REVIEW OF RELATED LITERATURE
CHAPTER-III
REVIEW OF RELATED LITERATURE

This chapter throws light on the available related studies in two broad areas of the problem under study:–
- Factors affecting psycho-social problems faced by the mentally retarded, and
- Helping strategies available for education and rehabilitation of the mentally retarded.

Each area has further been sub-divided. Pictorial representation of the review of related literature is given in Figure 3.1.

The problem of mental retardation is not a new one for this country. Mental retardates have from the very beginning attracted the attention of Indian psychologists, educationists and sociologists and efforts have been made to diagnose and treat these handicapped members of society. It may, however, be stated that relatively fewer studies have been done for ascertaining the psycho-social factors operating in the case of mentally retarded children, compared to other types of handicapped. The mental handicap leads to several psycho-social problems and stigma like prejudices, discrimination, isolation or segregation. The evils of stigma are more a social, psychological and national problem than a medical problem.

Psycho-Social Factors Affecting Mental Retardation

According to the modern authorities, mental retardation is a behavioural maladaptation. There was
Fig 3.1
Pictorial Representation of the Division of
Review of Related Literature

Related Literature

Psycho-social factors

- Socio-economic status
- Hereditary and environmental factors
- Rural-Urban differences
- Impact on the family
- Family factors affecting mental retardation

Helping strategies

- Self-Help groups for the mentally retarded
- Vocational rehabilitation
- Community based rehabilitation
- Education, training & rehabilitation
a distinction drawn between feeble-mindedness and mental subnormality in a conference on child Health and Protection (Ellis, 1933). They characterized the former as mental subnormality which is not necessarily accompanied by social competence. According to Doll (1941), the concept of "Social Competence" was valid criterion for detection of mental retardation.

McCulloch (1947) states that a society may be said "to set up threshold of tolerance which it employs to distinguish social competence and acceptable behavioural adaptation from incompetence and maladaptation".

Damle (1952) from his study concluded that many socio-psychological factors like order of birth, age-group, education, socio-economic status, parents, mother's physical condition during pregnancy, diet during infancy etc, operate in the case of mentally retarded children. These factors are contributory causes of mental retardation.

Psycho-social factors such as malnutrition, poverty, deprivation etc. are responsible for mental retardation (Wadia, 1954).

Takrani (1969) from his study concluded that factors such as nutritional deficiency, cultural deprivation, motor deficiency, sensory deprivation, language difficulties etc, contribute to mental retardation.
According to Ishtiaq and Chandra (1975) lack of motivation, emotional strain and stress at home account for mental retardation in an individual.

Jehan and Ansari (1981) concluded from their study that various psycho-social factors such as sex, age, socio-economic status of parents, birth order, parental attitude and type of family have played an important role in existing mental retardation in a person.

Postnatally, delayed crying, low birth weight, disease, sickness, injury, convulsions and epilepsy in infantile period may retard the growth of the child. Several other studies implicate pre, peri and postnatal factors in etiology (Kewalramani and Shastri, 1977; Behere and Tripathi, 1981). Some studies with regard to psycho-social factors which affect mental retardation area are quoted below :-

Dexter (1958), in his social theory of mental retardation attempted to explain the effects on the retarded children of their continuously being confronted with unattainable goals in an essentially competitive society.

Ganguly (1968) carried out a study on the adjustment behaviour among the mentally retarded children, and concluded that mentally retarded children are more easily exposed to social and emotional exploitation than the normals.

In a study Fletcher (1984), examined the benefits of conducting therapeutic groups with emotionally disturbed, mentally retarded persons. Results
indicated that group therapy with mentally retarded persons increased social interaction and problem-solving skills. It also helped to decrease feelings of defeat, rejection and isolation.

Osman (1987) suggested that learning disabled children frequently lack social competence and experience significant interpersonal relationship problems. Social problems could occur on the levels of social cognition and skill deficit, performance deficit and inability to self monitor.

Beveridge and Conti-Ransden (1987) in their study noted that the development of social cognition through guided interactions is difficult for handicapped children. These children may also experience difficulties in social interactions with peers.

Sprafkin, Gadow and Grayson (1987) in their study exposed 31 male and 15 female learning disabled children, within the age range of 6-10 years, to 6 aggressive and 6 control cartoons in school and the subjects social behaviour was observed. Results showed significant interaction of condition with IQ. The low IQ group became more physically aggressive following aggressive cartoons as compared with controls.

Wojnilower and Gross (1988) examined the relationship among knowledge, perception and performance of assertive behaviour in children with learning disabilities. Results showed assertive behaviour was more highly valued than non-assertive
behaviour and cognitive ability was found to be a positive predictor of social perception. Kim et al. (1989) studied the estimates of social competence of problem behaviour by using a child behaviour checklist. Results showed poor social competence and problem behaviours when compared to a normative group of non-handicapped adolescents.

Sater et al. (1989) conducted a study to address several questions regarding the social status and characteristics of learning disabled and low achieving children. This study was also to assess the frequency of peer rejection in these populations. Results indicated that such comparison assumes considerable clinical importance when one considers the possible need to later administer social skill treatment programmes for learning disabled socially rejected children if they indeed exhibit unique characteristics.

Socio-Economic Status

Many socio-cultural factors, subgroup membership, family etc, determine the mental growth of children. Some aspects of their inter-personal reactions are determined by the broad culture, other by their socio-economic status structure of their family, by their peer groups, and by the kind and extent of their formal education. Education and economic status of parents, their socio-economic class, ethnic group etc, also influence mental growth of a child. Under adverse socio-economic circumstances mental growth is hampered
which gives rise to mental retardation. Studies demonstrating the correlation between social class status of parents and IQ of the children are given below.

Estes (1953) in her study administered the Wechshler Intelligence Scale for Children (WISC) to 80 children, half belonging to high socio-economic status and the other half to low socio-economic status. Results indicated significant difference in the average test scores of the two socio-economic groups at the younger age. The difference was not significant in the old age group.

Burt (1953) from his study concluded that it is in the lowest or highest levels that significant difference in the thinking of various social class groups would exist when faced with academic type problems.

According to Wortis (1958), poverty is a major factor that determines the nature and degree of retardation.

According to Kagan and Moss (1959), the correlation between parental social status and children's intelligence is remarkably stable.

Amesur (1962) from his study concluded that poor social conditions, bad nutrition, insanitary surroundings, poor parental guidance are usually associated with low economic factors and with subnormal intelligence. There is a negative correlation between size of the family and intelligence. Children of later
pregnancy also show a higher percentage of mental defectives.

Gunnar (1964) on the basis of his studies concluded that the degree of mental retardation would be determined with the help of socio-cultural economic factors.

According to Das (1968), cultural deprivation is one of the factors that favour intellectual subnormality. Cultural deprivation refers to a complex set of conditions, which could be due to poor sensory experience, environmental factors associated with poverty, unstimulating environment and lack of verbal communication with adults.

Brijmohan (1969) from his study concluded that in India the slow learning children seldom exhibit disorders in body chemistry or neurological nature. They are victims of poverty and all that surrounds this evil.

Gupta (1970) conducted a study on 300 mentally retarded cases and reported that majority of the cases were severely retarded and further stated that less than 20 percent belonged to rural domicile and to the lower income groups.

Teja, Varma and Shah (1971) on the basis of their study concluded that "mental retardation was found to be associated positively with rural background, family history of mental retardation and organic psychosis, and negatively with age, income, sibling rivalry, neurotic traits and family history of neurosis. Sex
and family size were unrelated with this, although preponderance of males in the clinic population as a whole was observed. They further stated that "mental retardation was found to be associated with lower age group, lower income group, lower incidence of sibling rivalry."

Misra, Kalra and Dayal (1976) conducted a study on 100 mentally retarded children at Agra (India). Results indicated that 95 percent of the cases hailed from a lower socio-economic status with low parental education. All had delayed milestones of development and poor academic achievement.

From the above studies it may be concluded that the higher the socio-economic class of the parents, the brighter, on the average the children will be, while those parents from lower socio-economic class, with less education, belonging to rural domicile have chances of having a mentally retarded child.

**Hereditary and Environmental Factors**

There are indications that heredity and environmental factors could affect the physical and mental development of a person.

Skeels and Harms (1948), Skodak and Skeels (1949) from their studies done at the Iowa Child Welfare Station on children born of occupationally and intellectually inferior families and adapted into average or superior homes, concluded that the IQs of these children conformed quite consistently to the
norms of their adaptive parents with averages substantially higher than those of their own parents.

According to Charles (1953) and Reed, Reed and Palm (1954), stimulating environment is very effective for the development of intelligence.

Herndon (1954) concluded from his study that the relative effectiveness of heredity and environment on intelligence cannot be measured accurately unless we define the environmental forces.

Mundy (1957) conducted a study in Britain and supplied evidence that by living in a community one gains intellectually than residing in an institution for the mentally handicapped.

According to Frankestein (1965), environmental causes of mental retardation are growing due to the influence of educational neglect, poverty, impersonality of primary relationships, under conditioning of institutional routine, lack of intellectual stimulation, emotionally conditional blockings, regressions or distortions, psychotic personality disruptions, delinquent behaviour. Such factors produce feeble mindedness which tend to enter into configuration with other specific or non-specific factors. Weakness of parental guidance, cultural fusion, insecurity also lead to mental retardation.

Sinclair (1966) in a study states that "the biggest single cause of mental retardation is subcultural or familial mental retardation, because parents with low IQ cannot compete for a high social..."
position or the work that goes with this; they tend to drift to low paid work and an environment which is culturally low and not so stimulating that the children of these parents have not only an inherited low level of intelligence but also a deprived environment which further prevents any improvement in their condition”.

Isolation of the child from human contacts during infancy has been found to lead to emotional starvation and to lack of intellectual stimulation, as a result of which proper development of psyche of the child is not possible. Reports by Munshi (1954) concerning the "Wolf Boys" who are physically crippled and mentally idiotic bring out the importance of social contacts with human beings.

A study by Sarason and Gladwin (1959), reports that Negros of various ages enrolled in the schools of Altanta and Georgia by Graham (1926) and Oklahoma and Texas by Garth, Lovelady and Smith (1930) were tested. Results indicated that during the first two or three years of school, children of lower class or culturally marginal group deviated far less from the normal IQ than they did later.

Verma, Mangalwedhe and Misra (1976) stated that as compared to the emotionally disturbed children, the mentally retarded group had a significantly (i) less educated head of the household, (ii) non local residence and (iii) rural residence. On clinical variables they differed, on the reasons for seeking
help, type of treatment recommended, and type of follow-up maintained.

An exploratory study by Nanda (1978) revealed that the biological and environmental factors have equal effects on mental retardation. The variables examined were parental age, economic condition, sex, birth anoxia, convulsions, ordinal position, family history of mental retardation and mode of delivery.

Saha (1982) found that mentally retarded children become 'social isolates', who require greater parental involvement than is presently found in child-rearing practices.

Mudgil, Singh and Srivastava (1982) from their study on 200 cases of mentally retarded children, on their etiological and psychological study concluded that 65 percent belonged to nuclear families, in 60 percent cases the milestones were delayed, problems such as excessive dependency, bed-wetting, unsocial behaviour, hyperactivity, speech problems excessive fear were noticed. 36 percent parents had rejecting attitude and 34 percent indifference. About half the cases were due to natal and postnatal events.

Ottensbacher and Cooper (1984) from their study concluded that the special placement of mentally retarded children leads to better social adjustment than does regular placement.

Somasundram and Kumar (1984) conducted a study on 30 severely subnormal institutionalised individuals and matched with 30 severely subnormal individuals who
attended the outpatient services. Results indicated that self-injury, destructive behaviour, overall poor speech, self-help and literary ability, social and physical incapacity were the discriminating factors much more common for the institutionalised subjects than for the outpatient individuals.

**Rural-Urban Differences and Mental Retardation**

It has been observed in general that urban children do better on intelligence tests and on verbal items than children belonging to rural areas. A number of studies reveal that persons who live in cities are more "intelligent" than those who live in rural areas.

According to studies by Wheeler (1932) on Tennesse Mountain School Children, Smith (1942) on University of Kansas Freshmen, Nelson (1942) on State College of Washington Freshmen, urban children do better than rural children on intelligence tests.

A study by Ginzberg and Bray (1953) is based on World War II and Korean War data. According to them, in the United States, regional difference in intelligence corresponded quite closely to the regional differences in urbanization and concluded that most of the rural and urban differences were generalized in terms of the regional level. A study by Sarason and Gladwin (1959) explained that a city provides better opportunity, better schools and better teacher to teach children. The city, helps in developing various skills required for the performance of an intelligence test.
Some Indian studies have indicated that the rural/urban dimension was comparable (Teja, Varma and Shah, 1971) and there was a greater representation from the urban population Gupta (1970); Singh (1974); and there was a greater representation from the rural population (Verma, Mangalwedhe and Misra, 1976); and from a lower socio-economic status (Misra, Kalra and Dayal, 1976) and with low parental education (Verma, Mangalwedhe and Misra, 1976; Misra, Kalra and Dayal, 1976). The male/female ratio had been found to be different by different investigators. For e.g. 1.33:1 by Devi, Mathur and Dayal (1980); 1.50:1 by Nagaraja, (1976); 1.8:1 by Teja, Varma and Shah (1971); Verma, Mangalwedhe and Misra (1976); ratio was found to be 2:1 by Gupta (1970); Singh (1974); Behere and Tripathi (1981); Subramanya (1983); ratio of 3:2 by Malhotra and Chaturvedi (1984) and 7.3:1 by Kulkarni and Wagle (1977). In all the cited studies there is a preponderance of males.

Impact of the Mentally Retarded Child on the Family

The impact of the mentally retarded child on the family has been generally found to be negative with significant emotional stress on the family life cycle.

According to Farber (1959) the presence of a mentally retarded child interferes with the parent-child relationship and upsets the family life cycle. A study by Srivastava (1970) revealed that the number of retarded children increased with the number of
siblings, and that the nature of parent-child relationship played a vital role in the adjustment of such retardates.

Akhtar and Varma (1972) stated that the ultimate outcome depended upon the severity of handicap as well as the training given and the teaching facilities available.

Trevino (1970) and Gath (1974) concluded from their studies that the siblings of retarded children suffer from emotional disorders as the parents over involved themselves in the retarded child.

Dunlap and Hollingsworth (1977) conducted a study on 404 families to examine how they perceived the mentally retarded child. Results indicated that most of the families were adjusted where child was not perceived as having a substantial effect on them.

According to Prabhu (1978), mild mentally retarded children are not considered as a serious problem especially in the agricultural communities where they may not be noticed at all. Narayanana (1979) found that children of rural areas and particularly from non-nuclear families offer less problems to their mothers.

Nihira, Mayers and Mink (1980) found that conceptual and statistical linkages, existed between home environment, family adjustment and competency of the mentally retarded child.

Friedrich and Friedrich (1981) found that a less satisfactory mental life, less social support, and poor psychological well being, was significantly
present in families of handicapped children as compared to non-handicapped children. In another study, Ishtiaq and Kamal (1981) compared 20 moderately retarded children with 20 blind children. Results indicated that 72.04 percent of the families had marital disharmony as the result of the birth of the child, while 55.99 percent of the parents had negative attitude towards the child. Only 33.33 percent had a positive attitude.

Wig, Mehta and Sahasi (1985) conducted a study on parents of 100 severely mentally retarded children who attended the Child Guidance Clinic. Tools used were semistructured Parent Interview Schedule, Vineland Social Maturity Scale and intelligence tests. Results indicated that in smaller families parents spent most of the time with the handicapped child, whereas, in large families involvement with other family members reduced the time involvement of parents. Very few siblings resented the presence of the handicapped child. Teaching the child simple skills was a problem which many parents living in a joint family faced.

Tgllison, Palmer and Stowe (1987) conducted a study where the mothers of 16 male learning disabled and 16 male normally achieving students belonging to Grades 2-4 were administered an arithmetic task to their children in their homes to assess the effect of mothers' expectations, observed interactions and attributions. Results indicated that the mothers of the learning disabled children did not expect much from
their sons and provided more negative non-verbal responses. Significant differences were observed in the relationship between learning disabled and normative achieving sample performance and the number of teaching interruptions by mothers.

**Family Factors Affecting Mental Retardation**

Some parents continue to view mental retardation as an illness and blame the presence of such a child on past sins. Many parents neglect their mentally handicapped children. Social, economic and psychological stress is felt by parents in both, the Indian and Foreign settings. Parents have unrealistically high expectations from their child, thus leading parents to seek magical remedies. However, if treatment, facilities and training are adequate, the chances are that parents would co-operate and assist professionals in their work.

Spitz (1945) and Goldfarb (1943,1945), from their studies found positive relationship between maternal deprivation and mental retardation. Kent and Davis (1957) from their study concluded that the child’s IQ level depended on parental discipline.

Farber, Jenne and Toigo (1960) found from their study that the initial stress in parents appears to be sex-linked, which shifted with time. Mothers of mentally retarded and neurotic children undergo more stressful experience than mothers of chronically ill or normal children.
Kanner (1961) concluded that parents have five curiosities (1) the diagnosis, (2) causes of mental retardation (3) the therapeutic possibilities, (4) prognosis and (5) chances of normalcy.

Jain (1967) in a study examined the social problems related to the presence of a mentally retarded child. Results revealed that parental feelings were marked by anxiety about future. Also negative effect towards other siblings, psychological stress, decreased interaction with neighbours and relatives, misunderstandings within the family and economic loss were significant facts associated with the presence of the mentally retarded child in the family.

Prabhu (1968) carried out a study on 320 cases of mentally retarded individuals, the mean age being 9.23. Parents were interviewed. Results revealed that 31 percent of the parents did not accept the presence of mental retardation in their child, of the 69 percent, only 19.5 percent understood their child’s potential. According to him by underestimating their child’s potentialities and overprotecting their child caused more harm to the child.

Prabhu (1970) conducted a study on parental needs for institutional facilities for their retarded child. The sample consisted of 40 children whose parents preferred to send them to institutions and 80 children whose parents preferred to send them as day boarders in special schools. Results indicated significant differences between the two groups, found in terms of
severity of the mental handicap and the presence of behavioural disorders.

Trevino (1970) stated that the perception of the handicapped rather than the handicap itself is a crucial factor. Where the handicap is not severe, parents deny the situation thus causing more turmoil for all. The major parental reactions to the child's handicap are extreme depression resulting in absenting themselves physically and emotionally from their child, neglecting their child, guilt, difficulty in controlling hostility feelings towards the child, ambivalence, emotional unstability of parents which may get exaggerated by the arrival of the child.

A study by Justice, O'Connor and Warner (1971) indicated that parents of the mentally retarded children do not receive any support, public or private, nor are they aware of the additional service or that services are needed at all.

A study by Mazumdar and Prabhu (1972) conducted on parents of 39 male and 21 female mentally retarded school going children indicated that good parental cooperation can be expected in future efforts.

Fathers tend to view the child instrumentally whereas mothers tend to be more expressively oriented (Gumz and Gubrium, 1972). Fathers of mentally retarded or neurotic children experience significant stress associated with fathering a handicapped child. Some fathers' expectations with regard to the child were found to be highly influenced by non-family social

Freeman (1973) found that early relationship between the professionals and families having a mentally retarded child are instrumental in providing the necessary home support.

Anderson and Garner (1973) found that specific professions and visits made for diagnosis generated a low degree of maternal satisfaction.

Studies relating to the expectations of the family indicate that parental expectations tend to be unrealistically high (Sinclair, 1975; Shankar, 1976).

Bettschart et al. (1976) stated that professionals laid too much importance on establishing the etiology of any given case, rather than emphasising on the management plan and such an attitude creates resentment in parents and inhibited the child’s developmental possibilities. Hence, emphasis must be laid on the positive aspects of the child, so that the parents emerge from the sense of inferiority and defeat.

Lloyd-Bostock (1976) studied parental experience with professionals and found that in a sample of 97 parents, contacts with professionals were a major source of problems, which assumed often greater importance than problems arising more directly out of the child’s handicap.

Sethna (1978) examined the psychological effects of the mentally retarded child on the family. It was
found that parents tend to treat the child differently and wax from overprotection to shame.

Watson and Midlarsky (1979) from their study concluded that the parents of the mentally retarded children were more likely to express positive attitudes towards their retarded child and they would expect the average person in the community to have a negative attitude.

According to a study by Narayanan (1979), the initial reaction of the parents is grief, similar to the grief reaction experienced by those who experience grief and loss through death and separation. Parental initial reactions to the realisation of having mentally retarded child is shock, followed by coping mechanisms (Hariasara, 1981).

According to Ishtiaq and Kamal (1981), 72.04 percent of the families of 15 mentally retarded children had marital disharmony due to the presence of a mentally retarded child. 55.99 percent had a negative attitude towards the child. Only 33 percent had positive attitude towards the child.

Rastogi (1981) conducted a study in which he interviewed 85 parents of mentally retarded children and found that although generally they reported a favourable attitude, these attitudes were accompanied by feeling of guilt, pessimism, hostility and aggression.

Neglect of the child was found by Ishtiaq and Kamal (1981), who reported that 88 percent of the
mentally retarded children were neglected by their parents.

Chaturvedi and Malhotra (1982) in their study examined the treatment seeking pattern of parents of mentally retarded children. Results indicated that 45 percent of parents did not seek help from medical practitioners. They offer two main explanations (a) poor understanding of the condition (b) inadequate and unsatisfactory help offered due to a lack of expertise. Some parents seek magical cures, magical drugs, surgery and other illusory remedies.

Chaturvedi and Malhotra (1984) conducted a follow-up study of mental retardation with a focus of parental attitudes. 45 parents were considered for the study. Results indicated that 70 percent had a negative attitude accompanied by shame, 75 percent blamed it on past sins, 50 percent and over hostility and neglect. They found that rejection, hostility and neglect of child along with other negative attitudes were significantly more often seen in younger parents, urbanites and those with higher education. The negative attitudes were more towards a child with additional psychiatric problems.

Behere and Sinha (1985) interviewed parents of 36 mentally retarded children to find out their expectations from their mentally retarded child. Results indicated that in 65.8 percent cases, father was respondent; in 23.6 percent cases, the mother was the only respondent and in 10.6 percent cases both parents
were respondents. Majority were illiterate, 86.84 percent respondents expected their mentally retarded child to take education with other normal children, 76.32 percent expected that he should take care of himself for daily chores, 71.5 percent expected him to care and share the financial burden of the family, 89.47 percent wanted their mentally retarded child's destruction and hyperactive behaviour to improve and 23.68 percent expected miracle cure.

Friedrich, Cohen and Wilturner (1987), in their study assessed the quality of family relations and marital satisfaction in 131 two parent families with a mentally handicapped child. Results indicated that positive family relations were predicted by greater marital satisfaction, less maternal depression, and a more internal locus of control.

Fisman, Wolf and Noh (1989) in their study examined the role of parenting stress and parental depression of marital intimacy between the parents of handicapped children vs developmentally normal children and investigated discrepancies between husbands' and wives' report of marital intimacy. Results indicated that mothers of autistic children significantly showed greater stress and depression as well as lower marital intimacy than the mothers of normal children or mothers of Down's Syndrome children. Fathers of autistic children showed significantly higher parenting stress than other groups, as well as lower marital intimacy.
Thus, the above studies indicate that while emphasizing the child’s handicap, the professionals do not pay enough attention to the parental dilemma in understanding the kind of problem their child is facing. Hence, it is very essential to ascertain the felt needs of the parents, their attitude and the clinic’s intervention in the management of the child.

HELPING STRATEGIES

Education, Training and Rehabilitation

Integrated Education

There is a need for integrating mentally retarded children into regular schools. It would be difficult to start separate schools for separate categories of mentally retarded individuals. The teacher should be specially trained in order to teach and train the mentally handicapped individuals and special classrooms need to be provided in ordinary schools.

If enough opportunities are provided, through the system of integrated education, mentally retarded child would develop various social and personal skills as a normal child of his chronological age, would adjust and adapt to his surroundings, learn to face problems, by moving with peers promote a healthy self concept and develop positive attitudes in life.

Integrated education helps the mentally retarded individual to make gradual progress, gain experience and above all, this programme is highly cost effective. The system of integrating handicapped and non-
handicapped toddler and pre-school-age children has been existing since less than two decades (Allen, Benning, & Drummond, 1972; Bricker & Bricker, 1971).

According to a UNESCO Report (1979), summarizing programmes in Jamaica, Malawi and Algeria, has brought together a number of case reports of integration of older handicapped children and young people and indicated the success of this system of education.

According to Mittler (1984) integrated education should be provided during early school years, which helps the individual in preparing him for integrating into the community as an adult.

Mittler (1985) states that the system of integrated education is advancing. Children benefitted from their experience and made equal progress as they have done in special schools, often much more.

A study by Johnson and Mayer (1985) suggested that the aim of integration should be to develop positive attitude towards handicapped individuals, help the handicapped to develop various skills, develop friendship between the handicapped and non-handicapped and normalize the social status of the severely handicapped individuals.

Rietveld (1986) investigated the results of integrating 8 children with Down's Syndrome (DS) and non-handicapped peers. Results showed that while individual differences were apparent, DS subjects were at least as attentive, socially integrated, and no more disruptive than contrast children. They engaged in
social play for similar amounts of time and continued to acquire new skills at the same rate as during their participation in intervention programme.

Guralnick and Groom (1988) studied friendship pattern of 4 years old developmentally delayed and 3 and 4 years of non-handicapped children. Results indicated that majority of the children in the three groups established preference for a specific peer. The delayed group preferred non-handicapped older children but were least preferred as friends overall by play group participants. Delayed children did not take advantage of the potential benefits associated with friendship.

According to Jangira (1989) the Project Integrated Education for Disabled (PIED), aimed primarily at the development of context specific strategies for the education of disabled children in common with others in general schools. Utilisation of existing infrastructures and programmes under different sectors have been emphasized by PIED, and the development of social education manpower from within the educational system.

Peck et al., (1989) in their study investigated sources of resistance to the development of integrated preschool programmes, expressed in concerns raised during interviews and observations of parents, teachers and administrators, involved in system change. The study suggested the application of qualitative research methods to questions that were of considerable impor-
tance to early childhood educators, but that have received relatively little empirical study.

A study by Pandey (1989) study suggested the need of establishing special technical education institutions in India, for integrating the handicapped with the normal in technical institutions.

According to a study by Nigam (1989), integrated education started at Air Force Golden Jubilee Institute Delhi (India) in April 1986. The aim of this system of education was to provide appropriate education and training programme for the mentally handicapped, to take them out of their isolation and expose them to normal environment.

Shanmugavelutham (1989), in a study emphasized the importance of integrated education for the mentally retarded children and suggested the criteria for selection of teachers for integrated education.

Jayalakshmi (1989), reports that 21 boys and 12 girls mentally handicapped in the age range of two and half to 20 years were integrated with normal children and attended upto class V for academics, according to their age levels and various school activities. It was observed that normal children helped the mentally handicapped children in various skills.

A study by Krishnaswamy (1989) describes a demonstration programme for mainstreaming mentally retarded persons through integrated education programme, in which the target group consisted of teachers, educational consultants and administrators. This
programme was expected to achieve major goals of selection of training objectives for various groups and ability to create least restrictive environment for learning and to develop supportive relationship with co-workers and parents.

O'Hanlan's study (1989) examined views of the mentally handicapped within a wide philosophical context in respect to their inclusion within the UK education system under the term 'special needs'. Homogeneity of educational difficulties was emphasised and also the need for integrating all pupils as much as possible into ordinary schools.

According to Jangira (1990), in developing countries, where general and special education have developed and parallel systems, efforts should be made for mainstreaming and integrating the children with special needs from segregated programme to general education.

According to Wang (1990), the non-disabled do not lose their level of achievement if disabled are integrated in their schools. There would be no adverse effects on the non-disabled.

**Community Based Rehabilitation**

Mentally retarded individuals have difficulties in learning, reasoning, performing various tasks and they cannot cope up with the environmental needs. All mentally retarded persons are not alike. Depending on the category they belong to, they can be provided with training and education.
Only community attitude could provide better service for all mentally disabled persons. Hence, there is need to integrate the mentally handicapped individuals into the community as early as possible.

Through Community Based Rehabilitation (CBR) programmes, the mentally disabled could be educated and trained. The most encouraging development for many years has been the work of the World Health Organisation (WHO) in linking the primary health care unit to CBR. WHO (1983), has published a third revision of a detailed manual, 'Training the Disabled in Community'.

Gold (1975), believed that "low expectancy on the part of society is perhaps the single most critical deterrent to progress in the field" and this attitude largely accounted for the reason the retarded were relegated to mundane menial tasks which required minimal training.

The findings of Jaffe (1966), Gottlieb and Siperstein (1976) suggested that attitude could vary as a function of the specificity of the attitude referent presented, the expressed attitude of community residents towards already established facilities, may be more indicative of the community support which other such programmes expected.

Studies which attempted to gauge community attitude and support, however remained inconsistent (Heal, Sigelman and Switzky, 1978) ; whereas Trippi, Michael, Colao and Alvarez (1978) found that the vast majority (99%) of the sample of landlords were
negatively disposed to renting housing facilities to a person described as mentally handicapped. Margolis and Charitonidis (1981) using similar procedure found that 72% were willing to accept a mentally retarded person as a tenant.

Stephens, Kibbins and Salzen (1979) concluded from their study that a day-care programme, staffed mainly by non-professionals provided an important service to retarded children and their families and in many cases postponed or prevented institutionalization of the child.

CBR programme have been pilot tested by the World Health Organisation in nine countries and evaluated the results. They concluded that CBR programme was an appropriate, feasible and economically viable approach to provide the most essential rehabilitation in developing countries (WHO, 1982).

In studies where community support for existing community residences was examined, it emerged that upto one third had met with initial opposition, typically from neighbours (O'Connor, 1976; Lubin, Schwartz, Zigman and Janicki, 1982).

Hornby and Singh (1984) conducted a study on the behavioural group training with parents of mentally retarded children and concluded that the parents indicated that the programme was helpful and improved their knowledge of behavioural principals. Some positive changes in parent-child interaction at home were also observed.
Miles (1985), stressed the need for independent evaluations of CBR services. Murthy et al. (1985) conducted a study on a model programme for the rural mentally handicapped children and concluded that the Anganwadi Workers of the Integrated Child Development Service (ICDS) scheme could be trained in the identification, management and follow up of the children with mental retardation, epilepsy and behaviour problems and their services could be effectively utilised for mental handicap work, provided their work was supervised periodically by medical or specialised personnel.

A study by Mittler (1986) suggested that participating in community activities helped people to experience and realize that people with mental handicap are people first, and handicapped second.

MacDonald (1988) from his study emphasized the need for computer technology and the opportunities it offered for community rehabilitation agencies to improve service delivery.

A study by Wilgosh and Covassi (1988) expressed the need for social skills training in addition to job skills training and for adequate long-term support services for success in community living and employment.

McDonald et al. (1988) conducted a preliminary study on the parent involvement in a vocational service. Results of this preliminary study indicated that although the parents expressed a high degree of
satisfaction with both the vocational programme as a whole and their level of involvement with the programme, they reported limited direct involvement with the programme.

Persha (1989b) conducted a study on the role of community in prevention of mental retardation and concluded that for the success of a programme, community involvement and participation was very essential and the main media for the community to realize and assume the responsibilities would be through education and reaction of awareness among general public which could be achieved through mass media and reading material.

Cooley, Singer and Irvin (1989) instituted a programme in which 54 college student volunteers (aged 19-47 years) were trained to be friend and provide community participation opportunities to children with severe handicaps. Parents and volunteers indicated a high degree of satisfaction from the programme. Children were also pleased with their anticipation of outings. From this study it has been concluded that trained community volunteers could be a valuable and cost-effective source of support for children with severe handicaps and their families.

Rao, Jayanthi and Stephenson (1989) emphasized the need to train the mentally retarded children belonging to the slum areas, to meet the local needs. They should be trained for various skills required for the area they live in.
Early Intervention

Home based training of parents is an alternative to specialised residential institutions. There would be less need for special institutions if parents themselves can be taught to develop various skills, and modify the behaviour of their children. Studies have shown that such early intervention programmes provided support to the families, reduced the stress and anxiety of the parents and helped to cope with the management of their mentally handicapped children.

Kirk (1972) did a series of studies on young mentally retarded children and found that children given preschool training gained substantially in intelligence and social maturity, while the abilities of children who did not participate in preschool training, declined.

Schaefer and Aaronson (1972) conducted a study on implications of the home-tutoring programme and concluded that a necessary and crucial component was maternal interest and direct involvement in the teaching process.

Fox (1976) in a study compared the effects of Early Childhood Education (ECE) versus a traditional primary programme on pupil achievement and socio-emotional development and determined the relationship between student characteristics and programme efficacy. It was concluded that kindergarten children who were less mature socially and/or developmentally, seemed to
benefit most from ECE. Kindergarten may be the more effective time for ECE and did not influence significantly after that, regardless of ability or sex. After the age of 5, there seemed to be little change in effective development without specific objectives and intervention strategies.

Kirk (1977) in an experiment, assessed the effect of early intervention on a population of retarded preschoolers. He found that intervention at the preschool level accelerated the rate of mental and social development, while no intervention at that age level allowed the rate of mental and social development to slow. The findings were surely suggestive of the potential impact of early intervention on the handicapped child.

Smith, Kushlick and Glossop (1977) provided 6 months of home teaching services to 13 families of Wessex, England, with mentally handicapped preschoolers entailing an hour and a half home visit per week for each family. Results indicated that subjects achieved 82 percent of all objectives set for them. Most of the parents felt that their child had progressed with the services rendered.

Brown (1978) examined new evidence about the effectiveness of early intervention programmes, such as 'Head Start' which produced lasting gains in the cognitive development of disadvantaged children.

Sandow and Clarke (1978) conducted a 3 year programme of home-based intervention with two groups of
preschool severely subnormal children and their parents. Results indicated that the programme had apparently contradictory results. Frequently visited children, after initial superiority over infrequently visited children, later showed a deceleration in intellectual growth. Less frequently visited children conversely showed a rise in performance, after initial decrement. The interpretation indicated that parents in the later group were less dependent on the visiting therapist and more able to take positive action to assist their children and improve their own situation.

Carter (1978) compared the effectiveness of two preschool intervention programmes for disadvantaged inner-city toddlers, both programmes had behavioural and rational components. The first programme had help-agents working at community centre and home sessions while in the second help-agents worked only in the home supervising and training parents. Results indicated that children in both experimental groups improved significantly, more than the controls on IQ scales. Social quotients stayed constant in the two experimental groups in contrast to control subjects whose social quotient deteriorated significantly during programme period.

Stewart (1978) investigated the relationship between child characteristics and development gains, in an early intervention programme. Results indicated that children belonging to low socio-economic level made significantly larger gains on gross motor skills
than middle to high socio-economic children. Also Black children made significantly larger gains than White children on the gross motor, language and perceptual cognitive sub-scales.

Ludlow and Allen (1979) in a study described the effect of early intervention and preschool stimulation on the development of Down's Syndrome children. Results showed that the stimulated group scored higher on the IQ and DQ tests, particularly on personal, social and speech development. School placement suggested that they were more easily integrated into normal community.

Moore, Fredricks and Baldwin (1981) demonstrated efficiency of early childhood education, by indentifying trainable mentally retarded children three or more years after their preschool experience and studying the current behaviour of the children on a criterion referenced test (The Oregon Student Performance Record), and using parent and teacher ratings. Results showed better teacher and parent evaluations of children who have at least 2 years of preschool experience compared with children who had one year or no early intervention. Sandler and Coren (1981) examined parent evaluations of an integrated home/school programme by administering a 20 item questionnaire to 26 mothers of Down's Syndrome multiply handicapped, moderately retarded and learning disabled children. Results indicated that there was need to offer training experiences to interested parents that allow them to
take an active role in facilitating their child’s educational growth at home.

According to Mittler and Mittler (1983), the influence of home was greater in early years, and growth and learning in child could be only understood in relation to the environment in which the child lived in.

A study by O’Connell, Pfeiffer and Pfeiffer (1983) indicated that early intervention programme alongwith activities had been successful in eliciting high degree of parental involvement.

Bidder, Hewitt and Gray (1983) designed a study in which 38 developmentally delayed children received a home based training scheme according to developmental ability and manifesting problems. Results indicated that on weekly skill gain, suggestion proved less effective than activity charts or target setting. Severely delayed subjects made least progress on weekly skill gains. Group differences were observed in the serverely delayed subjects and older Down’s Syndrome subjects made least gains on the checklist. Parents preferred the activity charts, although were considered time consuming.

Bailey and Bricker (1984) analysed 13 programmes aimed at early intervention for severely handicapped infants and young children under 6 years of age, to evaluate impact of intervention. Though programme differed considerably, all showed some form of positive outcome.
A study of Bricker, Bailey and Bruder (1984) reported that economic benefits of early intervention showed that significant savings could be made if early intervention prevented the need for residential or institutional care or for special education.

Esenther (1984) discussed the structure and use of an early intervention programme, developmental coaching which seeks to integrate unique behaviours effective for Down’s Syndrome (DS) infants with the infants’ involvement in developmentally appropriate tasks. It was found that subject’s achievement rates were more accelerated than those of DS infants in the literature and that the response of young DS infants (less than 9 months old) to developmental coaching demonstrated more effective results than that of older DS infants.

Pieterse (1985) in a longitudinal evaluation of early intervention with DS children of Australia used Macquarie programme for developmentally delayed children (Pieterse, 1981). Results indicated that after one year programme, the experimental group were superior to the control group on developmental skills in language, motor, personal and social skills. Annual assessment over six years indicated that DS children in intervention programme maintained 80-100 percent of normal developmental skills on criterion-referenced tests. As a result of intervention, DS children remained in their mainstream classes. Although their mathematics was poor, general competencies were
considered adequate to remain in and be promoted to the next grade each year.

Sebastin (1987) conducted a study on the need of early home-based education for mentally handicapped children and concluded that children could learn much more at home than at the kindergarten.

According to La Greca (1987), not all learning disabled children experienced peer relationship problems and that learning disabled girls would be more at risk than learning disabled boys for peer problems. Hence, for social intervention, parents, teachers and peers should be involved in the intervention programme.

Fox (1989) studied the effects of an intervention programme on the interactions of young children with severe and profound mental handicaps and their parents. Results indicated that there was a functional relationship between the training a parent received and their increased use of facilitative strategies when interacting with their children. Parents reported positive difference in the quality of their interaction after intervention.

According to Mundkur et al. (1989) the primary aim of early intervention was to establish a bond between parents and the child to enhance motivation, reduce the effect of environment and treatment of preventable causes of mental retardation. This study laid down criteria for selection of cases and the factors which influenced the outcome of early interven-
Kohli (1989a), in a study discussed teaching method appropriate to early intervention programme for the mentally retarded children based on their needs and psychological built up and emphasised the need to use audio-visual aids, computers, films, puppet shows, toys etc, suitable to teach the mentally retarded children in India.

According to a study by Jayachandran (1989), the basic objective of the early intervention programme was to maximize cognitive, communication and motor skills of children with mental deficiency and to assist the family in training the child. This programme also focussed on the acquisition of self-help and social skills.

A study by Rege (1989), stated that developmental services provided at a very early age increased a child’s potential and likelihood to be educated in regular setting during their elementary and secondary schooling. Emphasis was laid on early detection of mental retardation and intervention with supportive equipment at appropriate age of the child.

According to Parekh (1989), early intervention programme helped to bring the child towards normalization and this type of intervention should include infant stimulation programme through parental involvement.
A study by Naik and Plumber (1989) emphasized the need for linking community awareness programmes with early intervention.

According to Persha (1989a), one of the major areas considered in early intervention programmes was the modification of child rearing practices which enhanced child’s development but worked out within the framework acceptable to existing culture and values.

The 6th Annual Report of National Institute of Mental Health (NIMH, 1989-90), Secunderabad, (India), stated that Early Intervention Services was started by the institute during the year 1989-’90. This service was provided on once a week basis to take care of children with developmental delays. Parents were given guidance on child rearing practices, nutrition, feeding, immunization and general health. Treatment for conditions like epilepsy and minor ailments had been undertaken. Genetic counselling whenever necessary was offered. Referrals for congenital deformities, orthopaedic conditions and other associated conditions were made available.

The Portage Training as Early Intervention

Portage training is a home based intervention programme, which intends to teach the pre-school mentally retarded children. The parents are involved directly in the education of their wards. This model is used under the guidance of a specially trained teacher. The home teacher trains the parents to train
and teach their wards and the parents are taught to target teaching goals for their children, to assess and reward them according to their performance so that continuously teaching goals could be modified and each child’s individual needs are catered for.

Cataldo (1977) states that the early intervention programme was generally beneficial for teaching and treatment of children.

According to Boyd et al. (1977), in United States of America, the Portage Parent Programme had made efforts to instruct parents in child management skill and appropriate teaching.

Baig (1979) designed a study to provide direction and aid to the parents of mentally retarded children and involve the parents as the teachers of their children. Results showed statistically significant gains in language development of experimental group.

Powell (1982), from a study concluded that parents receiving specific training found it easy to socialize their wards through the playway method.

Kohli and Dutta (1982) studied the effect of Portage home training intervention programme for pre-school mentally retarded children with motor handicaps. The sample was divided into two groups A and B of 5 children each. Group A was provided with weekly visits from the home advisor and training was imparted to them during the week by their mothers. Group B was provided specialized training by the same advisor daily. Result indicated that all children gained through Portage
service. However, group B achieved almost double than group A. There was a positive change in the attitude of parents and they expressed satisfaction with the programme.

Hewitt et al. (1983) in a study, administered the skills checklist to assess the developmental progress of 38 developmentally delayed children. Results revealed that the subjects made progress in inspection/tracking and perceptual problem solving skills in general, than they did in motor, self-help and visual-motor areas.

Ross (1984) examined the effects of a home intervention programme, setting up an experimental and control group. Results indicated that experimental subjects had achieved significantly higher mental ability scores as a result of intervention programme than the control group achieved.

Kohli and Saggar (1985) studied the effect of early stimulation on early deficits of infants under the Integrated Child Development Services (ICDS) scheme. They examined the effect by setting up an experimental and control group. Portage training programme was conducted for 8 weeks. Results indicated that almost every infant of the experimental and control groups gained in all the six individual Developmental Quotients (DQs) as well as DQ combined, though the experimental group gained much more as compared to the control group.
Kohl and Azad (1986b) studied the effectiveness of Portage home-based training programme on cognitive development of pre-school mentally retarded children. Results indicated that programme had been effective in improving cognitive handicaps of the subjects and showed substantial gain in combined DQs. Parents successfully acted as effective home teachers for teaching cognitive skills to their mentally retarded child.

Kohl (1989) in a study compared the effectiveness of Home-Centre Based Portage services given by professional, para-professionals and non-professionals to preschoolers belonging to various socio-economic status of society. The results confirmed a significant finding that para and non-professionals were equally effective in enhancing development of developmentally delayed preschoolers.

Thus, from the above quoted studies it is seen that home-based learning is very effective and that it should be part of everyday activity. Parents should try and find out what their child can learn and help the child. Children can learn much more at home than at the kindergarten because of the individualized attention paid towards the child and the more relaxed and less threatening atmosphere of the home may facilitate learning. Parent-child communication is important. Correct information should be given to the child and the children must be able to trust their parents' words.
Vocational Rehabilitation

The ultimate aim of educating and training a mentally retarded person is to help to be independent, earn his living, develop skills and modify behaviour, so that they too can participate like others in the activities of the society and adjust to its norms.

Only when the mentally retarded person’s capacity and ability to work matches with the requirement of the job, job placement is possible. His aptitude, emotional and social maturity, and physical stamina should be assessed before he is placed in a job. His progress should be monitored throughout which, would help in assessing his success or failure in the particular job.

Vocational rehabilitation could help the mentally retarded individuals to become self-sufficient and productive members of the society. It is a sophisticated and human treatment of handicapped individuals.

According to some studies conducted by Zeaman and House (1963); Zeaman (1968); Gold and Scott (1971), much of the research in discrimination learning could be applied to the training of developmentally handicapped adults. Since many trainees have difficulty attending to the relevant dimensions in learning a task, programmes should be designed using structured training procedures to direct the learner’s attention to the relevant cues.

The research studies of Zeaman (1968); O’Conner and Hermelin (1963) indicated that learning occurred
more rapidly as the number of relevant dimensions increased. In the area of discrimination training, certain specific teaching strategies could be employed to assist the developmentally handicapped person.

Gold and Scott (1971) emphasized the importance of arranging the educational environment to attract the developmentally handicapped person's attention to relevant dimension of the task. Brown (1975b) advocated the use of cubicles to reduce the amount of extraneous stimulation especially during the early stages of learning.

Gold (1972) and Whelan (1973) reported that more exposure of developmentally handicapped people to vocational training situations was insufficient in dealing with the vocational education. Training objectives must be defined in terms of specific skills, and that in developing an affective service delivery. It was necessary to incorporate certain learning strategies and teaching techniques in the instructional programmes.

Mittler (1973) stressed the need to consider the language used by the trainees, instructor or parent. In a task analysis the word to be used in training should be specified to ensure that the trainee hears the same thing consistently until he reaches criterion on task. The manner in which the verbal instruction is given is highly relevant to the learning of tasks (Brown and Hughson, 1972).
Woodward (1974) suggested that adult industrial materials should be employed in training vocational skills to the mentally handicapped persons and emphasized the need of stimulating an industrial work task and providing real work on the production and training lines.

Brown (1975a) found that low motivation was a common stumbling block in the rehabilitation of the handicapped and suggested that incentives and rewards may be used in training programmes to enhance learning and performance. Huddle (1966) studied the effects of monetary rewards in reaching an industrial assembly task to moderately mentally retarded adults and found that workers who received monetary incentive performed significantly better than those who received no reward (work production or social behaviour), and the kind of reward (concrete rewards, such as money or tokens or social reinforcement, such as verbal praise, a smile or a pat on the back).

Brown (1975a) suggested that in teaching the handicapped the mode of training was an important consideration to be made; visual demonstration was often more effective than auditory instructions in teaching the handicapped person simple vocational tasks. Retention of information was an aspect that was to be considered when training (Mcleod and Brown 1972), as indicated from their study that trainees had difficulty in retaining detailed interview information when asked to recall it thirty minutes later. In
addition, they found that retention was greater with verbal input. They concluded that the shorter and simpler the interview, the greater the degree of retention.

Brown (1976) cautioned that the trainer should not reinforce for speed of performance early in training, as this may result in an increased error rate. Early training needs to be concerned with accuracy, and reward to response must be carefully matched.

Brown (1976) stressed the importance of helping the handicapped person transfer learning from structured to unstructured settings. Once the trainee mastered the skills in the structured learning environment, opportunity to practice the task should be provided in a variety of situations to promote transfer and to keep motivation and interest high. The research studies of Clarke and Cookson (1962) indicated that if the training situation was well structured, there would be evidence that even severely retarded person could learn and transfer specific skills relatively rapidly.

Brown (1976) stated that placement and follow-up phases of the rehabilitation process were a part of the training environment and were within the training agency. These services provided support for the individual in his transition from the vocational training environment to community employment. Since this transition may be stressful for the trainee, a
familiar contact person, the placement officer, is most important at the time of work placement.

Marlett's (1976) study indicated that the difference between the learning of normal and retarded persons depended upon the length of acquisition time. Once he has achieved mastery of the task, he would perform as well as a non-developmentally handicapped person.

Brown (1977) discussed the importance of 'Programme and Trainee Match' and emphasized the need to modify the training environment to meet the individual's baseline functioning.

According to a report by Madhavan et al. (1988), the settings in which a mentally retarded could work are self-employment, sheltered workshops and open employment, depending on his aptitude and resources, and level of retardation.

**Self-Help Groups For the Mentally Handicapped**

Self-help groups are small groups of parents (ranging from 3 to 25), of mentally retarded children, who meet periodically. These groups meet either daily or weekly. 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 4 to 5 hours once a week, where they are encouraged to discuss their problems with the professionals, regarding their mentally retarded child.
Parents select a target behaviour (such as self-help skills, cognitive, language, socialization and motor) and work during the rest of the week. If required, they receive professional guidance in structuring the individual educational programme and the ultimate outcome of such a programme is, (i) it generates a group feeling among parents (ii) parent/parents share their experiences with other parents, (iii) parents can provide help to their children by themselves, with minimal professional help.

Biegel, David and Yamatani (1987) conducted a longitudinal survey of members of 10 self-help groups for families of the mentally ill in Pittsburg to examine members’ preceptions about the types of help giving activities that took place and the relationship between those activities and members’ satisfaction with the group. Results indicated that the activities that occurred most frequently, such as catharsis, explanation and normalisation, were related to non-directive, non-threatening aspects of social support. The least frequent activities such as confrontation or reference to group norms, were those that were more threatening and focused on behavioural change. The non directive non threatening activities were moderately correlated with members satisfaction with the group.

Palmer’s (1987) study gives guidelines for social workers and other resource persons assisting self-help groups and the purpose of the resource person meeting with group members on a consistent basis to provide
Halperin (1987) contends that the self-help groups have become an increasingly important vehicle for providing mental health services for populations that have been otherwise therapeutically disenfranchised.

Riordan and Beggs (1987) discussed the growth of self-help group movement and its current status. Topics discussed included a definition and typologies of self-help groups, the professionals and self-help groups and research on the effectiveness of self-help groups. 10 characteristics (e.g., member attraction and feeling of getting help, risk taking, demystification) of a well-functioning self-help group were identified.

A study conducted by Banerjee (1986), 'On reaching the disabled' in rural areas, indicated that it was indeed a challenging task to take services for the rural disabled in India, and concluded that there was abundant man power and potential of parents and disabled who needed relevant practical guidance from professionals and social workers.

Balgopal, Ephross and Vassil (1986) examined the current state on self-help groups and suggested solutions of potential mutual benefit to such groups and to professional helpers. The underlying philosophy was that the ideal way to assist those who encounter oppression is through mutual aid and support. A derivative paradigm for the role of the professional helper within self-help groups was presented.
Rao (1987) conducted a survey on the Down’s Syndrome children in the rural areas of Bangalore district and gave the model of early intervention programmes with a specific reference to Down’s Syndrome children and concluded that the unique feature of self-help approach was that it made the best use of the potential inherent in all parents and the communities. In self-help centres parents looked after children and guided other parents.

Rao (1988a) from a study on the community based programme through Seva-in-Action concluded that rural areas have a lot to offer in planning the services for the disabled persons and further stated that Seva-in-Action had started self-help centres which is a low cost alternative to the specialised services. A self-help group functions with minimal professional input and maximum community participation. Seva-in Action is an all women project which essentially works with families through its multipurpose grassroot level worker and has developed a service delivery model which is multi-category disability approach, wherein a grassroot level worker is drawn from the village community and is trained to meet the different needs of the disabled children. Self-help model could be one of the best methods of reaching the rural disabled children.

Study further states that it is essential to develop a locally relevant curriculum for rural disabled persons. The social, ecological and economic
conditions, should be taken into consideration in the development of curriculum, teaching methods and monitoring methods. As far as mobility aids and innovative teaching aids are concerned, it is a basic requirement to come out with aids such as wheel chairs, walkers, parallel bars, calipers and crutches which are designed for use in a rural set up. The urban models are not only exorbitant but also not suitable for rural use.

Rao (1988b) highlighted some of the issues and problems experienced in meeting the special needs of disabled children in preschools and indicated that the needs of disabled children were complex. Integration, though difficult, seemed to be a practical alternative. The community based service, was the only way of reaching the unreached rural disabled children.

Rao (1989) conducted a study on the service delivery models, urban and rural methods of using various models and concluded that community based rehabilitation programmes were fully integrated programmes and met all the governmental regulations for financial support.

A study, 'Parents helping Parents' by Pueschel et al. (1989) suggested that parents who lived through stressful time with their mentally retarded children would feel relieved of the problem to an extent by meeting other parents of mentally retarded children, by sharing their experiences and helping new parents.
According to the 6th Annual Report of the National Institute for the Mentally Handicapped (NIMH, Secunderabad 1989-1990), the institute provided community based rehabilitation services for the mentally handicapped persons, by organising self-help groups, rural camps and programmes in slum areas.

Rao (1990) from a study on 'Reaching the Unreached' through Community Based Rehabilitation (CBR) programme and self-help groups, concluded that CBR was a comprehensive process and included medical, economic, psycho-social and educational rehabilitation in order of priority to provide the disabled with equal rights and opportunity to be integrated into the mainstream. The longtime significance would be on community development rather than more social services.

Conclusion

Based on the review of related literature quoted above, it can be concluded that the psycho-social problems faced by the mentally retarded are many and complex in nature. Several factors affect and influence the problem and researchers are not in total agreement in many of the areas. However, the review brings out the effect of etiological, environment, hereditary, social and family factors which affect the psycho-social problems of the mentally retarded.

The review also covers the various avenues available for the alleviation of the problems faced by the mentally retarded. The studies cover integrated
education, studies relating to community based rehabilitation programmes, vocational training, intervention programmes including portage training programme, bringing out the distinct advantages and limitations of these approaches. Review of literature on concept of self-help groups to mitigate the problems of mentally retarded indicate that it is a fairly new strategy and it holds promise for reaching the millions of mentally retarded in India because of its distinct advantages of minimal infrastructure and professional help, the two resources which are meagre in India.

Most of the studies quoted over here have been conducted abroad and comparatively fewer studies have been done in India to assess the psycho-social problems suffered by the mentally retarded and the various helping strategies available. Indian studies on self-help groups for the mentally retarded are not many. The seriousness of the problems faced by mentally retarded and one of the most promising and suitable model of service delivery, appropriate for the Indian environment, is possibly, through self-help group programmes. Hence, there is a dire need to conduct research in this specific field in India. An attempt has been made by the investigator to study the psycho-social problems of the mentally retarded and the effectiveness of self-help groups in alleviating them.