CHAPTER – V
SUMMARY AND CONCLUSION

5.1.0 INTRODUCTION:

Mental retardation (MR) is one of the most prevalent mental health disorders in developing countries. Although there are no studies determining the actual prevalence of MR in our population, it is certainly higher than the 2-3% found in studies in developed countries. Despite the fact that clinical experience and common sense clearly indicate that the presence of MR is associated with difficulties in school such as high levels of repetition and dropout, no study has assessed yet these associations in our population. These investigations seem to be even more important in our country, as the recent educational policies have emphasized the strategy of inclusive education as a way to diminish distortions and chronic educational problems. Therefore, the main objective of this study will be to verify the association between school dropout and mental retardation of some cases.

Mental retardation is a worldwide problem and in India it is a shocking and alarming fact that approximately 2.5 to 3% of the total populations are mentally retarded. Mental retardation is not only a biological, educational or psychological problem but it is a multi-dimensional problem of a mixture of psycho-social, biological and educational factor. But the public and professional interest in the ethnology of mental retardation and there in the problems faced by mental retarded dropouts children in educationally and their families has been at best meagre and sporadic. This apathy has persisted despite the high incidence.

Concept of Mental Retardation:

Mental retardation is a relative term. Its meaning depends on what society demands of the individual in learning, skills, and social responsibility. Many people who are considered developmentally challenged in the complex modern world would get along normally in a simpler society. As already stated mental retardation is one of the major areas of special education mentally retarded or handicapped children are characterised by low intelligence in comparison with normal children and there are various degrees of this retardation Alfred Binet 1905 was assigned this problem by ministry of education in France suggested a method for grading mental retardation.
Binet 1908 introduced the concept of mental age based upon the idea that the majority children of a particular age are of normal intelligence and have a mental level approximating that age which mental could be termed as their mental age. If some child fall in his/her performance of certain tasks from the perform of the majority of the children of his age eight year her Performance on certain adequately determined tasks that of the majority of the 6 year old then he had the age of 6 years. So mentally retarded individuals are deficient in general intellectual ability that their enable task cares for themselves with disruptive behaviour.

**Meaning and Definitions of Mental retardation:**

Many definitions on mental retardation have been given by different individuals before the definition of the American Association of mental retardation. Among them Dolls (1941) defines mental retardation which then was called feeblemindedness as a mental deficiency. It is a state of social incompetence obtained at maturity' resulting from developmental arrest of intelligence, because of constitutional (hereditary or acquired) origin. Here Dolls emphasizes lack of social adaptability which was seen as a result of immaturity, lower intelligence which has occurred because of hereditary or environmental factors. Treads Gold views, mental retardation in a slightly different manner.

According to him mental retardation is a state of incomplete mental development of such a kind and degree that the individual is incapable of adjusting himself to the normal environment, like his fellows, in such a way as to maintain existence independently, of supervision, control or external support.

Other personnel in this area view, mental retardation as a deficit in intellectual functioning. According to Benoit, mental retardation is a deficit of intellectual function resulting from varied intrapersonal and / or extra determinants, but having as a common proximate cause a diminished efficiency of the nervous.

Mental retardation (MR) is defined as significantly sub-average intellectual functioning, associated with significant deficit or impairment in adaptive functioning, which manifests during the developmental period.
Causes of Mental Retardation:

Heredity and Biological:

These result from abnormality of genes inherited from parents, errors when genes combine, or from other disorders of the genes caused during pregnancy by infections, overexposure to x-rays and other factors. Inborn errors of metabolism which may produce mental retardation, such as PKU (phenylketonuria), fall in this category.

Chromosomal abnormalities have likewise been related to some forms of mental retardation, such as Down syndrome and fragile X syndrome. About 5% of mental retardation is caused by hereditary factors. Mental retardation may be caused by an inherited abnormality of the genes, such as fragile. Fragile X, a defect in the chromosome that determines sex, is the most common inherited cause of mental retardation. Single gene defects such as phenylketonuria (PKU) and other inborn errors of metabolism may also cause mental retardation if they are not found and treated early.

An accident or mutation in genetic development may also cause retardation. Examples of such accidents are development of an extrachromosome 18 (trisomy 18) and Down syndrome. Down syndrome, also called mongolism or trisomy 21, is caused by an abnormality in the development of chromosome 21. It is the most common genetic cause of mental retardation.

Symptoms of Mental Retardation:

There are many different signs of intellectual disability in children. Signs may appear during infancy, or they may not be noticeable until a child reaches school age. It often depends on the severity of the disability. Some of the most common signs of intellectual disability are:

Common features of developmental deficiency due to inheritance:

a) Delays in oral language development
b) Deficits in memory skills
c) Difficulty learning social rules
d) Difficulty with problem solving skills
e) Delays in the development of adaptive behaviors such as self-help or self-care skills.

Family therapy can help relatives of the mentally retarded develop coping skills. It can also help parents deal with feelings of guilt or anger. A supportive, warm home environment is essential to help the mentally retarded reach their full potential.

**Problems after birth:** Childhood diseases such as whooping cough, chicken pox, measles, and Hib disease which may lead to meningitis and encephalitis can damage the brain, as can accidents such as a blow to the head or near drowning. Substances such as lead and mercury can cause irreparable damage to the brain and nervous system.

**Illness or injury:** Infections like meningitis, whooping cough, or the measles can lead to intellectual disability. Severe head injury, near-drowning, extreme malnutrition, exposure to toxic substances such as lead, and severe neglect or abuse can also cause.

**Childhood illnesses and injuries after Birth:**

Defects that cause physical deformities of the head, brain, and central nervous system frequently cause mental retardation. Neural tube defect, for example, is a birth defect in which the neural tube that forms the spinal cord does not close completely. This defect may cause children to develop an accumulation of cerebrospinal fluid on the brain (hydrocephalus). Hydrocephalus can cause learning impairment by putting pressure on the brain.

Hyperthyroidism, whooping cough, chickenpox, measles, and Hib disease (a bacterial infection) may cause mental retardation if they are not treated adequately. An infection of the membrane covering the brain (meningitis) or an inflammation of the brain itself (encephalitis) cause swelling that in turn may cause brain damage and mental retardation. Traumatic brain injury caused by a blow or a violent shake to the head may also cause brain damage and mental retardation in children.

**Environmental factors:** A clinically significant behavioural or psychological syndrome or pattern that is typically associated with a painful symptom (distress) or impairment in one or more areas of functioning. Single environmental risk factors rarely occur in isolation. Much more common is the occurrence of several risk factors together often in the context of a broad risk factor such as low socioeconomic status.
Child maltreatment, for example, most often occurs this chapter describes a number of environmental stressors that children may be exposed to, along with the mental retarded problems that may be caused or exacerbated by such stressors. The chapter does not review every environmental factor that poses a risk to children’s mental retarded, but it does attempt to cover the specific environmental, primarily psychosocial, factors that pose the greatest risk and to illustrate generally the effect that environment can have on the development of children’s mental retarded problems.

Ignored or neglected infants who are not provided the mental and physical stimulation required for normal development may suffer irreversible learning impairments. Children who live in poverty and suffer from malnutrition, unhealthy living conditions, and improper or inadequate medical care are at a higher risk. Exposure to lead can also cause mental retardation. Many children have developed lead poisoning by eating the flaking lead-based paint often found in older buildings. Environmental agents have been shown to demonstrate neurotoxic effects either in human or laboratory animal studies. Critical windows of vulnerability to the effects of these agents occur both pre- and postnatal. The nervous system is relatively unique in that different parts are responsible for different functional domains, and these develop at different times (e.g., motor control, sensory, intelligence and attention). In addition, the many cell types in the brain have different windows of vulnerability with varying sensitivities to environmental agents. This review focuses on two environmental agents, lead and methyl mercury, to illustrate the neurobehavioral and cognitive effects that can result from early life exposures. Special attention is paid to distinguishing between the effects detected following episodes of poisoning and those detected following lower dose exposures.

Prenatal and childhood exposure to high doses of lead results in encephalopathy and convulsions. Lower-dose lead exposures have been associated with impairment in intellectual function and attention. At high levels of prenatal exposure, methylmercury produces mental retardation, cerebral palsy and visual and auditory deficits in children of exposed mothers. At lower levels of methylmercury exposure, the effects in children have been more subtle. Other environmental neurotoxicants that have been shown to produce developmental neurotoxicity include polychlorinated biphenyls (PCBs), dioxins, pesticides, ionizing radiation,
environmental tobacco smoke, and maternal use of alcohol, tobacco, marijuana and cocaine. Exposure to environmental agents with neurotoxin effects can result in a spectrum of adverse outcomes from severe mental retardation and disability to more subtle changes in function depending on the timing and dose of the chemical agent.

**Poverty and cultural deprivation:** Children in poor families may become mentally retarded because of malnutrition, disease-producing conditions, inadequate medical care and environmental health hazards. Also, children in disadvantaged areas may be deprived of many common cultural and day-to-day experiences provided to other youngsters. Research suggests that such under-stimulation can result in irreversible damage and can serve as a cause of mental retardation.

Immunization against diseases such as measles and Hib prevents many of the illnesses that can cause mental retardation. In addition, all children should undergo routine developmental screening as part of their pediatric care. Screening is particularly critical for those children who may be neglected or undernourished or may live in disease-producing conditions.

Newborn screening and immediate treatment for PKU and hyperthyroidism can usually catch these disorders early enough to prevent retardation. Good prenatal care can also help prevent retardation. Pregnant women should be educated about the risks of drinking and the need to maintain good nutrition during pregnancy. Tests such as amniocentesis and ultrasonography can determine whether a fetus is developing normally in the womb.

**Diagnosis of Mental Retardation:**

If mental retardation is suspected, a comprehensive physical examination and medical history should be done immediately to discover any organic cause of symptoms. Conditions such as hyperthyroidism and PKU are treatable. If these conditions are discovered early, the progression of retardation can be stopped and, in some cases, partially reversed. If a neurological cause such as brain injury is suspected, the child may be referred to a neurologist or neuropsychologist for testing.

A complete medical, family, social, and educational history is compiled from existing medical and school records (if applicable) and from interviews with parents. Children are given intelligence tests to measure their learning abilities and intellectual functioning. Such tests include the Stanford-Binet Intelligence Scale, the Wechs
er Intelligence Scales, the Wechsler Preschool and Primary Scale of Intelligence, and the Kaufmann Assessment Battery for Children. For infants, the Bayley Scales of Infant Development may be used to assess motor, language, and problem-solving skills. Interviews with parents or other caregivers are used to assess the child's daily living, muscle control, communication, and social skills. The Woodcock-Johnson Scales of Independent Behavior and the Vineland Adaptive Behavior Scale (VABS) are frequently used to test these skills.

Educational access to mental retarded child in India:

In India, the incidence and magnitude of mental retardation needs to be looked into. Theoretically, the horizon of special education is often restricted only up to the age of 18 years for persons with disabilities. “Schooling” or attendance in a classroom alone is often considered ‘education’ even among the literate population of the nation. NSSO Survey, 1991. The National Sample Survey Organization (NSSO) under the Department of Statistics, Government of India conducts large scale studies and surveys for socio-economic planning and policy formulation. The first large scale attempt to collect such information on the prevalence of developmental delays was made in the 47th round of survey by NSSO carried out between July-December, 1991, on children age group 0-14 years, coming from 4,373 villages and 2,503 urban blocks.

NSSO Survey, 1991:

The National Sample Survey Organisation (NSSO) under the Department of Statistics, Government of India conducts large scale studies and surveys for socio-economic planning and policy formulation.

Table: Prevalence Studies Based on National Sample Survey Organization

<table>
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<th>Sl. No.</th>
<th>Investigator/s Year</th>
<th>Target Population</th>
<th>Place of Study</th>
<th>Prevalence Rate/1000</th>
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<td>All India</td>
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<td>NSSO 1991</td>
<td>Stratified urban sample</td>
<td>All India</td>
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</table>

Data obtained from various sources indicate that the prevalence rate of mental retardation is about 20 per 1000 general population, while the prevalence of developmental delays is about 30 per 1000 in the population of children up to the age of 14 years.
Degrees of mental retardation are conventionally estimated by standardized intelligence tests. The diagnosis will also depend on the over assessment of intellectual functioning by a skilled diagnostician. Intellectual abilities and social adaptation may change over time, and however poor, may improve as a result of training and rehabilitation. Diagnosis should be based on the current levels of functioning.

**Early Intervention for Children with Mental Retardation:**

Awareness among the public in India, about the need to provide services to infants and children with mental retardation has come only in the last decade. With this awareness, at present, service centres are available, some providing exceptionally good services. But there are only 198 centres offering early intervention programs for the entire country, leaving the demand largely unmet.

**Parental-Child Development/Emotional Support/Respite Care/Parent Organisations/Social Services:**

The American Association of Mental Retardation (aamr.org, 2002) defines an Individual with mental retardation as someone having substantial, sub-average intellectual and adaptive behavioural functioning with onset before 18 years of age and limitations in at least two of the following areas: (a) communication, (b) home living, (c) Social skills, (d) community use, (e) self-direction, (f) safety, (g) functional academics, (h) leisure, or (i) work activities. Previous research has revealed that, given appropriate support and resources, parents of children with mental retardation can cope with the challenges presented by their children and, in turn, provide a nurturing home environment.

How well the child has adapted himself/herself in performing his/her daily living activities and how he has been helped to be “included” in normal settings by the other members of the community with cultural pluralism speak for the success of an early intervention program. Need for Social Audit on Program Implementation Services. In addition to the challenges cited above, the absence of a clear-cut social audit on program implementation that directly benefit the child receiving the services has been felt in the country. Several services are available each with a different type of program. There are those that are highly structured, and offer intensive individualized teaching directed at specific goals for each child, that enhance
development by counteracting delay or impairment, that are “catch all” ranging from group play, movements, music, dance, art, and any other, that are operating in a vacuum with no certainty that the children in need are actually benefitting. A social audit will give certainty and directions to the service providers enabling them to meet the needs of the child with disability. Of late, there has been a move in this direction by the Government of India. India has a vast resource in human potential and numbers. Many of the challenges can be met by involving this rich resource.

**Teaching Learning Material for Persons with Mental Retardation:**

The Department of Special Education, NIMH, had undertaken a project on the development of learning materials, specifically to teach persons with mental retardation. Twelve units of hardware material, four work books and four flip books were developed, designed in a way that the same unit could be used with pre-primary to pre-vocational level students to teach a specific core area and across different core areas depending on the intention of the user. The prototypes were field tested and modified colour is taught in the stages of matching, identification and naming. Similarly, the concept of counting meaningfully cannot be taught without teaching one-to-one correspondence.

Concept teaching should be transformed into a series of joyful, games, e.g., Ludo, Bingo, Treasure Hunt, etc. Much repetition with variations is required. Different ways to use the same teaching-learning material, in the form of activities and games must be thought of. A Forum for Expression of Needs of Parents for their Children.

At the conference, professionals and parents of persons with mental retardation and associated disabilities expressed their difficulties. Inadequacies in the infrastructural facilities from early intervention to independent living, medical care, special education, counselling for parents and social security for their wards were some of the issues brought out. Parents felt an urgent need to come together to have a clear understanding of the challenges, to plan strategies to meet them and to share concerns and experiences, etc.

The realization, in the sixties, on the part of the parents to come together has come to be known as the National Parents Association–Pariah.
Parents’ movement in India has faced challenges:

The services still continue to be basically child oriented; the emphasis is still largely on child skill training rather than on helping build strengths in the parents. Facilities for counselling parents and family members to cope with the emotional needs and responsibilities of handling a child with mental retardation is still not within the reach of all.

The focus currently is on extending parents’ services, and on encouraging parents’ involvement in programs for training and habituation and training different levels of workers, parents have the strongest voice. Being a constant factor in a child’s life, the family teaches the child ethical values and behaviour. Since they sacrifice the most, parents’ self-support groups need to be strengthened.

On the positive side:

The comprehensive action plan for inclusive education for persons with disabilities will immensely help the parents’ movement.

The National Policy for Persons with Disabilities will determine the course of action the parents’ associations will have to take in the coming years.

Parivaar and its various affiliates have given the required inputs on the inadequacies in the policy document and have urged upon the Government to revise it in the light of the U.N.

Constraints in education and training:

For children up to age three, services are provided through an early intervention system. Staffs work with the child's family to develop what is known as an Individualized Family Services Plan, or IFSP. The IFSP will describe the child's unique needs. It also describes the services the child will receive to address those needs. The IFSP will emphasize the unique needs of the family, so that parents and other family members will know how to help their young child with mental retardation.

For eligible school-aged children (including preschoolers), special education and related services are made available through the school system. School staffs will work with the child's parents to develop an Individualized Education Program, or
IEP. The IEP is similar to an IFSP. It describes the child's unique needs and the services that have been designed to meet those needs.

Many children with mental retardation need help with adaptive skills, which are skills needed to live, work, and play in the community. Teachers and parents can help a child work on these skills at both school and home. Some of these skills include:

a) communicating with others;
b) taking care of personal needs (dressing, bathing, going to the bathroom);
c) health and safety;
d) home living (helping to set the table, cleaning the house, or cooking dinner);
e) social skills (manners, knowing the rules of conversation, getting along in a group, playing a game);
f) reading, writing, and basic math; and
g) As they get older, skills that will help them in the workplace.

Role of Family Environment in treatment of MR:

Experience over the last decade has made it clear that intellectual disability is a multidisciplinary problem and optimal treatment is multimodal. Biological, psychological, social, and developmental dimensions should all be considered when designing a treatment plan for an individual with intellectual disability. Furthermore, an integrative treatment approach should focus not only on ameliorating symptoms, but also on restoring mental well-being. Typically, a treatment plan will include attention to psycho educational, psychotherapeutic, and psychopharmacologic interventions.

Role of Parental attitude in treating the MR:

From ages 3 to 21 years, specialized education services are provided through local school districts. The Individuals with Disabilities Education Act requires that public school systems serve all children with disabilities and institutes what are essentially legal provisions to do so. This process provides for notice that the child is being considered for special services; a formal, scheduled hearing at which the parent(s) and school personnel discuss what is the most appropriate school placement
and specialized services; the right to present a defense if parents disagree with school personnel; a written decision given to the parents notifying them of the school's decision; and the parents' right to appeal this decision, first to the school, then to district and state educational authorities, and eventually to the courts.

This entire process results in an individualized educational program (or plan) (IEP), which assesses the child's academic performance, provides annual goals and instructional objectives, describes services that the child will receive, and includes starting dates of services and when and how the child's progress will be re-evaluated. Although receiving services for one's child can be complicated, educational services have become a right—not a privilege—for parents of children with intellectual and developmental disabilities.

A further element of education law involves the right to a public education “within the least restrictive environment.” This phrase has led to many debates within the special education community about inclusion. Essentially, this debate centers on whether all children should be educated in classes composed primarily of typically developing children. Inclusion advocates conceptualize education alongside typically developing children as every child's right, whereas proponents of a continuum of care argue that the child's individual educational needs should be paramount. Mentally retarded children are particularly vulnerable to a range of negative attributions. The most powerful of these is likely to be the position of "social reject" to which, inevitably, they are subjected. Mentally retarded children are socially marginalized and rejected by almost all sections of the community agree that people who have mental retardation are often demeaned and ridiculed.

The present study thus hypothesized that, as with other people, contact with a mentally retarded child lone will not result in positive attitudes. In this study, it is specifically hypothesized that only those rents of children who did not view their child's disability as central, did not view their child as different, incompetent or inferior and did not feel they were unable to cope with the disability would demonstrate positive attitudes towards children with mental disabilities.

**Blind beliefs and lack of Scientific attitude:**

By most definitions it is more accurately considered a disability rather than a disease. Currently, there is no "cure" for an established disability, though with
appropriate support and teaching, most individuals can learn to do many things. Although there is no specific medication for "mental retardation", many people with developmental disabilities have further medical complications and may take several medications. Beyond that there are specific programs that people with developmental disabilities can take part in wherein they learn basic life skills. These "goals" may take a much longer amount of time for them to accomplish, but the ultimate goal is independence. This may be anything from independence in tooth brushing to an independent residence. People with developmental disabilities learn throughout their lives and can obtain many new skills even late in life with the help of their families, caregivers, clinicians and the people who coordinate the efforts of all of these people.

Persons with physical or mental disabilities often turn to religious institutions for comfort and belonging. They are not, however, always openly welcomed into religious circles. Many churches and synagogues fail to make the necessary accommodations for parishioners with disabilities and some show covert signs of hostility towards them. Possible reasons for this exclusion are examined, theorising that they stem from the most ancient of beliefs about the nature of disability and its relationship to God. Sources within the Jewish and Christian faiths are examined and it is hypothesised that there are four central views inherent in these religions that act as barriers to those with disabilities. These beliefs must be challenged so that all may find fulfilment and inclusion within their religious faiths. Religious leaders and followers must also acknowledge and redress the fact that such beliefs have contributed to the establishment of disability and an oppressed political minority within Western society.

Development of scientific attitude is one among the most important outcomes of science education. Even it is important equally as cognitive aspects of science education. Scientific attitude encourages questioning mind and a spirit of enquiry. Therefore without this, studies of science will only mean acceptance of dogma and will never led to development of proper orientation towards various scientific endeavors. Whereas in case of lacking of it and to the process of social change, as well.

Not only this, scientific attitude is one among the major determinants of MR children “ psycho educational tribal science – which has become a major quality normal IQ and behavioural of a children living in the present scientific society. Even
parents are also driven strongly by the urge of admitting their children in science courses. This also necessitates extensive research work in science education, specifically in the area of scientific attitude of mentally retarded special school tribal children.

5.2.0 NEED AND IMPORTANCE OF THE STUDY:

In the recent past, studies have emphasized the dysfunction of families with a retarded child much attention has been focused on rehabilitation, vocational training, and academic education for the retarded member. Some have focused on the decision to institutionalize the retarded child (Farber, et al., 1960; Thurston, 1960). Still others have focused on the impact of the retarded child on his siblings (Feely and Schriber, 1965; Graliker, et al., 1961; and Farber, 1959-1960). Considerable attention has been given to the attitudes and emotional reactions of the parents of the handicapped. Most of these studies have been concerned with such important areas as the adjustment difficulties of the parents while they are facing the problem of helping a handicapped child, or the relation of parental reaction to the treatment and adjustment of the handicapped child (Thurston, 1960).

However, it appears that little has been done in the area of attitudes of parents who have a retarded child and have almost no support. Parents who are residing in extreme conditions of food, shelter cloth situation with obsession of blind beliefs are the worst hit target under this area. What do such parents indulge and course of action they take. Do parents genuinely take the help of the resources made available to them.

Are they opening to the scientific advancement that has provided scope to provide a MR child better life than the one the child had earlier? Do parents who keep their child at home do so because they accept him even though he is retarded, or because they are denying the fact that he is retarded and fail to secure the specialized care that an institution may offer? These are some of the issues that are required to be pondered form the poverty ridden community camps of Indian continent. The study basically focuses on these issues.

The purpose of the study is to examine the effects of parent’s involvement in education on the academic performance of the mentally retarded learners in primary schools of selected schools to determine whether cultural beliefs among the parents
affects the enrolments of mentally retarded children dropouts. Specifically to study, whether the parents teach their mentally retarded children adaptive skills; establish whether the parents of mentally retarded children play their role effectively as far as the education of their children is concerned and to find out whether the parents understand and appreciate the importance of taking their mentally retarded children for assessment.

The study is to focus on that cultural beliefs, negligence, lack of sensitization and lack of technical skills among the parents and the teachers were the major causes of low enrolment of mentally retarded children in selected the under study. The study presumes that parents and their siblings should appreciate their little achievement in order to boost their morale. That they should be allowed to interact and socialize with their peers; simulative home environment be provided and an opportunity to learn through special education be provided. Modified curriculum is needed by teachers in order to accommodation all the needs of learners with intellectual challenges. There is need to provide specialized training for teachers and be given competencies for Identification of Mental retardation, and the Cultural beliefs that hinder their progressive growth.

5.3.0 STATEMENT OF THE STUDY:

“A Case study of role of scientific attitude and Family Education of Mentally Retarded dropouts”

5.4.0 OBJECTIVES OF THE STUDY:

1. To study the impact of Scientific attitude of family decision maker on the child IQ, and Behaviour modification during planned clinical treatment.
2. To study the impact of Educational level of family decision maker on the child IQ, and Behaviour modification during planned clinical treatment.
3. To study the impact of Co variables namely job status of family, family income per month, and the cast of the family, on the child IQ and Behavior modification
4. To study the impact of clinical treatment to the mentally retarded children and its influence on child behavior in relation to the child environment
5.5.0 RESEARCH HYPOTHESES:

1. There will be significant improvement in terms of IQ gain scores of the MR children having care taking parents with high scores on scientific attitude.

2. There will be significant improvement in terms of IQ gain scores of the MR children having care taking parents with high educational qualification.

3. There will be significant improvement in terms of Child behaviour modification scores of the MR children better education of mother.

4. There will be significant improvement in terms of IQ gain scores of the MR children having better education of father.

5. There will be significant improvement in terms of Child behaviour modification scores of the MR children better education of father.

6. The quantum of income per month, do not contribute towards improving the intelligence quotient of the M.R. child during the clinical intervention period.

7. The quantum of income of per month, do not contribute towards improving the self reliance behaviour of the M.R. child during the clinical intervention period.

8. The type of the job parents dwell, do not contribute towards improving the intelligence quotient of the M.R. child during the clinical intervention period.

9. The type of the job parents dwell, do not contribute towards improving the self reliance behaviour of the M.R. child during the clinical intervention period.

5.6.0 OPERATIONAL DEFINITION OF TERMS USED:

a) Mentally Retarded Child (MR Child):

A condition of arrested or incomplete development of the mind, which is especially characterized by impairment of skills manifested during the developmental period, skill which contribute to the overall level of intelligence, i.e. cognitive language, motor and social abilities. Mental retardation can occur with or without any other mental or physical condition.
b) **Family decision maker:**

He, she or both the parental responsible who take decision regarding the child at home for all his risk-free activities and maintenance. They are the one who wish to look after the child’s for his progressive well being and to make the child at least self-reliant for ay to day activities.

c) **Scientific attitude:**

Scientific attitude, represents the motivation which converts the knowledge about scientific facts and skills in the use of scientific methods into action and refers to a willingness to use scientific procedures and methods in each step of own life of an individual. It is explained by A bell and Lederman (2007) as an attitude to scientific ideas and information, particular way of evaluating them for transferring, in day to day experiences.

d) **Planned clinical treatment:**

It’s the standard operational procedure that is used to all the registered mentally retarded children with the activities like collecting preliminary bio data, family data, IQ of the child, behavioral assessment and providing necessary guidance, suggesting the tasks to be undertaken at home. Incase of cooperative families additional support of training is provided support providers.

e) **Family Education:**

The level education attained by the parents and those who guide the child to be self-reliant.

f) **Family income:**

The monthly income the family earned for its day to day maintenance. This is usually in terms salary or some support provided by the father, mother and elders who actively work as bread earning manpower.

g) **Caste of the Family :**

Indian society has the cast system. Each state has the Schooled list of casts. Cast is specific in the school admission certification for each child.

h) **Family job:**

The type of the job undertaken by the family members with the purpose of family earning for their livelihood.
i) **MR child IQ:**

In the present context, this is measurement that provides a measure of Social Age and Social Quotient. It will indicate the social deficits and social assets in a growing child. The day to day utilitarian social skills and thinking processes that go a long way in making the M.R children to be socially self sufficient.

j) **MR Child Behavior level and lag:**

Every child is expected to have normative behavior expected to that specific age group. The Mentally retarded children do not exhibit the expected behavior. The qualitative deficit exhibited by the mentally restarted child in comparison to the normative expectations is the MR child’s behavior lag. The magnitude of the lag is measured in terms of scale is M.R. Behavior level.

### 5.7.0 VARIABLES OF THE STUDY:

<table>
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<th>Sr.No</th>
<th>Variable</th>
<th>Status of Variable in the study</th>
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<td>Scientific Attitude Scores of parents</td>
<td>Independent</td>
<td>test in the of treatment</td>
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<tr>
<td>2</td>
<td>IQ test</td>
<td>Dependent</td>
<td>IQ test in the beginning and after six months.</td>
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<td>M.R. Behaviour</td>
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<td>behaviour Observation scale in the beginning and after six months</td>
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<td>Covariables: Income of parents, Job of parents, Community</td>
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<td>interview schedule.</td>
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<tr>
<td>5</td>
<td>Family Education Status</td>
<td>Independent</td>
<td>test in the of treatment</td>
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</tbody>
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### 5.8.0 REVIEWS OF RELATED LITERATURE:

The researches reviewed for the study can be broadly classified in to five sub parts. This classification is for the convenience of the study. The study is focussed towards issues related to mentally retarded child in relation to their nature of M.R. Further the study is focussed on the issues related to the role of parental role and scientific attitude of the parents. In view of his the reviews are classified as follows.
5.9.0 METHODOLOGY OF THE STUDY:

Researcher used different modes of analysis as per the requirement of the objective. For the first objective the researcher used descriptive analysis for qualitative information. The intent here was to identify the certain commonalities that strikingly hold up and provide as significant factors contributing to the status of the cases.

5.9.1 Population and Sample:

The population and sample is the form the Bidar district and round about area. This is the north tip of the Karnataka marked as most backward area. The area has people belonging to borders of Maharashtra and Karnataka. They speak mostly a mixed language of Kannada and Marathi and sometimes Urdu. The area has large population belonging to Muslim community and backward class. The sample is incidental and from the visiting group from the hospital for MR Child treatment. The research had access of 40 children for this study.

5.9.2 Methodology for objective 1:

Researcher used different modes of analysis as per the requirement of the objective. For the first objective the researcher used descriptive analysis for qualitative information. The intent here was to identify the certain commonalities that strikingly hold up and provide as significant factors contributing to the status of the cases.
Methodology of Data Collection and Analysis:

The first objective of the study is:

To study the impact of scientific attitude of family decision maker on the child IQ and Behaviour modification during planned clinical treatment.

The objective requires three tools basically an intelligence test, scientific attitude test and Behaviour modification scale. These should be sensitive for the M.R. Child and for the use in rural set up. Following is the details of the tools used and adopted.

Tools used:

The researcher has used intelligence test and behaviour modification scale as those are presently underused in the clinical centres. Researcher has prepared a test for parental scientific attitude test. A perform for the basic information was prepared and used. The details are presented below

1. Intelligence test:

The Vineland Social Maturity scale was originally devised by E. A.DOLL in 1935 and since then this test is being used in many parts of the world. It proved itself to be uniquely useful instrument in measuring Social Maturity of children and young adults. Since its first publication it has served the useful purpose of estimating the differential social capacities of an individual. The very first attempt to adapt this scale to Indian cultural conditions was done by Rev. Fr. Dr. A. J. MALIN while working at the Nagpur Child Guidance Centre. This scale is being used at many clinics, university departments and institutions for the mentally retarded. The present manual is only an extended version of the original manual.

Reliability and Validity of Tool:

Recent experiments and research studies (Goulet and Barclay; American Journal of Mental Deficiency, MAY 1963) have shown a consistent and high co-variation between VSMS Social Age (S.A.) and the Stanford Binet M.A., Doll reported a correlation of + = 0.85 and Patterson (1943) reporting a correlation of + = 0.96 with the Binet Scale on sample of normal children. This is a clear reflection of how social development and mental development are highly correlated.
Indian context:

The attempts have been made to utilize the VABS and Vineland Social Maturity Scale (VSMS) (Doll, 1935; Doll, 1965) in non-western cultures. Anjum, Khadi, and Phadnis (1990) used an Indian adaptation of the VSMS to study the development of social maturity in rural and suburban infants of 6–12 months in Dharwad City, India. This adaptation by Malin (1968) restricts the age limit from the original VSMS from 25 years to 15 years due to cultural variation. It is highly correlated with the Stanford–Binet test of intelligence and test–retest reliability is around .92. Further, validity is said to be satisfactory (Jayashankarappa, 1986). Goel and Sen (1981) found significant correlations between the Malin’s Nagpur adaptation of the VSMS and other intelligence tests among Indian children, 10–19 years of age. The highest correlation was with the Stanford–Binet test, at .55.

Vineland Social Maturity Scale (VSMS) was developed by Doll in 1935. Indian adaptation was done by Malin (1992). The VSMS gives an index of the child’s social & adaptive development and yields a Social Quotient. The Indian adaptation charts development till 15 years of age. Correlation coefficients ranging from 0.85 – 0.96 have been obtained from a sample of children with normal development.

Procedure of administration:

The administration should be carried out in a semi-structured informal atmosphere by having the mother along with the child or having the child alone depending upon the demands made by the items. It is preferable to request mothers to keep silent and non participant in the testing situation but just to provide security to the child, by being present. In the informal clinical situation an appraisal can be made by the clinician whether a particular behavioural (social) characteristic has emerged or has not emerged in the repertory of the child. If the particular characteristic described by the item has clearly emerged, a ‘+’ mark may be made on the left-side of the item. But if the evidence proves that it has not emerged still a ‘-’ mark may be put on the left side of the item. But if the clinician feels confident that the characteristic might possibly have emerged but in the clinical situation it cannot be assessed, based on supplementary information provided by the mother half credits may be given.
These half credits receive full credits within the range of otherwise continuous plus credits. A brief interview with the child informally would suggest to the clinician the approximate minimal social development that might have been attained. Just as with the Binet Scale an attempt might be made to obtain a Basal Social Age for the child and a further developmental appraisal may be started from that age-level at the end of assessment. Full and Half credits may be counted. If the total score falls exactly on the last item of a age level, the child is that age level.

2. Parental Scientific Attitude Test:

Scientific Attitude nature and context:

Third component of scientific attitude is action or behavioural component which is mostly cognitive. It is the tendency of a science learner to act towards his/her scientific belief in accordance with feeling or opinion. For one reason or another, a people do not or cannot always act the way they feel, but tendency is there. Scientific attitude, according to Rao (1996), represents the motivation which converts the knowledge about scientific facts and skills in the use of scientific methods into action and refers to a willingness to use scientific procedures and methods in each step of own life of an individual. It is explained by Abell and Lederman (2007) as an attitude to scientific ideas and information, particular way of evaluating them for transferring, in day to day experiences.

Scientific attitude and need of measurement:

The target group happens to be illiterates with rural background. The vocabulary of the parents is extremely poor and a mixture of Kannada, Marathi, and Urdu. This being the situation it is not possible to have a rating scale. The researcher decided to go with the questionnaire schedule based interview. The questionnaire was prepared following major step of tool development similar to the rating attitude. The tool has three major dimensions namely the parental perspective to view

iv. On solving issues with logical and rational mind.

v. Solving issue with avoidance of well set blind belief and Gods wish type feeling.

vi. Faith, commitment and perseverance to the psychotherapy and educational support to child.
**Procedure adopted to develop the tool:**

a) Preparation of the items :

b) Preparation of alternative responses :

c) Scoring :

d) Pre-try-out :

e) Try –Out :

f) Establishment of Reliability

g) Concurrent Validity:

h) Establishment of Norms :

i) Tools used for the study: Behaviour Modification

**Collection of data Phase:**

For the first objective the data collected is;

1. Scientific attitude scores with standardised scale as detailed in methodology of the family decision maker parent.

2. The IQ score through a standard test of the MR child in the beginning of the clinical treatment and at the end of 6 months period.

3. The chid behaviour scores on a scale of the MR child, indicating the childs behaviour towards normal expectations. This is a scale that is used in the clinic centre to estimate the level of MR level by the medical practitioners and clinical psychologist.

4. The size of the sample is 20 cases. The study is basically an in depth qualitative analysis study. However, some of the quantitative data is amicable for quantitative analysis. The quantitative data variables are detailed below:

**5.9.3 Methodology for the objective II:**

For the second objective, the research used survey method. The data is collected using the same tools that are used for the first objectives. Date collected is processed through SPSS software. Percentage analysis is done and classified table for the each of the independent variables are worked out. To test the hypothesis nn parametric test are used.
5.9.4 Methodology for the objective III:

The objective requires three tools basically an intelligence test, scientific attitude test and Behaviour modification scale. These are used for the objectives first and second. The same tool provided the information. The additional information required is in co-variables. For the study of this basic data is collected from the sampled cases. For the information required regarding the independent variables. The cases is registered in the hospital and the MR level is assessed in the presence parents. The child is further tested for his IQ. The details of the preliminary information required is also recorded. This is the first stage of the work. The child is provided clinical treatment for six months with periodical guidance. The researcher also visited regularly to the residence of the child to verify the proper utilisation of treatment as well to validate the preliminary data provided by the family member.

For the study of co-variables data is collected from the sampled cases. For the information required regarding the independent variables. The case is registered in the hospital and the MR level is assessed in the presence parents. The child is further tested for his IQ. The details of the preliminary information required is also recorded. The educational status data is recorded during the initial visit of the child to the hospital.

The respondents are the responsible person escorting the MR child to the hospital. They are either the other father or a senior relative who take care of the child at home. This is the first stage of the work. The child is provided clinical treatment for six months with periodical guidance. The researcher also visited regularly to the residence of the child to verify the proper utilisation of treatment as well to validate the preliminary data provided by the family members. The sample and data being similar to the first and second objective, there was no change in the procedure.

5.9.5 Methodology for the objective IV:

This is the major objective of the study. The researcher himself being a well trained clinical psychologist form NIMHANS, Bangalore decided to take in-depth study of MR Child drop outs. The investigator planned to have case study method as it is an ideal methodology where a holistic and in-depth investigation is needed. Robert K.Yin (1984) defines the case study research method as an empirical inquiry that investigates a Phenomenon and context are not clearly evident, and in which multiple sources of evidence are used.
The methodological comprises details in respect to identification of sample cases, tools procedure of conducting case study, construction of case history, and analysis of data pertaining to different cases under study.

**Unstructured Interviews:**

To get an in-depth, holistic and comprehensive description about the cases, unstructured interview was used as it helped in knowing myriad dimensions of the sample case. The researcher had no presuppositions about what of importance may be learnt by talking to people whom he will meet. Therefore he wants to maintain maximum flexibility to be able to pursue information in whatever direction it appears to be appropriate depending on information that will emerge from conversing to one or more individuals.

There was no predetermined set of questions as investigator doesn’t know beforehand as to what are the important questions to be asked. Most of the questions flowed from the immediate context.

Various personnel were interviewed in the process, they are; case themselves parents of the case, other family members, close relatives, neighbors, friends, schools teachers and principal, non academic staff, teacher, etc.

**Observation:**

For this, no observation made by making field visit to the selected students’ home, school, neighborhood, etc, the investigator had an opportunity for direct observation. It is provided a breath and depth of information about the participants and settings. Condition of house and school, mannerism and attitude of parents, neighbors, etc. were keenly observed.

Observation was made through the field visit, including those occasions while interviewing and collecting documents from home. Even the body language, gestures, facial expressions, temperament, etc. of the personnel were observed by the researcher.

**Sample for the Study:**

Sample and Population: For understanding the level of scientific perspective from different angles the researcher has a sample of 20 units. They are the parents of the mentally retarded child. Father, Mother are the basic responsible persons and are
the chief respondents. In case the child study with others the responsible care taker was considered as respondent.

**Procedure of data collection:**

Case study research is not sampling research that is a fact asserted by all major researchers in the field as stated by Yin (1993), Stake (1995) & Feagin (1991) but a process of deriving in-depth understanding. Therefore, here selection of case must be done to maximize our learning in the given period of time available for the study. In case study, a single case or multiple cases are studied in-depth. Using multiple cases, each case is treated as a single case.

In the present study, the objective is to get the deepest understanding the parental perseverance, use of resources provided to them form hospital and its impact on the case. Because of the in-depth nature of the study where profound understanding is sought, case study with a small sample was needed and selected. In the present study therefore, 20 MR were selected.

Cases for this study were selected from the three years i.e.2013 and 2015 registered for treatment and due to MR they have dropped out from school.

**Procedure of Case Study:**

In case study, no outline or procedure has been standardized but the general consideration is that a comprehensive account of the past history of the child and present statues is studied in depth. The purpose of the research was to construct deepest understanding of the MR case in terms of history, pro and cons up to registering as a case and the follow up. There were no fixed outlines and researcher was open to all the perspective information related to high achievers. Elaborated investigation, focusing on their past till date about all dimensions related to their MR and support are detailed out. The other dimensions kept in mind while indulging in data gathering were the aspects that have been listed in the objective 1 and 2.
5.10.0 SCOPE AND LIMITATION OF THE STUDY:

Several limitations to this study can be identified. First, the participant pool developed was based on specific criteria, the sample size was small, and generalizability may be limited. The participants were not equivalent on all demographic variables such as education level, family income, education level, or number of children in the home, making generalizability even more of a challenge. Although an attempt to obtain information from fathers was made, the number of fathers who participated was small.

Even when fathers were present during the interviews, mothers were the primary participant. This role for mothers as the primary caregiver and psychological center of the family is consistent with prior research (Singer & Irvin, 1989). Conclusions from a future study with more participation from fathers may yield different results. Future Research should include both qualitative and quantitative methods. Both qualitative and quantitative research should include fathers and siblings in their studies. Because fathers and typically developing siblings are not usually the primary caregiver, they are likely to have a different perspective on coping and stress. Qualitative research should include observations of parent–child and family interactions to cross validate self-report data.

A case study analysis could yield even more specific variables related to coping and stress. Several factors noted in this current study need further exploration: the perception of social support, creative community-wide support systems, the unique grief experience of parenting an atypical child, and how some families have been successful in creating periods of respite and rejuvenation. Quantitative research should focus on many of the same areas; a regression analysis could be especially enlightening in revealing which factors have the most notable mediating effects among social support, couple support, respite, community organizing, partnership with public education, and demographic variables. The development of a model program (with all of the known mediating resources available) and comparing it with standard resources on the domains of family satisfaction and long-term outcomes for the child should yield data significant to researchers, practitioners, and policymakers.
5.11.0 MAJOR FINDINGS OF THE STUDY:

a) Mentally retarded child family member having high scores on scientific attitude scale will provide better care taking of the child, resulting in to significant improvement of the IQ scores.

b) The scientific attitude of care taker significantly influence the MR child behaviour improvement. Care talks having high score on scientific attitude are better equipped to take care and significantly contribute in behaviour modification of the chid.

c) The scientific attitude of care taker significantly influence the MR child behaviour improvement. Care talks having mother differential qualification significantly contribute in improving the indigence of the chid.

5.12.0 FINDINGS AND INTERPRETATIONS:

The findings and inferences are contextually presented in the analysis chapter. They are once again listed here as a summary. The important findings that have been arrived from the case studies are summated as priority in the following details before presenting the results of quantitative analysis.

11. In Indian conditions the consangenisaus marriage is one of the major contributor towards the delivery of M.R. Child. The families specially having already such cases in their family are higher risk of having M.R. child.

12. The poor nutrition and heavy homework have contributed in delivery of the M.R. Child.

13. The illiteracy and negligence towards medical check-up is another important factor that has contributed immensely toward this problem.

14. Parent with orthodox out look and religious faith that its God that decides the fate of the child is a major issue that is man created factor compounding the issue.

15. The advice given by the doctor based on the condition of bay during child birth, if followed with rigour, the M.R child can not only be made self-reliant but also to live with dignity.

16. Negligence of the parents not to take care and send the M.R. child to especially abled school has magnified the issue.
17. Children attending the especially abled school have improved significantly towards becoming self-reliant.

18. Generally, the neighbours and community people are generous for inclusive society with M.R child.

19. Delay in care taking during early child hood will enhance the issue and progressive betterment of the M.R. child is difficult.

20. Parents with bad habits like being chronic alcoholic, smoking are likely to neglect the M.R. child care compared to others.

The finding form quantitative analyses are listed below.

**The findings form quantitative are as below;**

1. Mentally retarded child family member having high scores on scientific attitude scale will provide better care taking of the child, resulting in to significant improvement of the IQ scores.

2. The scientific attitude of care taker significantly influences the MR child behaviour improvement. Care talks having high score on scientific attitude are better equipped to take care and significantly contribute in behaviour modification of the chid.

3. The scientific attitude of care taker significantly influences the MR Child behaviour improvement. Care takers having mother differential qualification significantly contribute in improving the indigence of the child.

4. The mother education do not significantly influences the MR child behaviour improvement. Care talkers having high score on education do not significantly contribute in behaviour modification of the chid.

5. The scientific attitude of care taker significantly influences the IQ score improvement. Care takers having father differential qualification significantly contribute in improving the indigence of the child.

6. The father education is significantly influences the MR child behaviour improvement. Care talks having high score on education are better equipped to take care and significantly contribute in behaviour modification of the chid.

7. The scientific attitude of care taker significantly influences the MR child behaviour improvement. Care talks having high score on scientific attitude are better equipped to take care and significantly contribute in behaviour modification of the chid.
8. Mentally retarded child family member having high scores on scientific attitude scale will provide better care taking of the child, resulting in to significant improvement of the IQ scores.

9. The Income of the family of care taker significantly influence the MR child IQ improvement. Care talks having high score on Income of the family are better equipped to take care and significantly contribute in improving the intelligence.

10. One of the research hypothesis related to the variables family income and behaviour 246 behaviour246 on of the M.R. chid.

11. The income of the family significantly influences the MR child behaviour improvement. Families with low income need to be oriented with positive attitude for care taking M.R. child.

12. The job held by the family of care taker significantly influence the MR child IQ improvement during clinical intervention period. Care takers having better job are better equipped to take care and significantly contribute in improving the IQ of the child.

13. The job the family of care taker significantly influences the MR child behaviour improvement. Care takers having better job are better equipped to take care and significantly contribute in improving the behaviour of the chid.

14. The caste as variable does not significantly influence the MR child IQ improvement. Caste does not contribute in improving the IQ of the chid.

15. The caste of the care taker do not significantly influence the MR Child behaviour improvement.

5.13.0 IMPLICATIONS:

1. The scientific attitude of care taker significantly influences the MR Child behaviour improvement. Care takers having high score on scientific attitude are better equipped to take care and significantly contribute in behaviour modification of the chid.

2. There is need to change the attitude of parents of child from traditional orthodox tendency to rationalist and scientific attitude while interacting with the M.R child and setting his surroundings.

3. Majority of mothers belongs to lower education levels with hardly much variation. The results are not inconclusive. There is need to change the attitude
of parents of child from traditional orthodox tendency to rationalist and scientific attitude while interacting with the M.R child and setting his surroundings.

4. The mother qualification do not have high variation in present sample and the result are inconclusive. There is need to change the attitude of parents of child from traditional orthodox tendency to rationalist and scientific attitude while interacting with the M.R child and setting his surroundings.

5. Father contribute immensely in setting climate at home and decision making for improvements of M.R. child IQ.

6. Father educational levels significantly contribute in setting family conditions such that it contributes in changing self reliant behaviour in positive direction.

7. There is need to change the attitude of parents of child from traditional orthodox tendency to rationalist and scientific attitude while interacting with the M.R child and setting his surroundings for improvement of child behaviour.

8. The scientific attitude of care taker significantly influences the MR Child behaviour improvement. Care talks having high score on scientific attitude are better equipped to take care and significantly contribute in IQ score improvement.

9. Parents with low income group suffer in providing requirement, there by affect the IQ development of M.R. child

10. There is need to provide focus on low income family to develop positive attitude to wads concerns of M.R child.

11. There is need to equip better conditions for different low job profiles so that the family while interacting with the M.R child and setting and his surrounding, provide better fostering conditions.

12. There is need to equip better conditions for different low job profiles so that the family while interacting with the M.R child and setting his surroundings provide better fostering conditions.

13. Caste does not influence in any way and is not a variable while interacting with the M.R child and setting his surroundings.

14. Caste should not be focussed as factor while treating the M.R child, as it does not come in the way of improving the child behaviour.
5.14.0 SUGGESTION FOR FURTHER STUDY:

The present study is undertaken by a clinical psychiatrist working in the hospital. The case is incidental, and is limited to the scope within the preview of the routine work. The work has provided insight to further undertake work on following lines:

1. The cases of M.R child are of different grade require different types of graded well planned strategic treatment. Presently all M.R. cases are treated in one group. Study are required to develop strategies for training different types of children.

2. Presently there are no specific manuals and scientifically evolved guidelines and paths provided to the teachers of the special school for M.R. There is need to evolve such material and try out.

3. Considering the geographic area of Hyderabad Karnataka, the spread of specific schools and facility available are not evenly distributed as per the demand. A study of providing facility, infrastructure, role of Government and policy decision are required to explored.

4. A large number of dropouts due to low IQ need to be studied. They require to be specifically treated for the inclusion to the community. The role of parents, community and Government needs to be explored.

5. Lack of programme on awareness regarding the reason that lead to M.R child delivery needs to evolved and try out.

6. A study on present status of special schools for M.R. and to strengthen to be undertaken.

7. The present study may be enlarged with grater sample and with wider geographic location that will further strengthen the results of the study.

8. A large number of cases are identified where in the parents and care takers lose interest in the M.R. child and let his/her fate. The motivational package for such parents may be evolved and may be tried out.

9. With the advent of ICT, there is vast scope to develop specific multimedia programme that can be used to train the child. They may be evolved and tried out.

10. There is a need to evolve mandatory decision making and action to be taken when anomalies and M.R state conditions are identified during pregnancy by
the doctor. The role of parents in such stage needs to be well defined. The judicial laws need to be evolved and addressed to policy makers. In the absence of such laws the carelessness has resulted in high rate of M.R. children.

5.15.0 CONCLUSION:

In India, a large number of mentally retarded cases are mainly man made that can have avoided. India is a country with large mass with poor education and scientific attitude. Added to this the low socio-economic conditions, the poor sanitation and unhygienic habitat have contributed in a big way. The new schemes such as ‘Swachh Bharat’ and ‘Subsidised LPG supply to the BPL card holders called Ujjwal Yojana’ have helped to a great extent. The struggle is still a long way to reach. Educating the community, providing medical assistance during pre-natal and delivery stages and educating the community towards the rights of M.R children for their life are some of the major steps that need attention immediately. The community participation wholeheartedly will definitely help to bring reduction in the percentage M.R children and to look after them better.