disabilities and making compensations but not permitting the handicap to overrule family interactions.

The Reality Crisis

As postulated by Menolascino (1967) and Wolfensberger (1967), the third crisis the parents of the retarded child have to encounter is the reality crisis. Together with the emotional trauma the parents face unto a number of concrete concerns. As displayed in studies by Wolfensberger (1967), Farber (1964), the first of the reality concerns is the financial problem. Many retarded children have medical problems that require treatment or remediation.
Most parents are also obligated to find private training and education for their retarded child. Other realistic concerns, as proposed by Hewett (1966) include the way that relatives, neighbours and normal siblings accept the retardate. The parents may develop a satisfactory acceptance of the retarded child, but the traumatic and emotional influences of the social environment and the inadequacies of remedial and therapeutic facilities for the retarded, hamper the adjustment to the child's retardation.

Studies by Cazden (1972), Cegelka (1970) and Goldstein (1965) display that parents report a concern about the long term care of the retardate. A constant worry is what will happen to the child after the parents are no longer able to provide proper care. Most parents, according to Cazden (1972 are familiar with the poor quality of the care provided in many of the traditional state institutions and legitimately fear that their child will have to be placed in such a location.

Holt (1958), in one of the most thorough research projects on the families of retarded children, painted a very negative picture. He interviewed 201 sets of parents in England to determine how the presence of a retarded child in the family affected them. They also postulated that they (the parents) had to provide continuous care, which was a tremendous strain. 63 of the 201 children assessed were diagnosed as destructive, aggressive, hyperactive and
required constant supervision. 21 of the sample retardates required attention at night, which meant that the parents, particularly the mothers, never got a full night's sleep. In 40 per cent of the families, the parents revealed a low marital integration level. A large number of the mothers showed signs of tremendous strain. They were in poor health, continually exhausted, and showed signs of acute stress. Several required hospitalization for these symptoms and two had actually threatened suicide.

Barsch (1968) interviewed 177 parents of mentally handicapped children of Milwaukee. These parents however displayed little indication of guilt or shame and showed a positive acceptance of the child's retardation. Because of the discrepancies between these studies, it is difficult to draw many firm conclusions beyond the fact that some parents are able to adapt to having a retarded child with few disruptions, while for other families, the presence of a retarded child is a major disruptive influence.

Development of theories of parental reactions

A retarded child is regarded as having injected the potentiality of crisis into a milieu of interpersonal familial relationships. Once the parent considers his child as mentally retarded, he must reevaluate the efficacy of the norms and roles in the family for meeting the adverse situation of having a retarded child. Only when the parents
perceive the child as mentally retarded and define their present norms and resources as inadequate, does the crisis develop.

A number of theories have been postulated to account for the parental reactions of a handicapped child.

**Farber's theory**

Farber (1968) considers two kinds of 'crises behavior' among the families of the retarded. In the tragic crises, the aims, aspirations and anticipated 'adjustive' family life are frustrated. Since the retarded child himself is identified as the reason for the family frustration, hostility tends to be directed towards him.

While the retarded child is regarded as the precipitator of frustration, various factors prevent the parent from acting aggressively against the child. First, the parent cannot regard the child as having become retarded intentionally. Secondly, the parent may even view the child's retardation as only one link in a chain of events resulting from the parent's own activity or personal attributes. Hence, the parent cannot easily rationalize his hostility toward the child, he is motivated to continue in his parental role of providing love and care for the child.

In the role-organisation crises, the predicament facing the parents is not one of frustration of aims and aspirations but one of coping with a seemingly interminable care
problem during which the normal family life cycle is arrested. Ordinarily, mothers with normal children can visualize that eventually the children will achieve independence; the mother with the mentally retarded child faces a prolonged infancy period and the prospect that socially the child will never achieve adulthood.

Essentially, whereas the tragic crisis develops mainly through the emergence of problems regarding ends of family life (i.e. aims, aspirations, values) the role organisation crises is concerned with the inability to organize a system of workable roles or means. The presence of a system of workable roles implies an ability to control activities of the individual members. Hence, unlike the tragic crises, role organisation crises occurs in the wake of what is regarded as controllable by the family members.

Kanner's approach to the family crises

Stemming from the crises behavior the family adopts, the retarded child's development evokes several patterns of response from parents. Kanner (1953) found that the parents of mentally deficient children characteristically react by acknowledgement, disguise or denial of the child's conditions. The first response, of course is the mature one. The parent accepts the reality of the child's retardation and recognizes his limitations. He approves of the needs of his retarded child, as well as those of the normal children, and tries to fulfill them.
In the second response, the parent tries to hide from himself the existence of his child's limitations. Such a parent often engages in a continuous search for a doctor, treatment, regime or miracle that will restore his child to normal, he ignores the recommendations he dislikes. This reaction contradicts the best interests of the retarded child. It puts him under pressure to perform at a level that is impossible for him to attain and he becomes frustrated and anxious. As a result, he is unable to make a comfortable adjustment and becomes increasingly incapable of using the limited resources he has.

In the third response, the parent is unable to accept the reality of the child's retardation and flatly denies it. He expects the child to meet the standards of normal children. He may become rigid and a persistent disciplinarian, punish the child for failures and fail to perceive his successes, which may result in severe emotional problems.

No doubt the birth of a retarded child causes frustration and destruction of decisions and plans for the future. The initial impact may take some sort of a transient stress disorder, particularly for the parents, or it may even have a permanent debilitating effect on the entire family unit.

Stringham's theory of parental responses

Stringham (1964) postulates that whether or not an event becomes a crisis depends on three basic conditions -
(a) The nature of the event (severe/mild), (b) resources of the family, and (c) how the family defines the event.

Primarily, the degree of severity is an important variable. In the mild ones - the parents may be unaware of the child's handicap unless he meets academic failures. In severe cases - the degree of severity is obvious and probably easy to acknowledge rather than to accept. The socio-economic and intellectual levels of the family may be factors in the degree of impact in mental retardation. Chinn in discussing the limited family suggests that there exist a number of united families in which the retarded child's intellectual limitations do not set him apart from the rest of the family. In these families, parents as well as siblings have intellectual limitations. In such cases however, guilt, anxiety, ego threat, or despair about the future are seldom evident.

Rosen's theory of the stages of parental response

Rosen (1966), postulated that the reactions to the advent of a retarded child into a family may vary according to the individual's family unit, particular religious orientation, and whether or not the child was wanted in the first place.

Rosen has suggested five stages through which many parents of retarded children progress from the time they first sense or become aware of a problem until the time
they accept the child for what he is.

These are - (a) awareness of a problem, (b) recognition of the basic problem, (c) search for a cause, (d) search for a cure, and (e) acceptance of the problem.

Rosen points out that a child represents the extension of the parents self, and the birth of a defective child can represent a serious threat to the parental ego (Hayes and Kovaceous (1964)). Parents hope to see the child achieve physically, educationally, professionally, and financially. Parents also have tendencies to feel that they can transcend death through their children. Their children can provide them with a legacy and measure of immortality. This can create further frustration.

According to Rosen (1965) the most often, utilized defence mechanism by such parents is 'denial'. Appel (1964) suggests that this common reaction especially during the initial stage of adjustment, provides a form of self protection. Because of this attitude there is a tremendous delay in treatment and stimulating educational programmes - being meted out to these children.

Begab (1965) suggests that parents consciously or unconsciously wish the death of the child or immediately institutionalize them. This reaction leads to a form of even neglect and hostility of the parents towards the retardate. Rejection is another form of reaction against the retarded
children. Often there are instances of the child's behavioural patterns which exceed the tolerance level of the parents. Gallaghar (1958) lists four expressions of rejection:

a) There are strong under-expectations of achievement. The child is so underrated that even positive values are ignored.

b) There is usually the setting of unrealistic and unattainable goals for the children.

c) There is often complete desertion of the child. This may take the form of abandonment or immediate institutionalization of the child.

d) The parents may try to overcome their feelings of rejection with overprotection and care which can mean tension for the family unit as a whole - especially the normal siblings.

The 'family care' approach

The gradual development of the view that the ideal place for the care of the mentally handicapped person in his or her family home was in part a response to the realization that providing institutional care for all mentally handicapped would be costly and detrimental to the retardate's mental health. Bowlby (1952), summarised a number of studies of children in institutions, in the
1940's and early 50's, as compared to those living at home and attributed the slower rate of development among the former to the absence of maternal affectional bonds.

By the 1960's evidence accumulated by Krik (1967), Zuk (1961), Ingram (1969), Reuss (1965) and Thorpe (1962), clearly showed that retarded children raised in small family like settings made more progress and presented fewer behavior problems than those living in large wards in institutions.

**Two contrasting approaches to the problem**

There seem to be two basic professional and research orientations to the care of the handicapped person in the family, those based on a 'pathological' model and those based on a 'normal' family model, Thorpe (1962), Matheny (1966), Illingworth (1961) and Knobloch (1966). These start from fundamentally different assumptions concerning the impact of the handicapped person on family life, and therefore lead to an emphasis on different aspects of family organization and functioning. Clearly the birth of a handicapped child has important long term implications for the family. The retardate's presence is likely to slow down the gradual progress through the cycle of family life, and ultimately to result in its arrest, as propounded by Farber (1968). Instead of the parents eventually losing the responsibility for child care as their children grow up
and leave home, they are faced with an indefinite period with a dependent child. More immediately, the family is faced with a burden, in terms of care and management, which is beyond their expectations of 'normal' children.

**The pathological model**

Many writers, Maloney (1958), Olshansky (1962), Zuk (1961), Ingram (1969), and Kirk (1965), have taken as self evident the proposition that the birth and presence of a handicapped child will have intense damaging effects on the family as a unit and upon the individuals within it. Stringham (1964) reports, 'The development of a family life of near normal character, not only for the parents but also for the other siblings, is beyond the possibilities for most of these parents'.

The birth of the handicapped child, observed by Kanner (1952) and Appel (1964), is seen as a tragic event in the life of the family, the consequences being analogous to the consequences for the individual of the onset of an incurable disease. Kanner (1952) in a study of the siblings of handicapped children, after defining the family with a handicapped child as a handicapped family, reports that 'the handicapped family faces certain special problems which actively disrupt the normal functioning of the family and often demand a readjustment of role relationships among its members.'
This pathological model still underlies much professional thinking about the treatment, care and support of the mentally retarded and his or her family. The tendency of the professionals to advocate institutional care for the handicapped child, reported by Hewett (1964) and Simches (1963) is a reflection of this approach in professional practice. Simches (1963) sums up the dilemma that families are faced with as a consequence of the application of the pathological model in professional practice.

'If they seek to contain the retardate within the home they are open to accusations of being over protective and retarding the child's further development. If they try to maintain a normal pattern of living inside and outside the home, they are failing to 'accept' the child's handicap, seen as another sign of emotional maladjustment. If they admit their child to residential care they encounter social disapproval for rejecting him and feel a need to justify their actions to others'.

The normal family model

The other main approach to the family with a handicapped member emphasises the essential normality of the family and takes parental statements about the nature of the crisis situation at face value. Whilst it is recognized that families with a handicapped member are subject to strains and stresses, it is pointed out that a handicapped child is
just as likely as any other child to be born into a family with pre-existing strains and stresses, Hewett (1964). Hewett (1964) further emphasizes that the 'normality of' many of the problems experienced by families with a handicapped child and concludes that such families meet the day to day problems, that the retardation creates, with patterns of behavior that, in many respects, deviate little from the norms derived from studying the families of normal children. Hewett's concluding remark was that these families have more similarities with ordinary families than differences from them.

The process of defining the situation in which a family with a handicapped member finds itself, extends also to the child himself. Jaehnig (1966) in his studies found that the parents he interviewed emphasized the retardate's normality and resemblance to non-handicapped children. He emphasized that the parents described their child as a 'child with a handicap', rather than a 'handicapped' child. According to Piaget (1952), this distinction is important, as in the former term, the emphasis is on the fact that he is a child, whereas in the latter the emphasis is on the handicap.

Researchers like, Farber (1960), French and Levbarg (1953), Floor (1975), Freeman (1970) and Fredricks (1976), postulate that the profound problem of mental retardation takes its own coloring from the particular model utilized to analyse it. The research orientation is towards the adoption
of utilizing the 'normal family model'. Jaehnig (1966) postulates that the focus of attention should be drawn by the problems of practical management encountered by parents rather than the disturbance of interpersonal relations suggested by professional model, pertaining to the families of the retarded, to be their main problems.

The social effects of retardation on the family unit

One of the major issues under consideration are the relationships within the family of the retarded. One of the most comprehensive studies of the effects of a retarded child on the parents marital integration level was conducted by Farber (1968). He assessed 175 families where the retardate was living at home and 65 families where the retardate had been admitted to an institution. He found greater marital stability and cohesiveness among parents where the retardate was a girl, and when the retardate was in an institution and made periodical visits to the home. A similar trend has been reported by Dazden (1972), Garrison (1971) and Goldstein (1965).

The effect on the siblings

The major concern of the parents, is that the normal children of the family will be harmed in some way by the presence of the retarded child in the home, and this is
occasionally given an excuse to institutionalise the child. According to studies conducted by Graliker, Fishler and Koch (1962), most siblings of retarded children report greater prevalence of adjustment problems than would be expected in any group of comparable children.

Grossman (1972), extensively interviewed a large number of college students who had a retarded sibling, in order to determine their reactions. Consistent with other research, Taylor (1964), Goldstein (1965) and Adams (1960), the ability of the normal sibling to adapt to having a retarded child in the family seemed to be closely related to how well the parents accepted the problem as well as how openly the parents discussed the retarded child.

Schipper (1959), reported that if normal siblings were called upon to help coping with the retarded child, the social life of the former suffered grossly. Farber (1964) postulates that the siblings, unless they are much older than the retarded child, have no opportunity to experience a novelty crisis or a value crisis, as far as they are concerned, having a retarded sibling is not at all unusual. However, the children pick up the attitudes of the parents, and if the parents express guilt, shame and hostility regarding the retardate, the siblings are also likely to indulge in such behavioral modes.

Two further studies by Farber (1968) and Beck (1966) also reported that the normal siblings emotional adjustment
was also likely to be affected by the presence of the handicapped child.

In another study by Stoddard (1965), parents reported that the siblings had suffered adverse effects. Farber and Ryckman (1965) concluded that the retarded child's siblings were affected adversely by the high degree of dependency of the retarded child. This dependency adversely affected the siblings' relationships with their mothers in that increased responsibility was given to the siblings for the care of the retarded child.

The possible pervasiveness of the influence of a retarded sibling is indicated by Farber (1964), who related life goals to the degree of interaction of the normal with the retarded sibling. The parents of these siblings rated the 'high interactors' (the normal siblings with the retarded one) as nervous, moody, stubborn and prone to anger outbursts.

**An overview of dominant attitudes**

The attitudes of some retardation experts, as expressed in their writings, may be summarized as follows: a) the retarded child is a traumatic event, Abbraham (1958), which gives rise to grief, guilt, frustration, anger, and precipitates a crisis, Farber and Rykman (1965), Mercer (1966 and Begab (1963). This leads to a chronic sorrow syndrome which further gives rise to needs for emotional support and
life long counselling, Appell (1963) and Olshansky (1962). The parents should however, resist the desire to institutionalize the retarded, as this can give rise to feelings of guilt and self recrimination on the part of the parents, Goodman (1964), W.H.O. (1964) and Bloom (1964). Institutionalization of the retardate fails to dissipate the initial reaction of guilt and helplessness, since follow ups done even after 15 years, show emotional disturbance and unhappiness in evidence, Thurston (1963), Giannini and Goodman (1965).

The long term effects of retardation

The effects on the family in its relations with the outside world can be usefully separated into short term and long term effects. The former concerns day to day interaction between family members and others in the community, whilst the latter refer to the social mobility of parents and siblings. Research studies by Beck (1966), Evans (1954), and Silverstein (1964) have consistently reported limitations on extra familial relationships. Holt (1960) and Hewett (1964) found that most parents of retarded children were unable to go out together, and the families social contacts and outside activities were limited. Hewett (1964) postulates that the retarding influence of the handicapped child on the family cycle, and parental activities, become more apparent as he or she grows older.
Studies on the long term effects of the handicapped child on extra familial relationships are concerned with the family's position in the social structure. Very few studies have been conducted in this area. A study of the social mobility of parents of retarded children in Chicago, showed that the earlier in the marriage the child was born, the more likely this was to retard the family's social mobility, Saengar (1967). There is however insufficient research data in this area.

Practical problems faced by families with a retarded

Studies by Hewett (1964), Bayley (1960), Loeb (1966) have described in some detail the day to day practical problems that have to be faced and how these are dealt with. Hewett (1964) described the problems of physical care, management supervision etc. of families with retarded children. Problems of intravenous feeding or temper tantrums were debilitating factors in the interactional pattern of the family.

Johnson (1971) postulates that as children grow older and the discrepancies between the handicapped and the normal child grow, the mothers of the former will identify a bigger range of problems. In the early years the objective problems presented by the handicapped child can be interpreted in a framework of normal expectancies concerning the problems of caring for the young, but this becomes progressively
more difficult as the child grows older but fails to develop. Self help care for a retardate adolescent presents a range of problems. The daily burden experienced by the family of a retardate are severe and as time advances, the capacity of the family unit and the individuals within it to deal with these problems is lessened.

Material problems

There are two ways in which the retarded child may have an effect on the family's material standard of living. On the one hand, the earning capacity of either of the parents may be reduced. This may be bought about by the possible depressing effect on social mobility and therefore on the earning capacity of the father. Additional to this, as displayed in studies by Adams (1960) and Farber (1960) the effects of a retarded child are likely to determine the mother's job prospects. Supervision of the retardate, alone, takes up most of the mother's time and energy, Edwards (1967). Adams (1960) reports in his study none of the mothers of the handicapped, as compared to the group of mothers of normal children, were working full time.

Meeting the needs of the handicapped person may cause the family additional expenditure. A retarded child spells out additional expenses, like special clothing, special equipment, incontinence aids, special educative and recreational equipment, damaged furnishings etc. Tizard (1961)
concluding a series of studies on retarded children, summarised that the handicapped member does present the family with financial problems which would not otherwise be incurred.

Support from the community

Tizard (1961) in a review of services and the evaluation of services, comments that although education and to a lesser extent residential services have received a fair amount of attention, much less work has been done on the evaluation of other services. There is however an increasing tendency, among the policy makers, to emphasize institutional placement for the retardates, Bayley (1960) and Tizard (1961). Bayley (1960), referring to the experiences of families with retarded children and adults, comments that the training centres were much appreciated by families, because they provided structural help which was directly relevant to the daily routine.

Stringham (1964), also commented on the importance to families of the E.M.R. child's attendance at school, because this constituted direct support with the daily family routine. However, Bayley (1964) commented on the marked lack of services, other than education, on the community support of the management and supervision of the retardate. A series of studies by Hott (1960), Farber (1964) and Jeanne (1964) reported the great needs of families for contact with official services for management of the retardate.
In elaborating the theory and practice of community care, policy makers, professionals and research workers alike have tended to fail to recognise the existing structures of support for families of the retarded. Adams (1960), postulates, that 'understanding and help from friends and neighbours and from the community at large are needed to help the family to maintain a normal social life and to give the handicapped member as nearly normal a life as his handicap permits'.

In an extensive survey of community support for the afflicted families, Bayley (1964) revealed 70 per cent of the families to receive positive support from the neighbours. In a similar investigation by French & Levbarg (1953), reported that 60 per cent of the families were receiving frequent support from relatives, but 40 per cent were receiving minimal help from neighbours. Another study, in Northern Ireland (1962) of families whose child suffered from cystic fibrosis, reported 89 per cent of mother to be receiving some practical help from their family or friends and about a third of mothers relied on relatives or friends to help with their domestic routine.

**Community support and a need to institutionalise the retarded**

The relationship between the decision to institutionalise the retarded and the amount of support obtained from the community has received attention lately. Saengar (1957)
postulates that encouragement of community care and a supportive environment for the retardate, would enable the families to keep the handicapped members at home. He concluded that the provision of more community services would reduce the demand for institutional care.

**Effect of intervention agencies on parental attitudes**

Positive intervention may not only break up a maladaptive circularity, but may even institute a beneficial cycle. French & Levbarg (1953) documented a case in which a home management method was worked out with the mother, resulting in dramatic improvements in the intelligence and behavior of the child and concomitantly in parental adjustment.

Johnson (1971) points out the beneficiary effects of a retardation programme in Berlin where extensive rehabilitative measures, in the form of management, vocational placement, and adjustive guidance were implemented, which resulted in the psycho-social progress of the retardates assessed.

Counselling measures, for the parents, with effective instructions for the retardates psycho-social guidance, were deemed very facilitating in the retardates growth. This was displayed in a number of studies reported by Evans (1954), Gath (1977) and Loeb (1966). Evans (1954) elaborates that counselling help for the families resulted in improved adjustment of the siblings and the parents to the retardate.
The families had been assessed prior to the counselling programme to provide a baseline for interactional adjustment or maladjustment.

**Parental attitudes and progress of the regarded child's behavior**

Beck (1956) showed that the child's progress depends in good part upon the parent's attitudes. Stang (1957), postulated that it was impossible to help the retardate without helping the parents. Scott (1960) found that the parental attitudes and behavior had a direct effect on both the retardate and the normal siblings. Apell (1964) felt that a child may suffer if parents hold poor attitudes.

Scott (1960) conducted extensive interviews with 50 families whose child had attended a special training centre. Although no control group was used, the parents reported not only great improvement in the child's behavior in a number of spheres, but also in their own attitudes and perceptions.

**Effects of a congenial home**

Childrens, especially the mentally retarded ones, need love and encouragement in order to progress and be creative. The retardates, as displayed in studies by Farber (1960), (1964), Bloom (1964) and Bayley (1960) are more prone to feelings of worthlessness, despair, following rejection of parents. Devoid of encouragement and nurturance, the retardates, develop inadequate self-concepts
and sink to lowered levels of functioning.

Studies by Goldstein (1971) and Berkson (1973) revealed that retardates were sensitive to uncongenial home milieux. A rejecting attitude renders a retardate fearful, insecure and anxiety prone.

Johnson (1971), postulated, that a congenial, nurturant milieu can provide a retarded child with a basic security to develop to his growth potentials. A retarded child has certain predictive psycho-social growth potentials, which he can reach, if tended with care, justive supervision, guidance of self help skills and social grace and adequacies.

Realising the prime importance of the family unit, professionals have to perceive the family as a primary intervention agency in the psycho-social development of the retardate. The institutions and the state, apart from providing adequate housing facilities, therapeutic centres, day care creches, training centres for management and supervision, effacacious special education programmes, have also to provide counselling measures for the families. The family needs to be realised and assessed as the main intervention programme for the retardate, as social facilities are grossly few.

The need for counselling

Families afflicted with a moderately mentally retarded child, need to be counselled about the handling of the
These children can be encouraged and stimulated into learning social adaptive measures, self help skills and simple academic skills. Given this encouragement these children can lead better lives and they can become somewhat self sufficient. This is a tremendous responsibility upon the family, which it has to perform as a total unit. A single member of the family being sympathetic and helpful towards the retardate is of no help as the retardate does not benefit at all from this partial 'care', also this particular sympathetic member has a big share of the responsibility of the handling of the child and 'he' or 'she' may not be able to cope up with it. The important factor is that the child should receive help and encouragement from all members of the family, as an environment of neglect and hostility can cause the retardate to regress to lower levels of functioning. Family counselling is hence vastly important to make the family realise its responsibility. The family should also be continuously encouraged by personnel, in the field of mental retardation, as the task of caring for a retardate can be one with a lot of psychological and economic problems.

Counselling parents of the retarded

Wolfensberger (1967) and Cummings (1962), report a recognition of the counsellors that the impact of a retarded child on the family unit is an agonizing thing. Certainly, parents may need counselling at the time when the diagnosis
of retardation is first confirmed, but many parents are too distraught at that time to absorb much information or effectively face their feelings. Fredricks (1976) and Wolfensberger (1967) propose a number of sessions of counselling, spread over a considerable length of time, may be required in order to assist parents in working out their feelings and recognizing the ramifications of their child's problems. In addition as the child develops, new types of crises are continually presenting themselves.

When the retarded child first goes to school or is exposed to other social milieux, the family is faced with a host of new problems. Most counsellors, according to Stock and Cummings (1962), report that any other family crises, like illness or an economic crises is likely to be magnified by the presence of a retarded child.

**Counselling endeavors**

Such endeavors on the part of the counsellors of afflicted families can be distinguished on the extent to which they are primarily educational in function versus the extent to which they are concerned with the family's attitudes and feelings. Counselling at the latter end of this continuum resembles psychotherapy, in that, discussion of day to day reality problems is discouraged in favour of considering the parents' deeper feelings, not only toward their retarded child, but also towards themselves and their interpersonal and economic aspects. The goal in such
counselling as postulated by Cegellka (1970), Howett (1964), Goldstein (1965), is to make the parent more aware of his or her defenses and anxieties. At the opposite extreme is counselling whose primary function is to increase the parent's knowledge about mental retardation, of the causes and probable prognosis of the retardation in their own child, and of specific management techniques.

Wolfenoberger (1967), has noted a distinct conflict between parents and professionals regarding the aim of counselling, parents being more interested in the solution to practical, everyday problems such as, therapeutic handling of toilet, emotional, feeding and educative problems. Professionals, on the other hand, are more interested in focusing in on the parents' feelings. This difference in outlook is one source of parental dissatisfaction with professionals, and is often a barrier to effective counselling.

Roos (1963) in discussing effective counselling proposes that the counsellors should treat the parents with acceptance and respect, the parents should be allowed total freedom in their expression of emotions, and the counsellor should not attempt to mislead or encourage the parents by presenting an overly optimistic view of the retardates potentials, as such a strategy can lead to parental frustration and misgivings.
Professionals in the area of mental retardation, Stang (1957), Hewett (1964), Goldstein (1965), Ginzberg (1966), propose group counseling of the afflicted parents. Taylor (1964) in reviewing a number of studies found that group meetings of the parents generated a positive feeling among the parents that they were not alone in being afflicted with a crisis. These meetings also lead to the evolution of improved intervention management strategies, by the parents of the retardates. Smith (1966), proposes that group counseling leads to the break down of defenses such as denial on the part of the parents and this enables the parents group members to take positive steps towards the acceptance and rehabilitation of the retardate.

The role of stimulation and care in the rehabilitation of the mentally retarded child

Gunnar Dybwad (1964) reports that if the mentally retarded child is treated as if he has little hope for improvement, he will not improve. If he is provided with the opportunities of learning and is encouraged, he will function at a higher level. His strengths should be reinforced rather than ignored. Assessment and re-assessment of the child should be continuous.

What seems inherent in the vast literature of mental retardation is that these victims require stimulation and care and as the number of special educational schools catering
to them is grossly inadequate, if falls upon the family, the primary-socialization and intervention agency, to carry on the upheaval task of inculcating basic self help skills and social adaptive measures within the retarded child. If the family, within its protective co-oon, ridicules and neglects such a sensitive and retarded child it is very probable that the child will sink deeper into his retarded shell. Patterns of scorn, ridicule, grief, neglect, pathogenic anxiety all directed towards the retarded child are vividly imprinted upon his brain and this can lead to fresh complication in the rehabilitation of the retarded child. Hence, it is very imperative for the family - (that is, the functional family group, the living unit comprising of all those who live together as family under a single roof) to revitalize its resources and try its utmost to stimulate the child and improve and maximize his basic potentials.

Review of Indian Literature

Mental Retardation literature now contain ample material on problems and issues like medical research of mental retardation, the clinical pathology of mental retardation, the various syndromes of mental retardation, survey, care, training, guidance social services catering to the retarded, rehabilitation programs etc. A thorough scrutiny of the Mental Retardation abstracts published in India has revealed that the family study of the mental retarded has been neglected and is yet almost a virgin
field in India.

**Scarcity of Family Studies**

It has been observed that the tragedy of a mentally retarded child is always greater for the parents than for the child himself. In view of this, while scanning early literature one is struck by the fact that very little mention is made of parents, of their attitudes, feelings and sensibilities; or of the impact of the stigmata of diagnosis of mental retardation on them; or the gross impact of coping up with a retarded child.

**Outline of Certain Studies**

Prabhu (1968) attempted to point out the role of the parents participation in the services for the mentally retarded. Theoretically the paper assessed that there are several ways by which parents can take an active role in the programme for the retarded and some of them could even involve starting schools and workshops for the retarded. The parents of the mental retardates can form themselves into groups like 'Alcoholic Anonymous' or 'League of desperate individuals' etc. These groups can meet and discuss the problems that come up to them and thus with their previous experience guide the new cases to a fruitful solution.
In another study Prabhu (1970) outlines the counselling procedures to be meted out to the family of a mental retardate. These procedures involved putting forward certain stimulation and encouragement programmes by the family for the mental retardate.

Stringham (1964) in his paper, postulates that a retarded child has the same basic needs such as love, acceptance, security, protection, independence, faith, guidance and control. These basic emotions must be fulfilled by the retardate's family members.

A series of studies conducted by Mcconnel (1976) in Ahmedabad were centred around special educational and therapeutic aids for the retardate. Aspects of the retardate's initiation to school, revision of curricula were extensively undertaken by Mcconnel. An effort was made by Mcconnel (1977) to incorporate certain counselling measures for the parents in the school curricula. A similar trend was also perceived in Indian studies by Sinclair (1966), Ian and Zooki (1969), Das (1968), Dasgupta (1948), Srivastava (1970), Gupta (1970).

Minimal emphasis has however been observed in the area of assessing the family resources and dynamisms of the retarded children. The family emerges as the main intervention unit of the retarded, in a country, where educational training and therapeutic facilities are minimal. An assessment of the family dynamisms and resourceful planning related to a positive functioning of the retarded children need to be undertaken. An understanding of the family dynamisms would lead to the development of efficacious counselling measures for the families to be undertaken at the personal or institutional level.

To fill the research gaps within the Indian setting the present research was undertaken. The study affords an insight into the dynamisms of the family of an E.M.R. child attending a special school. To partial out the dynamic, maintenance and management role of the family the study was conducted on a longitudinal model in two phases. Phase I involved an identification of variables within the family milieu and the perceptual framework of the E.M.R. child attending a special school and Phase II involved an assessment of the family dynamisms of E.M.R. children having already left the special school purview 3/4 years ago. In both the phases, variables, related, to the optimal psycho-social functioning of the retarded child were isolated, assessed and the implications were emulated in providing a more nurturant care for the retarded in India. Keeping in mind the research aim, the methodology of the research programme was developed.