Review of Literature
CHAPTER - II

REVIEW OF LITERATURE

The study of related literature for conducting research is important and helpful in understanding the need for the research undertaken. It is also done in order to familiarize oneself with the work that has been done in the areas of one's interest and to get some useful information in order to understand the problems and issues of the research topic.

A review of the concerned literature helps to ascertain that the same work has not been put to scrutiny before. Thus, it was essential to review the relevant literature for the selected psychological variables of their parents (mothers only) i.e. attitude, self-confidence, emotional competence and adjustment and selected psycho-motor variables of mentally retarded individuals i.e. behaviour problems, weight, strength, agility and psycho-motor vocational performance, from various sources which are given later in this chapter.

The review cited in this chapter has definitely helped the researcher to imbibe her awareness and understanding of the various selected techniques available for conducting such a study and interpretation of the data. In the process of conducting the study, the researcher tried her best to be thorough and meticulous which in turn increased awareness of the issues of research that helped her in forming scientific reference.

The review enlisted in this chapter was based on various sources as that of journals, periodicals, encyclopedia, books, unpublished Thesis, educational surveys, dictionaries, articles and psychological abstracts etc. which were available in various libraries. The libraries which the researcher consulted were A.C. Joshi Library and the libraries of the Departments of Psychology and Education, Panjab University, Chandigarh, library of the Government College of Education, Chandigarh, library of the Post-Graduation Institute of Medical and Research, Chandigarh and libraries of NIMHANS, Bangalore and NIMH, Secunderabad. The relevant results of studies have been briefly presented in this chapter to provide the background material so as to evaluate the significance of
this study as well as to interpret its findings. Every research begins from where the previous researchers have left and moves it forward.

The review of related literature was done for the chosen study. The findings have been presented briefly under the following headings.

1. Literature related to psychological variables of parents (mothers) of mentally retarded individuals.
2. Literature related to psycho-motor variables of mentally retarded individuals.
3. Literature related to vocational guidance for parents (mothers) of mentally retarded individuals.

2.1 LITERATURE RELATED TO PSYCHOLOGICAL VARIABLES OF PARENTS (MOTHERS) OF MENTALLY RETARDED INDIVIDUALS

According to Maslow (1952), the feeling of insecurity and rigidity leads to lower self confidence.

According to Rasey (1953), some of the major obstacles to overcome in moving towards a better self confidence of the parents were: more courageous facing of reality and more adequate adjustment with their retarded child.

Hurlock (1955) indicated that the mothers of retarded children from a favoured social environment have positive attitude in their personality than the mothers from less favoured social environment.

Holt (1958) in a study on 207 families with a subnormal child living at home found that 19% of the mothers were exhausted by physical work and adjustment involved. Fathers were said to suffer to a lesser degree.

Locke and Wallace (1959) pointed that mothers of mentally retarded when assessed on their martial relationship obtained conflicting results with adjustment in their family as well.
Fabraga and Haka (1967) noted in their study of 47 families of mentally retarded children that those parents who showed unresolved grief had low self confidence.

Barsch (1968) felt that the presence of a mentally handicapped child hinders the growth of their own and their mothers' personality as the family found it difficult to adjust to society in situations like entertaining friends or attending cinema or religious places together.

Jain and Satyavathy (1969) in their examination of social problems related to the presence of mentally retarded child in a comparative study between normal and mentally retarded children indicated that parental feelings were marked by anxiety about the future. Constant psychological stress and poor self confidence had negative effects on the other siblings. Misunderstandings within the family, decreased interaction with the neighbours and relatives, and economic loss were significant factors associated with the family of mentally challenged individuals.

Kurtz (1969) showed that frustration and anxieties occur in the parents of mentally challenged children because their child had not been performing even as well as younger normal children; they realized that the youngster was becoming bored doing the same type of school work that their mentally challenged child was given in the past years with no discernible progress and they recognized that they were unable to control the circumstances related to his educational development and future as they would like. These were anxiety and frustration provoking conditions and to some extent affected emotional competence of even the most well informed parents.

According to Prabhu (1970), parents of mentally retarded children who over-estimate the potentialities of their child were more extroverts, emotionally unstable and had poor self-confidence.

Arya (1970) found that the diagnosis of retardation gave a shock to the child’s parents. Birth of such a child called the need for professional people to work with parents of mentally handicapped child. Over attention, negligence
anxieties and frustrations of parents could increase the level of retardation and decrease the level of self confidence.

McDaniel (1970) observed rejection and hospitality in the parents of mentally retarded children. It was indicated that mothers showed more negative attitude towards their mentally retarded child as compared to their fathers.

Rutter (1970) stated that the presence of retarded child in the family brought about frequent quarrels between the parents that led to frustration and stress.

Tredgold (1970) concluded that the mothers of mentally challenged children are under the grab of pity and sympathy. There was also apparent much irritation, resentment, frustration, anxiety and insecurity. The mother expressed her hostility against fate. Under these circumstances conditions of rejection with bitterness and resentment were not free from anxiety. This led to feeling of insecurity which was injurious to her self confidence.

According to De Lissovy (1973), mothers of retarded exhibited more punitive child rearing attitudes and a high rate of disturbed mother-infant interactions and characteristics that were expressed within the home environment causing low self confidence and feeling of insecurity.

Parshad, Kaushal and Verma (1973) found that mothers of mentally retarded children were more emotionally disturbed and stressed than others.

Crow and Crow (1973) were of the opinion that it was a fundamental inner urge for a mother to be secure in the affection of her retarded child and that feeling of insecurity led to lower self-esteem as it rested upon her emotional relationship with the child.

Begab and Richardson (1975) observed that trauma of having a retarded child reduced the self confidence of mothers.

According to Robinson & Robinson (1976), many additional stresses and strains such as imbalances in the family budget, poor relationship between the siblings and non-acceptance by relatives also lead to stress in parents, especially affecting their mothers’ adjustment.
Mc-Andrew (1976) found that families with mentally challenged children indicated often experiencing social isolation. Mothers reported that their relationship with family friends were adversely affected by the birth of mentally challenged children and this in turn affected their personality, making them more stressed.

According to Kaur (1977), the presence of a child with a mental handicap could become a source of low self-confidence and poor feeling of security on the family members.

Gath (1977) reported that marital breakdown that caused stress seemed to be greater in the families with mentally retarded child than in normal cases.

Kumari and Sathyavathi (1977) compared maternal behaviour towards mentally handicapped children and normal children and found that mothers of mentally handicapped children held an attitude of ignoring their children while mothers of normal children tended to be more possessive.

According to UNESCO report (1978), a satisfying relationship between the mother and her retarded child during first few years of life played a vital role in her feeling of security which left an impact on her adjustment in their day to day life.

Buss (1978) stated that mothers of retarded children, who had negative attitude towards them as well as towards society, usually possessed negative self concept. They demanded sympathy and pity from others and displayed abnormal behavior and depression of mood such as seen in neurotics or psychotics.

Bhattachary (1978) found that the parents of a retarded child very often suffered from frustration and anxiety over the question of meeting their child’s needs thus impairing their emotional adjustment. The parents were likely to feel frustrated as they took the child’s handicap as a blow to their own success as parents, more so because of their unrealistic demands upon the retarded child.

Dupont, Bernsen, Sturup and Earlisen (1978) indicated that the authoritarian parental (especially mothers’) attitudes might in turn reflect in the
marital adjustment of the parents as well as the stress experienced. They reported that the temporal, financial and mental stress was considerable.

Narayana (1978) studied the impact of mentally challenged children on their mothers. The results showed that mothers of mentally challenged children showed more attitude problems.

Srivastva, Saxena and Saxena (1978) found that mothers of mentally retarded children fostered dependency in the upbringing of their children, were more strict, suppressed their aggression, got easily irritated, displayed low confidence in their conduct and avoided communication with their children as compared to mothers of normal children who expressed their feelings freely, encouraged their children to participate and believed more in independence of children.

Findings of the study of Seth (1979) revealed that 87% of mothers reported inability to carry out household work, 83% reported that their social life was hampered due to loss of prestige, feeling of shame, social stigma and difficulty in visiting others. Hence, mothers of mentally retarded children experienced more severe anxious and pathological attitudes than those of normal children.

Wilkin (1979) concluded that the handicapped children dominated the daily routine of the mothers who generally received little help with childcare and housework and got burnt-out which in turn led to loss of self confidence.

Owens and Birchenall (1979) found that the parents of mentally handicapped child experienced problems in particular areas such as their marriage, physical and mental health, and socio economic status. The problems of routine management made them anxious and poorly adjusted.

Jones (1980) indicated that individuals low on self confidence showed general reduction of non-verbal behaviour on most measures. Stress was seen to be associated with decreased social interaction among mothers of mentally challenged children.
According to Mason (1980), information in explaining different components of emergent literacy for caring the mentally retarded child was likely to strengthen the correlations between the mother-child interactions and attachment which would further affect the self-confidence of the parents.

Nihira, Myers and Mink (1980) opined that an educationally stimulating home environment for the mentally retarded children depended on the level of mother's self-concept and affected her self confidence negatively.

According to Srivastava, Saxena and Saxena (1981), mothers of mentally challenged children were likely to be more reserved, homely and apprehensive about their children and consequently did not encourage independence and their child's outgoing behaviour as they felt anxious and less confident.

Wikler (1981) found many parents to report that uncertainly of their mentally handicapped child's future caused family's deep concern leading to negative attitudes. This attitude 'recycled' at each juncture of the life span when a developmental step would normally occur in the affected person. Every time, the parents felt hopeless about child's situation, they felt insecure too.

Agathonos and Vales (1982) pointed out in their study that the mothers had lower self-concept and self-confidence because of the birth of a retarded child, felt lonely, depressed and guilty and avoided every outing, fearing comparison of their child with normal children. The mothers having moderate self-concept and self confidence were more realistic and had made efforts to adjust to the problem. The remaining found no burden of their retarded child.

Dybwad (1982) expressed that physicians, social workers and psychologists were convinced about the mere presence of a mentally retarded child in a family had a negative attitude and feeling of insecurity among the parents.

Pain and Nandi (1982) found that mothers of mentally challenged children had more psychotics. Mothers of normal children were more extroverted than mothers of mentally challenged children. The findings also suggested that mothers of mentally challenged child were introverted, solitary, lacked in the
feeling of empathy and self confidence, felt frustrated and hostile towards others, and were unconventional.

Friedrich, Crinic and Greenberg (1983) showed that anxiety and depression were common squalors of stressful life events. These psychological problems could be viewed both as contributors to and consequences of stress and low self confidence in mothers of mentally challenged children.

According to Chaturvedi and Malhotra (1983), unhealthy and negative attitudes towards their retarded child were more in educated urbanities and those belonging to higher socio-economic status. They were let down by their retarded child and took it as a personal defeat. Therefore, despite their better understanding of illness, they tended to reject the retarded child. Younger parents had more negative attitudes due to the increased burden so early in life.

According to Sutherland (1983), society had a tendency to believe that ‘good’ parenting leads to effective child rearing and optional child outcomes. However, opinion on what constitutes ‘good parenting’ varied substantially among those considered to be experts as well as parents with different demographic characteristics and backgrounds and high self confidence levels.

Beckman (1983) focused on the retarded child’s characteristics namely temperament, responsiveness, repetitive behaviour patterns and care-giving demands and found that these were significantly related to the lower level of adjustment among the mothers.

Fickline (1983) also proposed that adjustment was often compounded with dissatisfaction, stress, morale, anxiety, tension, conflict, pressure nerves, boredom, fatigue, strain and depression.

Booth and Potts (1983) discussed the needs and sources of support available for mothers. It was argued that the children in the study created a great deal of extra work. It was mainly the mothers that took on the burden of this extra care and got the feeling of low self confidence.

Sexton (1983) indicated that personality of mothers of mentally challenged children was related to anxiety, low self-esteem, hostility, dogmatism, aggression, loneliness, rejection and low emotional competence.
Seshadri, Verma, Parshad (1983) reported that the mentally challenged child introduced new responsibilities in the family. In turn, this could affect the marital harmony among the parents and the amount of stress experienced. Parental attitude could determine the extent of social and marital stress.

According to Goodnow (1984), different constructs on parental concepts of development focussed on parental attitudes and ideas of child development and found these attitudes to affect parental feelings and behaviour, their ideas, feelings and behaviours that interact to affect child’s development outcomes.

According to Drew, Logan and Hardman (1984), denial, projection of blame, guilt, grief, withdrawal, rejection and acceptance were the usual parental reactions because of their own feeling of insecurity and low self confidence. The siblings also experienced feeling of guilt, shame and embarrassment.

According to Joginder (1984), alienation among the mothers of mentally retarded was concerned with the influence of the variables of poor adjustment and feeling of insecurity because of the presence of their abnormal child.

Chaturvedi and Malhotra (1984) revealed that most parents had unrealistic hopes and expectations from their mentally challenged child which added to have a negative impact on their self confidence among other reactions of rejection and hostility towards the child.

Pelz, Levy, Tamir and Spenster (1984) stated that good parental attitude and functioning led to better self-concept among the mothers of mentally retarded children.

Slater and Haber (1984) found that high family conflict was related to lower self-esteem and low self confidence among the mothers of mentally retarded individuals because of their presence.

According to Chamberlain (1985), the caretakers of mentally retarded children, generally the mothers, were exposed to more stress and disappointments that limited their quality of life and marital adjustment.

Crnic and Greenberg (1985) found that the cumulative impact of daily parenting hassles and difficulties in dealing with children represented significant
stressors that could subsequently affect personality of parents and their adjustment.

Foster and Gallagher (1986) compared the coping behaviour of depressed and non-depressed mothers of challenged children. Depressed mothers were significantly more likely to use emotional discharge as a coping technique and were weak in emotional competence. The non-depressed population consistently rated all methods of coping as more helpful than did the depressed sample regardless of the frequency of use.

Sigel (1986) in his research suggested that parental knowledge about the process of child development influenced the way parents understood the behaviour of the children. This perhaps affected their self confidence and the way they interacted with their children.

Mathur and Nalwa (1986) pointed out that most of the parents overestimated the abilities of their retarded children. Parents sometimes set goals and expectations so high that they were unattainable which led to disappointments, stress and negative feelings and attitudes towards their children.

Sulzby (1986) pointed the role of primary caregiver, usually the mother, in mediating between written languages and the developing retarded child was considered essential for her self confidence.

The studies of Fagot and Hamilton (1988) suggested that fathers and mothers differed in terms of their choice of coping strategies. It was also reported that mothers tended to be less confident and reacted to problematic situations via emotional expressiveness and that fathers more often acted on their environment instrumentally through constructive or destructive means. Gender differences were seen in the expression of behaviour.

Mann (1988) revealed that the working mothers of mentally retarded children experienced more adjustment problems as compared to non-working mothers.

Vieki, Harris and Susan (1989) examined the problematic situations experienced by mothers of mentally challenged children and stated that child
welfare issues and restrictive time demands were the most intense family problems reported by mentally challenged children's mothers. This had a negative impact on their emotional competences.

Flynt and Wood (1989) indicated in their results that black mothers of retarded children had lower self confidence than the white mothers. He also pointed out that older mothers had lower self confidence than the young mothers.

According to Bretherton (1990), certain elements of conversations (e.g. references to feelings) could advance early conscience development because they fostered an understanding of the repercussions of the mother's actions and emotional understanding. The nature of these conversations should be related to the affective quality and feeling of security of the relationship between the mother and her mentally challenged child so as to make her feel better on self confidence.

Crnic and Greenberg (1990) found that the cumulative impact of daily parenting hassles and difficulties in dealing with children's adjustment and associated behaviour represented significant stressors that could subsequently affect parent and family functioning.

According to Beckman (1991), mothers generally reported lower self confidence than did fathers; however the direction of difference depended on the individual scale. Parents of children with disabilities reported more care-giving requirements and low self confidence in all domains. Self confidence was negatively associated with informal support for both parents and positively associated with increased care-giving requirements for mothers.

Arya (1991) studied the personality traits of mothers of mentally challenged children and observed that they had higher scores of neuroticism, tension, social anxiety, low on adjustment and self esteem, high self doubt, hyper sensitive to criticism and were prone to feeling of guilt, shyness, reclusiveness and submissiveness. They scored high on nervousness, depressiveness and inhibition.

Dyson (1991) explored that the feeling of attitude among the mothers was related to the care of a child with special needs.
Sen and Tuli (1991) highlighted the agony of parents of mentally handicapped individuals including their adjustment problems and said that no other type of disability caused as much of personal, family, social and psychological problems as that of mental handicap. All the members of a family were affected psychologically, emotionally and socially; this in turn affected their personality.

According to Prasad (1992), women high in concern for status of their mentally handicapped child more often reacted emotionally and expressed displeasure, sentiments and anger on instance of discrimination and maltreatment to their child. This often resulted in their protests and revolts against the traditional social norms and taboos which place them in inferior position and affected their self confidence.

Flynt, Wood, Scott (1992) examined the utilization of social support and the perceptions of adjustment problems to mothers with a child who had mental retardation. Measures of adjustment and social support were administered to subjects with a child in one of three normative transition periods. There were no significant differences in adjustment scores across the groups. Analysis of variance procedures revealed significance difference in the utilization of intimate support across the age groups.

Pestonjee (1992) reported that two mothers with different levels of stress tolerance and self confidence when faced with same stressful situation exhibited different coping styles. People with low stress tolerance and low self confidence were more concerned about protecting their ego than solving their problem. They insulated themselves from surrounding reality because low stress tolerance and low self confidence made them fail in their initial encounters with stressful life events. The negative feedback generated by unsuccessful coping with stress was said to have made them defensive and withdraw from unpleasant reality.

Rousey, Best and Blacher (1992) commented that stress in families with children who had special needs, which has been the focus of much research interest, is usually assessed solely from a maternal perspective.
Misra and Sahu (1993) studied that role stress was significantly related to emotional competence, self confidence and depersonalization but not personal accomplishment. Conditions related to exhaustion included workload, role-conflict, ambiguity and non-contingent punishment.

Orr, Cameron, Dobson and Day (1993) indicated that sub-normal children belonging to all the three groups that is pre-school, middle childhood group and the adolescent group were strong sources of low self confidence for mothers. The second trend that was evident was that mothers in the middle childhood reported consistently very low self-confidence than did mothers in the other two groups on both parents and child domain scores.

Kraus (1993) reported on the parenting stress that mothers of disabled children experienced more stress and poor adjustment.

According to Kaur (1994), there were psychological factors which affected the feeling of security and insecurity of the individual. These factors included interest in various activities, motivation, personality traits, self concept, self confidence etc. An individual felt insecure when he/she was rather lost in the world. She further added that security and insecurity were closely related.

Rogner and Wessels (1994) observed that mothers of mentally challenged children showed more emotional stress, felt more burnt out, indulged in more self-criticism, had low self confidence and searched more of social support in the process of adaptation.

Terry (1994) pointed that coping responses were influenced by generalized control belief. Individuals with internal control beliefs used more problem-focused coping and less emotion-focused coping than persons while externally controlled beliefs did. This had a negative impact on their self confidence.

Greenglass, Fiksenbaum and Burke (1994) quoted perceived social support and work to overcome adjustment problems to be interacting variables.

Beresford (1994) reported that families with mentally challenged children do experience high levels of stress. However, the research has also shown that
stress is inevitable. The nature of stress has been shown to have an impact on several aspects of family life such as daily care demands, emotional distress like maternal depression, low self confidence, anxiety and social isolation.

According to Rangaswami (1995), the presence of mental retardation had a profound impact on the family. They first became aware of the problem, recognized it, tried to seek the cause of the problem and then searched for rectifying it. Though the presence of a retarded child need not create family crises, the stigma of mental retardation imposed by the society caused suffering to the parents.

Heckhausen and Schulz (1995) gave two general modalities of coping among mothers of retarded individuals i.e. activities directed to the outer world in order to improve one’s situation and to achieve one’s goals (primary control or assimilative processes); and activities directed inwards to protect one’s motivational system, self confidence and self-concept against losses in life (secondary control or accommodative processes).

Malhi and Singh (1995) showed that the parents of children with mental handicaps have unique liabilities to have their own concepts, hopes, ambitions and expectations from their child. But when these dreams got disrupted, they were badly disappointed, had increased level of stress and frustration, thus ending up lowering their own self confidence.

According to Benasich and Jeanne (1996), maternal characteristics were associated with both maternal knowledge and maternal behaviour towards their retarded child that could change the attitude of the mother. Consequently her behaviour towards the child was likely to change.

Ray (1996) highlighted the importance of early diagnosis, early intervention and training in enabling a mentally retarded child to lead a better life. The paper highlighted the assessment of different types of social and emotional problems of parents of mentally retarded children. Education and training of the siblings were said to change their perception of the mentally retarded child that was important to lessen the burden of parents regarding the uncertain future of their mentally retarded child.
Annapurna and Bharathi (1997) pointed out in their results that age, gender and birth order of mentally handicapped child did not significantly influence the attitude of fathers, mothers and significant other persons.

Blacher, Shaprio, Lopez, Diaz and Fusco (1997) examined the frustration and stress among women who have children with mental retardation. Results showed that these mothers reported more family problems, worse health, more negative feelings and low confidence about parenting their child with mental retardation.

Chen and Tang (1997) pointed that regardless of the duration of stress, all forms of support were perceived as equally useful for incontrollable stress, whereas tangible support was regarded as more useful than informational support for controllable stress among mothers of children with mental retardation that in turn makes them more confident to face life situations.

Reddy, Narayan and Prakasan (1997) pointed in their research that needs of parents vary depending on the age and characteristics of the child and the source that provides information. It was found that one third of the parents were not aware of services available. Influence of age of the retarded persons and literacy level of parents was found to be significant on the informational needs of parents. Thus, professional help was suggested.

According to Thompson (1998), a child’s early relationship within the family is important in the context of the family relationships. These mentally handicapped children had their earliest experience with the behavioural and moral standards of the social world. A child’s daily interactions with care givers, including shared pretend play, humour, negotiation of conflict, enforcement of behavioural standards and conversations with family members provided children with a natural laboratory in which they learnt about the social world that made the mother socially and emotionally secure and competent, and more confident in life.

According to Laible and Thompson (1998), emotional laden discourse about a child’s past experiences could make emotions more accessible and less threatening for the mother of a mentally handicapped child when reflecting upon
past personal experiences (particularly the negatively charged emotional experiences). This idea was supported by the significant association between the mother of the handicapped child in reference to the feelings of self confidence and evaluative factor, and attachment security. The findings were consistent with previous research that suggested that a secure attachment was important in fostering the understanding of negative emotions.

Chandran and Peng (1999) found that mothers of children with mental retardation showed significantly higher stress than control subjects in both the child related domain and parents related domain. A large proportion of these mothers experienced substantial parenting stress and a low self confidence.

Paterson, Luntz, Perleszm and Cotton (2002) reported that mothers of mentally challenged children experienced high levels of stress and poor adjustment.

Diter (2002) evaluated anxiety, stress, burnout and general psychological symptoms in the mothers of mentally challenged children in comparison with those in the mothers of normal children. The study showed that mothers of mentally challenged children were reported to be more anxious, stressed, introverted and neurotic than those of normal control group because of association with their adjustment behaviour and related problems.

Singh, Jahan, Nizamie and Singh (2002) found that families not only affected but were also affected by their disabled members in various ways. Results showed that mothers of mentally retarded individuals felt more stressed as they lacked emotional competence. Parents who were attending the counseling service for a longer duration felt significantly less anxiety and irritability due to the presence of mentally retarded children.

Baron (2003) categorized the various modes of defending against stressors and various modes of coping by an individual as: physiological, which included learning to reduce tension in our muscles through progressive relaxation or regular vigorous exercises; behavioural, which included a wide array of actions to alleviate or change the source of stress e.g. time management techniques; and cognitive, which referred to ways in which an individual employs social and
psychological mechanisms to deal with stress, for instance, cognitive restricting. Better the coping, more adjusted were the parents of mentally retarded children.

Mamta and Punia (2003) in their results indicated that parents of mentally retarded wards had high self-confidence once they had moderate knowledge through guidance on all aspects of facilities available to help the special child.

Screiber, Marchetti and Crytzer (2004) pointed that individuals cope by having equilibrium between claims and resources. If the claims increased and resources decreased, it led to a sense of loss of control over one’s life situation. This mobilized efforts to restore control by adjusting claims and resources or developing new ways of behaviour to meet new challenges.

Stoneman, Gavidia and Susana (2006) indicated that when daily stressors were higher, the mothers viewed their marriages more negatively. They reported higher marital adjustment when focused on coping strategies suggested by guidance and counseling professionals.

2.2 LITERATURE RELATED TO PSYCHO-MOTOR VARIABLES OF MENTALLY RETARDED INDIVIDUALS

Cline (1960), Kohen (1970), and Zillenger (1977) in their researches came to the conclusion that the phenomenon of behaviour problems was accelerated with the increased complexities and social disinterest in the needs of special children.

According to Zajone (1965), the presence of others served as a source of arousal for the mentally retarded individuals. Arousal increased the likelihood of an organism making habitual or well learnt responses which improved performance at simple tasks and impaired performance at complex or difficult tasks.

Rutter, Graham and Yule (1970) in a study found psychiatric problems in 30% to 42% of retarded children and adolescents as opposed to 7% of the children with normal intelligence levels. Rates were similar among non institutionalized samples in the United States and Sweden.
Akhtar & Verma (1972) revealed that the problems of mentally retarded were enormous and that the role of their parents was important. When the parents became aware of defect in their child, they went through various reactions like shock, denial, anger and insecurity. Because of unrealistic expectations, mothers became over concerned and anxious.

Fullmer and Bernard (1972) in their study pointed that sources of pressure on behaviour were: specific and general, immediate and remote, external and internal and real and fantasized. Analyzing the source and the intensity of pressure helped to explain the individual’s pattern of labeled behavior. It also helped in the qualitative judgment of the behaviour.

Weiner (1974) reported that delay in academic instruction to the mentally retarded could impair the final level of scholastic attainment. More appropriate skills and social behaviours could result from utilization of the time made available by such delay.

Delp (1974) concluded that not only should the unnecessary or too difficult academic work be eliminated but the selection of curriculum material should be guided by the criterion of what is immediately relevant and meaningful also.

Sloan (1975) compared the motor proficiency of matched groups of normal and mentally retarded individuals and found reliable differences between the groups. He concluded that motor proficiency is not an isolated function, but is one additional aspect of the total behaviour of the human being.

Coleman and Ayoub (1976) examined the physical work capacity of educable and trainable mentally retarded males. Analysis of results indicated that the physical work capacity of the tested population was 20% to 30% below that cited for non retarded subjects of similar age and sex. They also suggested that the development and maintenance programmes of physical fitness were required in order to help mentally retarded persons to qualify for and maintain employment on most of the manual occupational tasks chosen for them.

Conolly (1978) reported that the abilities of mentally challenged children are not limited and recommended introduction of special development
programmes form birth onwards to promote an increase in intellectual development.

Veninga (1979) found that adjustment problems among the parents of mentally retarded individuals were due to debilitating psychological conditions brought about by work related frustrations of their wards that resulted in lowered productivity and morale.

Johnson and Nelson (1982) stated that a higher degree of total flexibility and agility in whole of the body is desirable and unmoved amount of flexibility and agility in certain body movements is necessary for maintenance of correct body form.

Friedrich, Crnic and Greenberg (1983) reported that the problems faced by families of mentally retarded were clearly multidimensional and that the scores on a given dimension could not predict or be predicted from knowledge of the scores of the remaining directions.

In a study by Koller, Richardson and Kartz (1983), behaviours ranging from the aggressive and impulsive acting out of the mildly retarded to the stereotyped purposeless motor release or the self injurious actions of the severely retarded were the expression of a reduced capacity for mental control of emotional states. These behaviours frequently increased during adolescence. In a five year follow up study of mentally retarded adolescents, the incidence of conduct disorders was 59%.

Bos and Tierney (1984) reported that mildly retarded children generated the same quantity of inferences as did non-retarded students, but the inferences were qualitatively inferior.

Brooks and McCauley (1984) reported that many of the cognitive problems of retarded individuals are due to attention problems.

Mathew (1984) determined the relationship of selected measurements namely height, weight, arm length, upper body length and performance and indicated that these variables showed significantly higher relationship with performance.
Tomporowski and Ellis (1984) concluded that vascular efficiency improved in the group that was given the treatment of physical exercises where as IQ and adaptive behaviour did not improve. Even though standardized tests reflected a little change in the adaptive behaviour of participants, subjective reports suggested that physical exercise training may serve as an effective rehabilitation programme for many institutionalized mentally challenged children.

Glidden (1985) has shown that the mentally retarded individuals, though deficient in the spontaneous use of learning strategies and executive control processes, can be taught to use such processes successfully.

Schurrer, Weltman and Brammell (1985) indicated that the mentally challenged children who attended exercise sessions regularly reduced their body weight and the maximal oxygen consumption increased in them. Further, favourable behaviour changes occurred during the 23rd week of physical training programme.

According to Baron (1986), performance is dependent upon the number of cues or destructions present in the situation and endorsed the viewpoint of social psychologists that social facilitation in humans is influenced by both psychological and social facilitation and that these are influenced by both physiological arousal and cognitive processes (such as distraction and evaluation apprehensions).

According to Dunn (1987), language was especially important in a child’s moral and socio emotional development. The daily conversations a child shared with parents were often imbued with messages about social and moral issues and references of adjustment.

In a study reported by Oliver, Murphy and Corbett (1987) it was found that with greater degree of mental retardation, aggressiveness, feeding disorders (e.g. pica rumination and vomiting), stereotyped movements and above all self injurious behaviour were more frequent. 10% to 15% of the mentally retarded manifested self injurious behaviour with the incidence increasing as IQ decreased. The onset of self injurious behaviour was usually found after puberty. Self injurious behaviour was more frequent in mentally retarded persons with
mood disorders (both depressive and manic), schizophrenia, personality disorders (borderline type) and anxiety disorders (obsessive compulsive).

Mines (1988) studied the family resources and behaviour problems associated with families having a mentally retarded child. Results indicated that child's characteristics and family's crisis meeting resources were significant predictors of various forms of behaviour problems.

Montgomery, Reid and Seidl (1988) evaluated the physical fitness programme conducted by the physical education graduate students using Canadian standardized test of Fitness, MANOVA. Results revealed that both the six month and four month programmes increased the physical fitness of the mentally challenged workers although cardiovascular endurance improved only as a function of four month programme. Training affected the psycho-motor performance of individuals; their analysis showed that the group who had pre test training with moderately challenged children did significantly better than severely retarded ones. It appeared that the performance could be developed through training.

Sharma (1988) discussed behaviour problems as the major modern malady that presented a recurrent crisis in the lives of parents of mentally retarded children owing to maladjustment and discontent with the rapidly changing values of the society.

According to Holden and Edwards (1989), parental feeling of behaviour problems, knowledge of child-rearing, parenting behaviour and child outcomes were interrelated.

According to Vitiello, Spreat and Behar (1989), family history of anxiety disorders was an important indicator. Obsessive ideas were relatively rare in the retarded whereas compulsions (repetitive ritualistic behaviours) were quite frequent, especially during adolescence. Mental retardation was found to be a risk factor for compulsive disorder. An ego dystonic component could be absent in the mentally retarded; they did not recognize that their obsessions and compulsions were unreasonable and often became upset if someone interfered with their ritualistic behaviour. The more common rituals were ordering verbal
perseverations, compulsive eating or drinking, and masturbation; stereotypies were frequently associated.

Narayan (1989) conducted a study with the purpose to find out the effectiveness of modeling as a teaching technique for mentally retarded children in Indian conditions. The sample size of the study was 150 mentally challenged children including 75 educable mentally retarded challenged (EMR IQ (51-70)) and 75 trainable mentally challenged children (TMR-IQ-(25-50)), their chronological age ranging form 10-14 years. Each group was randomly divided into three treatment groups namely the adult model group, the peer model group and the no model group. Four models (two adults and two peers) were prepared to train the subjects. The results of the study indicated that peer modeling was the most effective technique for learning of performance skill in motor, perceptual and communication areas for both EMR and TMR children. The adult model was found to be better than no model condition.

Rawat (1989) reported that cardiovascular endurance, lean body weight and various motor skill variations were main contributors to enhanced performance.

Stratford and Ching (1989) concluded that specific teaching approaches like dance, movement and music affected the performance of mentally challenged children in variables like movements, social development etc.

Whitehead (1989) in a study investigated motivational outcomes among mentally retarded children consequent to participation in physical fitness resting procedures. Seventh and eighth grade school children (N=105) were administered the Intrinsic Motivation Inventory before and after participating in a fitness test where they received positive, negative or no verbal feedback (control). MANOVA modeling procedures revealed that positive feedback increased intrinsic motivation while negative feedback decreased. Analysis showed that changes in intrinsic motivation were mediated by changes in perceived competence. In a second experiment, seventh and eight grade school children (N=370) participated in either the president’s challenge or the fitness programme or fitness tests because of their different evaluative procedures and incentives schemes.
Purnima (1990) concluded that the problems experienced by parents of mentally challenged children in relation to their behaviour varied at different stages of the life cycle and this affected their mother’s personality.

Peshwaria, Venkatesan and Menon (1990) in a study conducted with an aim to analyze the areas of behavioural problems in the mentally handicapped persons found that the trends in parental needs of handling the behavioural problems of their mentally challenged children in terms of severity and sex had implications on the findings with service provisions.

Arya (1991) in his study indicated the efficacy of NIMH Development Screening Schedule in assessing mental retardation in rural children.

Dwarka (1991) concluded that the physical variables namely speed, arm strength, power, dynamic balance, agility, flexibility, height and weight were found to be significantly related to the performance and abilities of individuals.

Dyson (1991) investigated the differences between families with children with special needs and those with children without special needs with regard to family functioning. Five families with young children with handicaps were compared with a matched group of families of children without handicaps. The results provided strong evidence that family-stress was related to the care of a child with special needs in middle class families.

Youn G. and Youn S. (1991) assessed the training effects on the psycho-motor performance of individuals with mental retardation. Their analysis showed that the group who had pre test training opportunities performed significantly better than those without that training while moderately challenged individuals did significantly better than severely retarded ones. It appeared that the performance could be developed through training.

According to Gleser (1992), a modified form of judo training indicated improvements in physical fitness, motor skills and psychological attitude of mentally challenged children. The authors concluded that a modified form of judo could be a therapeutic, educational and recreational tool.
Boswell (1993) studied the effect of movement sequences and creative
dance on balance of children with mental retardation. There was a significant
difference between the creative dance group and the traditional gross motor
programme group.

Dana (1993) stated that the most evident features of the anti social
disorder were aggressiveness, lying, difficulty in establishing social relationship
and participation in anti-social groups. The border line disorder in retarded
adolescents was characterized by mood swings, weak self-image and difficulty in
controlling impulsive and poor interpersonal relationships. The depressive
component of the borderline personality disorder was especially intense.
Avoidant adolescents were isolated and expressed feelings of inadequacy. They
were shy and hypersensitive to frustrations.

Dosen and Gielen (1993) discussed symptoms mimicking a depressive
state (apathy hyperpyrexia, crying); vegetative symptoms (loss of appetite or
weight styptics asthenia); psycho-motor agitation with temper tantrums, self
injurious behaviour, or conversely, catatonia and stereotypy; tendency to
withdraw form or lack of interest in the social sphere; and childish behaviour
related to dysphoric mood of severe forms of mental retardation and suggested
clinical criteria for the diagnosis.

Fernhall (1993) reviewed in his paper on physical fitness and exercise
training of individuals with mental retardation and quoted exercise to have a
positive impact on three physical fitness components. The components
considered in the study were obesity, cardiovascular fitness and muscular
strength and endurance.

Millar, Fernhall and Burkett (1993) concluded that the ten week training
programme given to adolescents with Down’s syndrome did not produce
improvement in aerobic capacity; it did produce gains in walking capacity thus
suggesting that adolescents and young adults might not improve their aerobic
capacity but might improve agility when performing a walk/jog.

Redl (1993) studied from a clinical standpoint that all forms of
schizophrenia could be found in retarded subjects often with mixed clinical
features (disorganized paranoid catatonic) that lead to a diagnosis of undifferentiated psychosis. In adolescence, a mixture of positive and negative symptoms was more frequent; naive fragmentary delusions or simple hallucinations; disordered thoughts, especially verbal expressions (echolalia, verbigeration, negologisms) and psycho-motor disturbances (excessive motor activity or stupor). Acute-onset schizophrenia was more often associated with severe behavioural symptoms such as aggressiveness, impulsiveness and self injurious behaviour. Negative symptoms have a negative prognosis; massive relational withdrawn, catatonia, mutism and affective blunting or silliness were associated with poor outcome. The disorganized and catatonic forms were more frequent in adolescence; while the paranoid forms were much more frequent in adulthood. The earlier forms generally followed a more severe course and were less responsive to pharmacotherapy.

According to American Psychiatric Association (1994), hyperactivity was said to be manifested in excessive motor activity often associated with clumsiness; mentally retarded adolescents talked excessively and made excessive noise during activities. In such adolescents, gross motor activity and a subjective feeling of restlessness often remained excessive and sometimes hyperactivity became more severe. It was further highlighted that impulsivity could also become more severe in retarded adolescents significantly interfering with familial, social, educational and behavioural adjustment.

O’Hagan, Smith and Pileggi (1994) concluded that a planned and supervised regular exercise improved the physical functioning and daily activities.

Ramgopal and Rao (1994) attempted to assess the behaviour disorders in moderately mentally retarded and their relation to parental attitude. The findings showed that anxiety problem was the highest among parents of mentally challenged children.

Yamanaka, Furuya and Shibagaki (1994) concluded that various training programmes have been devised to achieve greater physical fitness for mentally challenged children. Such training could also facilitate socialized behaviour and play at school.
According to Khokhar and Khokar (1995), mentally retarded children showing deficit skill behaviour if imparted training by scientific methods could become self-dependent. Techniques of teaching skill behaviour such as shaping, modelling, limitation and token economy were discussed in their study. Physical restraint, response cost, extinction and ignoring were emphasized for alleviating problem behaviours. Parents' need for guidance for the same was highlighted.

Harden and Swomley (1995) pointed out that flexibility is a primary pre requisite for good execution of the movements. He further added that lack of agility and flexibility can result in difficulty in learning new elements and incompletes the expression of conditional abilities that further adds stress in an individual.

Peshawaria, Venkatesar and Menon (1995) found that because of behaviour problems of their mentally retarded children, more than 10% parents of such children reported emotional reaction, mental worries, extra demand, strained relations, loss of support, social restrictions, facing ridicule and problem in career adjustment.

Benasich and Jeanne (1996) in a prospective longitudinal study of a mother of mentally challenged child showed that knowledge given through intervention and consequent quality home environment had an effect on child's cognitive and behavioural outcomes since maternal beliefs were associated with maternal personality.

In a study by Costello (1996), the clinical features of the most important psychiatric disorders in mentally retarded adolescents were described as: mood disorders, psychotic disorders, severe behavioural disorders, personality disorders, anxiety disorders and attention deficit disorder with hyperactivity and of not being fully functional members of society in adulthood. This burden of disease was said to include the prevalence of mental illness morbidity and cost. More child mental disorders were said to persist into adulthood. 74% of 21 years old with mental disorders had prior problems. It was further pointed out that criteria for child psychiatric disorders needs to include not merely emotional or behavioural abnormality, but should consider functional impairment as well. The
frequency of mental health problems was highest among the very poor, but, most children with mental health problems were from the middle class. Important issues to consider were risk factors and protective, as well as co-morbidity of disorders, which was very common. He also pointed at underutilization of specialty health services for which possible reasons could include stigma, cost and parental space dissatisfaction with services.

Masi, Marcheschi and Luccherino (1996) stated that adolescence is a particularly important phase for the mentally retarded because intellectual impairment could reduce adolescents' ability to integrate bodily and psychic transformations increasing the risk of psychopathology. The clinical characteristics of psychiatric disorders in mentally retarded adolescents were said to be influenced by the intellectual disability. Since clinical features were often not well defined and symptoms were more aspecific as the intellectual impairment becomes more severe diagnosis, it could be particularly difficult. In addition, the course of mental disorders often differed for the mentally retarded. For example, reversibility was less frequent. The role of traumatic life events was especially important, since they more frequently had a triggering effect than for those with normal intelligence. The issue of psychopharmacological therapy was considered complex as mental retardation has been considered an exclusion criterion in most studies on the efficacy of psychotropic drugs.

Pati and Kumar (1996) in their study indicated that the effect of IQ level complexity of the exploratory behaviour was significant. The moderately retarded subjects were more exploratory than the severely retarded. Further, simple stimulus object elicited more exploratory behaviour than the complex stimulus object.

Barown, Sethi and Sen (1997) in their study on thirty mentally retarded subjects found that task complexity was related to the traditional mental age scores (general intelligence) as measured by the Sequin Form Board test and Stanford Binet Intelligence Scale.

Peran, Gil, Ruiz, Fernandez and Pastor (1997) in their competition oriented athletics training programme held twice a week showed a significant
improvement in the test scores measuring strength, speed and endurance and a tendency towards an athletics morphotype.

Wang and Chang (1997) indicated that the jumping activity might effectively evoke the automatic and dynamic postural control. Moreover significant improvements were seen in walking balance in children with mental retardation.

Handen (1998) felt that most extensive and common interventions for treating mental retardation are educational and guidance services.

Kalaairasi (1999) made a survey of educational facilities available for the mentally retarded children in special schools. Thirty schools from Tamil Nadu and five schools from Karnataka were selected for the study. The researcher developed a questionnaire and used it as a tool. Percentage method was used to compute the data. It was found that majority of the schools taught the subjects like gross motor co-ordination, fine motor co-ordination, eating, toileting and receptive and expressive skills.

Annapurna (1999) studied the impact of mentally retarded children on their families and explored the nature and type of problems experienced by the parents and siblings of mentally retarded individuals coming from rural and non nuclear families. These children were said to pose much less problems to their mothers. Mothers of mentally retarded children were found to be more stressed and maladjusted.

Lexell (1999) gave the conclusion that exercise could not only improve strength and endurance but also balance and mobility of individuals.

Kamalam (1999) stated that incorporation into their curriculum for training mentally retarded, adequate contents of mental retardation and related motor, physical and psychological aspects to enhance the capacities of regular teacher trainers to enable them to teach/train as well as to guide caretakers and mild mentally retarded individuals effectively.

Gosch (2001) concluded from his study on mothers of mentally retarded children that regardless of its etiology, such mothers found it more difficult to
accept their child than did mothers of non-disabled children. Further, specific behaviour problems associated with behavioural phenotype of a syndrome were also said to influence the level of maternal stress.

Thressiakurtty and Rao (2001) conducted a study on parental perceptions of adjustment problems and expectations regarding their mentally retarded children. The study revealed that due to these problems and expectations, parents suffered from anxiety and insecurity.

Ulrich, Angulo, and Yun (2001) in their study found that with training and support, parents could use treadmills in their homes to help their infants with Down's syndrome. They could learn to walk earlier than they normally would.

Verela, Sardinha, and Pitetti (2001) noticed the effects of an aerobic rowing training regime in young adults with mental retardation and results showed that an exercise training regime did not improve the cardiovascular fitness but did improve muscle strength, exercise endurance and work capacity.

The findings of Juyal (2002) indicated that the attitude of parents of mentally handicapped children differed in respect of acceptance, permissiveness and domination of their children. Mentally handicapped children also showed better emotional adjustment at home when accepted by their parents and had lesser behavioural problems. Social adjustment was found to be related to permissiveness and domination of the father.

Gupta and Jain (2002) revealed that less educated parents of mentally retarded children and those belonging to low-income groups and rural areas had a significantly high proportion of problems because of adjustment and related problems and were more stressed.

Weiss (2002) indicated significant group differences among displaying behavioural problems among mothers of autistic, mentally retarded and typically developing children in ratings of depression, anxiety, somatic complaints and burnout.

Wang and Ju (2002) proved that the subjects with jumping training had greater scores for balance and motor proficiency than those without exercise.
Analysis of variance showed pre test and post test differences on scores for beam walk, floor walk and horizontal and vertical jumping.

According to Wind, Schwend and Larson (2004), sports could improve strength, endurance and cardiopulmonary fitness while providing companionship, a sense of achievement and heightened self esteem. Family engagement was said to be the key component in treatment participation and care, and the effective implementation of that care. Research indicated the importance of effective treatments and emphasized capacity for individualization and the mentally retarded child and parent relationship. The treatments that prescribed principles and general processes but allowed flexibility for adaptation (to strengthen needs of individual children and families, and those that involved families and practitioners in the development of the interventions) produced encouraging results. These included intensive case management, wraparound services and multi systemic therapy.

Lotan, Isakov and Merrick (2004) recommended following a physical fitness programme conducted on a daily basis as it was capable of improving functional ability of children with mental retardation. Although all items of functional ability measured showed impressive positive change, some of the 31 items on it statistically showed significant improvement (knee walking, going up and down stairs and speed of walking for 25 m). Task skill was said to be more quantifiable, teachable and amenable to the ways that self efficacy could be improved through enactive mastery experiences or modeling exercises. Further, it was opined that social efficacy was not enough to ensure desirable job performance.

Rimmer, Heller, Wang and Valerio (2004) concluded in their study that as compared to control group subjects, the training group improved significantly in cardiovascular fitness, muscular strength and endurance and had a slight but significant reduction in body weight.

Schreiber, Marchetti and Crytzer (2004) demonstrated a reduction in energy expenditure index and a slight improvement in maximum running velocity. Activity level remained at a relatively high level too.
White, Pritchard and Stokes (2004) concluded that there was inadequate evidence to evaluate the effect of exercise on functional ability in people with mental retardation. The result suggested that progressive resisted exercise could improve muscle strength in affected muscles.

Wind, Schwend and Larson (2004) were of the opinion that sports could improve strength, endurance and cardiopulmonary fitness while providing companionship, a sense of achievement and heightened self esteem.

Andriolo, Dib and Ramos (2005) highlighted the need for well conducted research which examine long term physical outcomes, adverse effects, psychological outcomes and costs to further investigate and support existing evidence that support improvements in psychological and physiological aspects from strategies using mixed physical activity programmes to make important practice decisions.

Eldin (2005) conducted a 3 month swimming programme with music being used as one of the tools. The result showed significant improvement in agility, self esteem and behaviour patterns. The programme was thus found to be effective in enhancing the integrated development of mentally challenged children.

Rao, Narain and Mani (2005) while supporting the manual for teachers regarding the early education by a calendar and activity cards that helped the mentally challenged child develop basic psycho-motor skills for further education/vocation.

Bergeron and Floyd (2006) conducted a comparison between sets and subsets of objects on mentally challenged children and reported that despite normative deficiencies in IQ’s, children with mental retardation demonstrated a wide range of performance across various measures.

Lotan (2007) gave a review that persons with mental retardation are at risk because of life of inactivity that can result in a multitude of medical problems. So quality physical intervention activities should be implemented for this population.
Kaushik (2008) found the effect of physical exercise to have a positive effect on attention concentration, strength and agility of mentally challenged individuals.

Tracey and Masting (2008) in a cross-sectional analysis, on mothers' positive perceptions of their child pointed that acceptance was negatively associated with maternal anxiety, depression and stress, such that mothers of mentally retarded who were generally more accepting reported fewer psychological adjustment problems. Longitudinal analysis showed that acceptance is bi-directionally related to anxiety and depression. Mindfulness was not significantly related to maternal distress and avoidance coping was positively and cross-sectionally associated with depression only. There were no associations between psychological variables and maternal positive perceptions. It was concluded that acceptance in particular could be a construct to explain some variance in maternal distress.

Mukherjee (2008) in a seminar on fitness pointed that for many individuals, the complications associated with weight gain, obesity and weight management were often related to lack of diet and exercise. For some individuals however, there was an increased risk for developing obesity simply due to metabolic disorders or complications associated with a health conditions. Individuals who suffered form mental retardation were at a unique disadvantage often gaining weight, living with obesity and rarely finding the right balance for weight management. As the parent of child who is mentally retarded, it is important to understand the issues with regard to weight management. With greater obesity found in the mentally retarded who are classified as mild to moderates, parents are often surprised to learn of the health risk in their disabled child. In addition, the greatest risk for their development will most likely occur in their home as many children who are classified as mentally retarded and living in institutions experience significantly less frequency of weight gain and obesity.
2.3 LITERATURE RELATED TO VOCATIONAL GUIDANCE FOR PARENTS (MOTHERS) OF MENTALLY RETARDED INDIVIDUALS

National Society for Mentally Handicapped Children (1967) found that the parents felt very ill supplied with informal guidance about management of their child and their own feelings in relation to him. The mentally handicapped child was more vulnerable to illness than other children. The parents are likely to make more demands on their doctor's services than they would with a normal child. They were withdrawn socially and felt anxious, stressed and sensitive about the attitude of society as whole.

According to Crites (1969), Seligman (1994), Herr and Cramer (1996) and Brown and Brooks (1996) in their respective studies, most career or vocational textbooks were reported to have organized the presentation of material around either life stages or career development theories or phase of career intervention. Each of these approaches has distinct advantages for highlighting facets of what we know through research in vocational psychology. However, a focus on research activities rather than life stages, theories or career interventions per se may provide the best way to provide an overview for the field of vocational psychology as traditionally conducted so as to distinguish it better from developmental psychology or career counseling. It may be more useful to focus on research-oriented subfields (reflecting the activities and interests of vocational psychological researchers) rather than on vocational theories per se (reflecting the theories of theorists). Many of these theories were likely to apply to both vocational psychology and career counseling for the advantage of the subjects.

Crites (1969) defines vocational guidance as the study for vocational behaviour and development. He further defined vocational behaviour to comprise of all responses that the individual makes in choosing and adjusting to an occupation.

Kirk (1969) concluded that parents of mentally retarded children were mainly anxious whether their children would be able to support themselves and
find a niche in life; they were quite reluctant and hesitant in letting their children
do some manual work.

Mental retardation has traditionally been considered as an intelligence
disorder, principally requiring pedagogical or social interventions. Following the
work of such pioneers as Menolascine (1968), a growing number of researchers
are dedicated to understanding the peculiarities of psychiatric illnesses in this
population, specifically regarding clinical manifestation, diagnostic instruments
and pharmacotherapy to provide more rigorous bases for the psychiatric study of
mentally retarded adolescents.

Gumz and Gubrium (1972) in a study on 50 parents of young mentally
retarded individuals revealed that they had a negative influence on their parents,
especially mothers, for their care and future concern.

Biswa (1980) pointed out that parents generally felt ashamed of their
mentally challenged offsprings because of reactions of others. They withdrew
almost completely from the community activities because of the presence of
mentally deficient child in the family and hence required counseling service.

According to Chauhan (1982), persons in all walks of life sense the need
for means for gaining new understanding regarding the significance and purpose
of life itself. Hence, the interest increased in the use of what is now known as
group guidance.

Results of the study done by Veena (1985) indicated that the nature and
extent of disability of the disabled member affected the problems faced by the
family that needed guidance.

The National Policy on Education (NPE, 1986) and its modification (1992)
has laid a lot of emphasis on the education of the mentally handicapped. It is
emphasized that mentally retarded individuals should be provided with equal
educational opportunities as others with the aim of developing in them the self-
confidence, courage and integrating them into the mainstream of community as
equal partners.
Balgopal (1986) reported self-help groups to have become an increasingly important vehicle for providing vocational and educational guidance and mental health services for this population and found it to be highly cost effective.

Gupta (1989) in an exploratory study on some aspects of high academic stress and symptoms in 12-15 years old students by imparting career awareness and career design making skills through guidance and found a significant impact of the same on the career planning skills and career related attitudes.

Lehman (1995) pointed that most vocational rehabilitation programmes had a positive influence on work-related activities but most failed to show substantial and enduring impacts on independent and competitive employment. Vocational rehabilitation intervention was reported to have exerted positive influences on such clinical outcomes as medication compliance, symptom reduction and relapse.

The functions of guidance as laid out by the Adult Educational Guidance Initiative of Scotland (AEGIS) (1995) include:

- Providing information.
- Helping people interpret information and make choices.
- Helping people find out what they want and need and work out various ways of meeting their wants and needs.
- Helping people’s ability to choose opportunities appropriate to their personal, educational and vocational development.
- Providing learning experience to help people gain the skills needed to make decisions and transitions.
- Supporting people in dealing with educational institutions or employment agencies, in a way that encourages them to do it by themselves another time.

Guidance as stated above is an impartial, holistic, client-centered service which works primarily with individuals who use the service of their own free will. The importance of such guidance for lifelong learning has been recognized to
varying extents, in a number of documents. For example, the National Advisory Council for Education and Training Targets (NACETI) (1997) pointed out that it was important for people to do the right learning, to get them where they wanted to go making career education and guidance vital for people of all ages.

Sturm (1997) in debate about the feasibility of implementing parity for mental health and physical health services for both children and adults in private sector highlighted the unmet need for child mental health services.

According to report by National Ambulatory Medical Care Survey (NAMCS 1998), United States, each year there are more than 150 million pediatric visits for primary care. Most children with mental health problems see their primary care providers rather than mental health specialists. Parents trust these primary care providers more than others. Yet, many barriers impede the delivery of effective mental healthcare. The average visit was only between 11 and 15 minutes (NAMCS, 1988; CBS, 1997).

According to Clark (1999), the guidance process itself provides learning experience to enable clients to acquire knowledge, skills and competencies related to making personal educational and career decisions.

According to Greenberg (1999), well established, empirically-validated programmes should be followed. He added that effective programmes have three important components. Firstly, these build cognitive and behavioural skills that are protective, secondly, these help families and children gain better emotional awareness and regulation, and thirdly these improve the relationships of children with their parents and peers. He also highlighted opportunities to utilize effective models of prevention in integrated systems of mental healthcare. He emphasized the need for a system of care that integrates prevention services, which are relatively low cost, along with other services (early intervention and high-end, high-cost services) into one seamless system.

Burnam and Escarce (1999) further added that the meaning of parity is changing under managed care as the defined benefit does not necessarily directly correspond to the level of care provided under management policies.
Das, Pillay and Diwakar (2001) in a study to rate the performance of students placed in accordance in vocational assessment recommended practicing vocational guidance for them. Results of the study showed a significant difference in 11 areas in favour of students who were placed according to the recommendations: effort, attitude towards work, ability to get along with others in class, taking directions in class, appropriate behaviour on the job, ability to accept supervision of the instructor, attention span and ability to complete a job, ability to accept boredom and repetition on the job, quality of work produced, overall performance and grade average. The study concluded that placement of students in vocational areas recommended as a result of vocational assessment and successful performance ratings appeared to be systematically related.

Gawali (2003) administered Family Needs Schedule on the parents of mentally retarded children followed by intervention process useful for rehabilitation of mentally retarded children through videotapes. He found a positive impact of such interventions on the rehabilitation of mentally retarded children.

Nystul (2003) pointed that guidance and counseling may be viewed as a process by which one person (the counselor) helps another person (the client) more effectively not only with his inner world of feelings but also with the stresses imposed by the impact of other people and his physical environment. Effective guidance is not predicted on guess work or hunches but is and should be based on best scientific knowledge at our disposal. Only after evidence of constructive change in the client can we lay a rightful claim to being effective professional counselor.

Parents of mentally retarded individuals while supporting them through their training select target behaviour (such as self-help skills, cognitive, language, socialization, motor etc.) and work during the rest of the week. They receive professional guidance in structuring the individual educational programme for their children. This ultimately generates a group feeling among parents. Parents can provide help to their children by themselves with minimum professional help. There are various helping strategies to promote education among mentally
retarded children such as special education, integrated education and community-based rehabilitation programmes which include home-based early intervention programme such as portage rural-based District Rehabilitation Centre Scheme, vocational training and self-help groups. Intervention through self-help groups’ programme cares and provides training and education to all levels of mentally retarded individuals according to their individual rehabilitation plans. Parents are involved directly in the training and education of their mentally retarded children.

Steps suggested to integrate mental health into systems of childcare, education and other key systems include: (1) Effective training for teachers and child care workers in social and emotional development; (2) Effective training for mental health professionals in evidence-based prevention practices; (3) Information for consumers on effective preventive models; and (4) Removing the disincentives in insurance systems for prevention activities so that healthcare professionals, especially primary care providers and others in the community will have incentives to provide early mental health preventive services.

Behl (2006) quoted a study done by Kohli in 1998 who remarked that India, a developing country with meager resources, massive population and geographic immunity, is faced with an estimated population of 3 percent mentally retarded, which required services in various areas. Self-help groups programme could easily find a suitable place within the locality, convenient to all. Further in her explanation she said that self-help groups are small groups of parents (ranging from 3 to 25) of mentally retarded children, who meet periodically. In the daily self-help group, the parents assist the teacher (in rotation), which takes the form of a school. During the weekly self-help groups, parents meet for 3 to 5 hours once a week, where they are encouraged to discuss their problems with the professionals regarding their mentally retarded child.

According to Kaur (2007) mother also have needs for looking after their mentally challenged child, such as personal safety, development of basic behavioural skills and care giving needs, autonomy in making choices for design making, intellectual stimulation and creative opportunities. The needs of the mothers of mentally challenged children, their psychological and physical health
well being, and feeling of burnout and frustration should be met with friendly approach that may reduce their level of stress.

Mukherjee, Kaushik, Mukherjee and Kumar (2007) pointed that people with disabilities are excluded from main-stream society and employment a number of barriers. Reassurance can be provided through peer support groups in which disabled persons can learn from each other and from people with disabilities who have been successful in securing jobs.

Oka and Miura (2007) pointed that when families express some concern about the retarded members’ ability to profit by his training; they are usually expressing their own anxieties for his success. They have a real need for him to succeed, yet have a reluctance to free him to the point of allowing him to try and thus guidance is required to handle such situations.

Joneja (2008) while discussing the vision for teacher education pointed that teacher trainer must become more sensitive to the emerging demands from the school system and be encouraging, supportive and human facilitator in teaching-learning situation. This according to him would enable the learners to discover their talents, realize their physical, motor and intellectual potentialities to the fullest, and to develop character and desirable social and human values to function as responsible individuals for day to day problems related to educational, vocational, personal and social needs. A pedagogic medium for acquiring knowledge in various subjects/fields, developing values and learning multiple skills were emphasized so as to make productive work.

The compilation of the studies undertaken in the field of special education of mentally retarded individuals and the related variables of study may be far from adequate. More studies are warranted in the areas chosen for research. The compendium presented here is not exhaustive. However, the researcher tried to update the same by incorporating the results of other research studies. It was observed that there is an urgent need to make efforts for research in the exact chosen area. The hypotheses were framed for the study and have been presented in Chapter 1.