THE FAMILY AND FORMAL EDUCATION AND THE SOCIAL FUNCTIONING OF THE MENTALLY DISABLED INDIAN CHILD

by

INDRANIE PILLAY

Submitted in part fulfilment of the requirements for the Degree of Master of Arts in the Department of Sociology in the Faculty of Arts at the University of Durban-Westville

SUPERVISOR: PROFESSOR G F SCHOOMBEE

JOINT SUPERVISOR: DR L H P STEARS

Date: November 1991

UNIVERSITY OF DURBAN LIBRARY WESTVILLE

A:980292B

FOR BOB

THANK YOU FOR YOUR UNFAILING SUPPORT AND UNDERSTANDING.

ACKNOWLEDGEMENTS

I would like to express my appreciation to the following individuals who assisted in various ways with this study.

1) First and foremost my supervisors, Professor G F Schoombee and Dr L H P Stears, for their sustained encouragement, patience and constructive criticism throughout the study.

2) A special thanks to Mr Teo Lazarus from the Department of Psychology who helped greatly in the structural layout of my statistical analysis.

3) To all the School Principals and School Counsellors who kindly completed and submitted questionnaires.

4) To all parents who willingly gave their time to participate in the main study.

5) I wish to express my indebtedness to the typist, Pops Pillay, for her speedy and efficient typing of the manuscript.

6) Last but not least, my family, Mr & Mrs V Govender and Bob for their emotional support and understanding.

TABLE OF CONTENTS

	Page
Acknowledgements	i
Table of Contents	ii
List of Tables	vi
CHAPTER ONE	1
MOTIVATION AND OUTLINE OF THE WORK PROCEDURE	1
1. Importance of the Study	1
2. Aims of the Study	3
3. Working Hypotheses	3
4. Research Methodology	4
CHAPTER TWO	9
A THEORETICAL FRAMEWORK FOR ANALYSIS	9
1. The Mentally Disabled Child	9
1.1 Introduction	9
1.1.1 Brief History Review	10
1.1.2 Definitions of General and Medical Concepts relating to Mental Disability	14
1.1.2.1 General Concepts	14
1.1.2.2 Medical Concepts	19
1.2 Disability and the Concept of Self	22
1.2.1 The Relationship between the Self Concept and Adjustment	23
1.2.2 The Relationship between Disability, Self Concept and Sex	29
1.2.3 The Relationship between Disability and the Significant Others	30
1.3 Basic Needs of the Mentally Disabled Child	31
1.4 Social Stigma	35
2. The Influence of the Family and the Home Environment	39
2.1 The Importance of the Family	39
2.2 Reactions of the Parents to their Handicapped Child	42

2.2.1 Grief and Guilt of Parents 46
2.2.2 Shame, Embarrassment, Denial and the Self Esteem of Families 47
2.2.3 Acceptance and Adjustment 49

2.3 Emotional Factors that Parents Experience over their Disabled Child 51

2.3.1 The Effect of the Handicapped Child on the Marital Relationship of the Parents 51
2.3.2 The Effect of the Handicapped Child on the Siblings in the Family 55
2.3.3 The Effects that the Handicapped Child has on the Financial Position of the Family 58
2.3.4 Stress and Practical Problems experienced by Families of a Handicapped Child 60

2.3.4.1 Stress 60
2.3.4.2 Practical Problems 63
2.3.4.3 Housing 66

2.4 Counselling Parents of a Mentally Disabled Child 68

2.4.1 Introduction 68
2.4.2 Services and Support for Parents of Mentally Retarded Children 72
2.4.3 Services for Parents of Mentally Retarded Children 72

CHAPTER THREE **77**

3. EDUCATION IN RELATION TO THE DISABLED CHILD 77

3.1 Importance of Education 77
3.2 The Objectives of Education 78
3.3 Pre-School Education 81

3.3.1 Introduction 81
3.3.2 The Major Goals of Pre-School Education 82
3.3.3 Role of the Family in Pre-School Education 86

3.4 Special Education 88

3.4.1 Special Arrangements for the Mentally Disabled Child 91
3.4.2 Advantages and Disadvantages of Special Schools 93

3.4.2.1 Advantages 93
3.4.2.2 Disadvantages 95

3.4.3 The Advantages and Disadvantages of Residential Institutions 96

3.4.3.1 Advantages 96
3.4.3.2 Disadvantages 97

3.5 Relationship between Parents and School Authority 101

3.5.1 Nature of the Relationship 101

3.6 Integration and Mainstream Education 106

3.6.1 Introduction 106
3.6.2 Advantages of Integration and Mainstream Education 107
3.6.3 Disadvantages of Integrated and Mainstream Education 108
3.6.4 The Integration of the Disabled Child in Normal Schools 110
3.6.5 Counselling the Mentally Handicapped Child 112
3.6.6 Conclusion 115

CHAPTER FOUR **117**

THE EMPIRICAL FIELD STUDY: THE METHODS USED IN THE RESEARCH

4.1 Review of Relevant Literature 117
4.2 Methods of Data Collection 118
4.3 The Pilot Study 127
4.4 The Choice of Locale 128
4.5 Selection of Study Population 129
4.6 Data Processing 131

CHAPTER FIVE **132**

EMPIRICAL FINDINGS 132

5.1 Influence of Familial and Home Background Factors on the Social Functioning of the Disabled Child 132

5.2 Formal Educational Effort on the Social Functioning of the Mentally Disabled Child 193

CHAPTER SIX 232

CONCLUSIONS, RECOMMENDATIONS AND SUMMARY 232

6.1 Conclusions 232
6.2 Addressing the Working Hypotheses 237
6.3 Recommendations 237
6.4 Areas for Future Research 239
6.5 Summary 239

BIBLIOGRAPHY 242

APPENDICES 255

LIST OF TABLES

			Page
Table 1	:	Identity of Persons Interviewed	133
Table 2	:	Age Range of the Children	134
Table 3	:	Sex Ratio Among Disabled Children	135
Table 4	:	Incidence of Various Types of Disability	136
Table 5	:	Ages of Children when Disabilities were First Manifested	137
Table 6	:	Extent of Children's Disability According to Parents	138
Table 7	:	Sources from which Parent sought Advice	140
Table 8	:	Family Responses towards the Disabled Child	141
Table 9	:	Responses of the Disabled Child Towards Others	145
Table 10	:	Frequency of the Disabled Child's Preference to go Visiting	147
Table 11	:	The Companionship the Disabled Child Prefers	149
Table 12	:	Restriction of Social Activities Imposed by the Disabled Child	151
Table 13	:	Degree of Comfort the Child Experiences in the Care of Family Members	152
Table 14	:	The Degree of Appropriateness with which the Child can Cope, in the Presence of Visitors	153
Table 15	:	The Amount of Attention Demanded by the Disabled Child	154
Table 16	:	Behavioural Problems of Disabled Child	158

Table 17	:	Disabled Child's Influence on the Psycho-Social Development of the Normal Siblings	161
Table 18	:	Degree in which the Normal Children Manifest Resentment	162
Table 19	:	Disabled Child's Attitude Towards the Normal Siblings	164
Table 20	:	The Extent to which the Mother Neglects the Normal Siblings for the Disabled Child	165
Table 21	:	The Intensity of Embarrassment Experienced by the Disabled Child in Comparison with Normal Children of his Age	167
Table 22	:	Body that is Responsible for Taking the Disabled Children on Holidays	170
Table 23	:	Are Special Adaptations Required in a Home, Due to a Disabled Child?	173
Table 24	:	The Extent to which Family Expenditure is Increased	174
Table 25	:	The Extent to which the Disabled Child is Affected Due to Conflicts at Home	176
Table 26	:	The Frequency in which Family Counselling will Influence the Life of the Disabled Child	178
Table 27	:	The Extent to which the Disabled Child has a Problem in Coping with Situations Outside the Home	180
Table 28	:	Parents' Prediction Regarding the Future of their Disabled Child	181
Table 29	:	The Parents' Perception of the Interest that the Disabled Child has in Regard to his Education	183
Table 30	:	The Extent to which the Disabled Child is Forced to go to School According to Parents' Perception	185
Table 31	:	Body Responsible for the Child's Education According to Parents	188
Table 32	:	The Degree to which Parents Assist their Disabled Child in School Work	190

Table 33 : Number of School Functions Attended by Parents 191

Table 34 : The Extent to which Special Education is Necessary for the Disabled Child 194

Table 35 : The Extent to which Disabled Children are Embarrassed to Attend Special School 196

Table 36 : The Extent to which Special Education Allows for Greater Independence 197

Table 37 : The Extent to which Special Education Allows for Employment and Productivity in the Future 199

Table 38 : The Extent to which Pre-school Children Adjust to Formal Schooling Environment 201

Table 39 : The Reaction of the Disabled to their Inability to Understand Basic Concepts 204

Table 40 : The Reaction of the Disabled in Regard to Education 205

Table 41 : The Extent to which the Disabled Child can Maintain their Concentration in the Classroom 207

Table 42 : The Ability of the Disabled Child to Cope with Criticism 209

Table 43 : The Extent to which the Disabled Child will benefit from Integrated Education 211

Table 44 : The Extent to which the Advantages of Pre-school Education Outweigh the Disadvantages, According to Teachers' Perception 214

Table 45 : The Extent to which the Advantages of Special Education Outweigh the Disadvantages, According to Teachers' Perception 215

Table 46 : The Extent to which the School Work of the Disabled Child is Affected by Factors outside School 217

Table 47 : The Extent to which Teachers Interact with Parents Regarding the Child's Education 219

Table 48 : Extent of Parents' Interest in the Child's Education 221

Table 49 : Parental Interest in the Administration of the School 224

Table 50 : Parental Interest in the Teaching Methods of the School 225

Table 51 : Parents' Helpfulness in Extra-Curricular Activities 227

Table 52 : The Participation of Disabled Children in Extra-Curricular Activities 228

Table 53 : The Extent to which Participation of the Disabled Child in Extra-Curricular Social Activities Change as they Progress at School 230

Table 54 : Difficulties Experienced by the Disabled Child at School 231

CHAPTER ONE

MOTIVATION AND OUTLINE OF THE WORK PROCEDURE

1. IMPORTANCE OF THE STUDY

In virtually all societies, those who suffer from mental impairment are recognized as different in some way from other people (Wilkin, 1979:11).

Traditionally, professionals and families of handicapped people themselves have tended to look upon handicapped persons as being 'deficient' in just about every disability. Few inalienable rights existed for persons with mental disability. They were not free to make decisions or even to give their consent when decisions were made for them. Too many were denied an education, sterilized, made to work for no pay, and treated inhumanely (Furey and Haber, 1989:137).

However, it is important to note that the status of the disabled in society has increased remarkably from one in which they were rebuffed, ignored and punished, to a more tolerant and enlightened approach that prevails today. Therefore to compete successfully with their non-handicapped counterparts in society, handicapped persons need at least equal educational opportunities. However, in the past decade, educators and parents have become increasingly concerned about

many of the programmes and curricula associated with education for the handicapped (Clark et al, 1989:397).

The provision of appropriate social facilities and aids, along with acceptance and a supportive attitude by parents, can encourage the handicapped and assist in developing their abilities to their maximum potential. Thereby the individual is enabled to participate meaningfully in social activities.

This study is undertaken because the researcher is interested in the plight of the mentally disabled and because of the apparent need for it. While a considerable amount of sociological research has been conducted on the mentally disabled overseas, in South Africa sociological research and thus data on social functioning is greatly lacking regarding, especially, the mentally disabled child in the Indian community. So far as could be determined, this also applies to some extent to other groups in the Republic of South Africa. The current research is related to that which has been done elsewhere both in the theoretical discussions in Chapter Two and when conclusions are drawn in the last chapter.

The introduction of special schools and facilities and a realization of the importance of this, together with informal socialization within the family, is a relatively new development for the Indian disabled child. The present study is directed at ascertaining the peculiar needs of the Indian child, in these respects, thus assisting in the improvement of existing methods and facilities.

2. AIMS OF THE STUDY

2.1 To determine how the home environment and the attitude of the family affect the social functioning of the mentally disabled child.

2.2 To examine the present schooling arrangements for these children and the difficulties that are experienced by parents, staff and scholars.

2.3 To make recommendations in the light of findings towards the improvement of existing methods and facilities.

3. WORKING HYPOTHESES

3.1 Parents play an important role in the social and informal educational development of a mentally

disabled child.

3.2 Formal education contributes significantly to the social independence of a mentally disabled individual.

4. RESEARCH METHODOLOGY

A brief outline of the research methodology is given here to orientate the reader in broad terms. In Chapter Three a detailed description is given.
The researcher concentrates on the Indian schools for the mentally disabled situated in the Durban and Westville municipal ares. The three (3) respective schools which cater for the mentally disabled Indian children of all ages, both at primary and at secondary levels, are:

1. Golden Gateway Training Centre in Cato Manor
2. S Dass School in Phoenix
3. Westpark School in Westville.

These schools have a total population of three hundred and fifteen (315) students. The entire universe of three hundred and fifteen (315) parental couples is established from the school records, and will serve as a main data base. The interviews thus constitute a complete census, avoiding the need for a sample being drawn. A structured questionnaire is designed for an

in-depth study to determine the attitudes of these parents regarding the educational needs of their children and the facilities that should be provided for them. All questionnaires will be personally administered by the researcher for the following reasons:

a) to gain access to authentic and qualitative information; and
b) to ensure a high level of return.

Further data is obtained by administering a separate but related questionnaire to staff members of the respective schools. A literature study to provide a theoretical basis for data analysis is conducted prior to constructing the questionnaires.

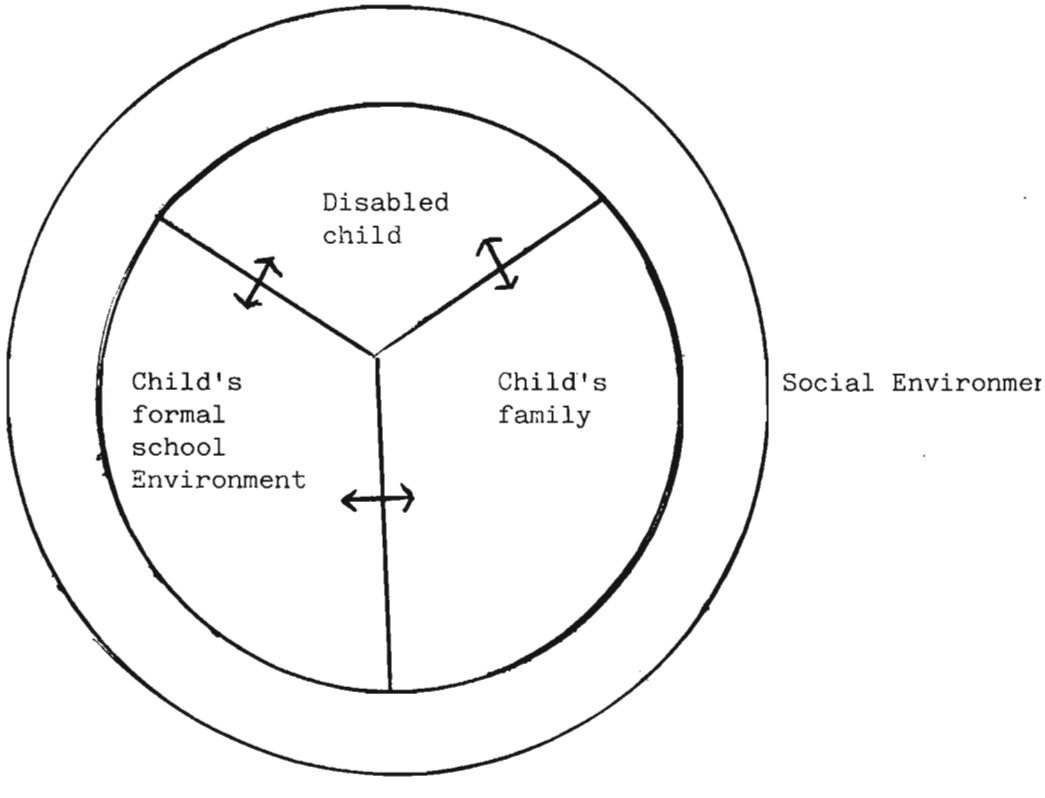
It is necessary to structure the analysis of data relevant to this study with reference to a theoretical model. A functional model is used in this respect. The main elements in the interaction system to be analyzed are:

i) the disabled child;
ii) the child's family; and
iii) the formal school education of the child.

In addition, this interaction system must be seen within the context of the surrounding social environment. The theoretical data analysis is done with the above interaction system as frame of reference.

The frame of reference can be diagrammatically depicted as follows:

DIAGRAM 1: THE FUNCTIONAL INTERACTION SYSTEM



All three elements must be in a state of positive social functioning if the total interaction is to achieve its goals effectively. The three subsystems must also be reciprocally related in such a way that a state of functional equilibrium is attained in the total system. Furthermore, the interaction system is related to the surrounding social environment.

The analysis of theoretical data obtained from literature sources is done with reference to the above model. First, the needs of the mentally disabled child which must be fulfilled if the child is to achieve positive social functioning, are probed. Second, a similar analysis regarding the family is made. Third, this is also done with regard to the formal school educational needs of the disabled child. The surrounding social environment is referred to throughout the analyses.

Subsequently, the questionnaires were constructed with reference to the variables identified during the data analyses. These questionnaires were pre-tested in the field to determine their effectiveness before they were administered to the respondents in the survey proper.

After all the data had been gathered, a systematic analysis was done and appropriate statistical methods were applied to determine the validity of the results. Finally, conclusions were drawn about the validity of the working hypotheses and recommendations regarding the future improved social functioning of the mentally handicapped child were made.

The next chapter deals with the theoretical analysis of data obtained from the literature study.

CHAPTER TWO

A THEORETICAL FRAMEWORK FOR ANALYSIS

1. THE MENTALLY DISABLED CHILD

1.1 INTRODUCTION

We live in a society that embraces the normal or average man, a society that easily recognizes or supposedly accepts individual differences, but is mainly organized around the concept of similarity. When an individual does not correspond to society's standards for normality, we become disconcerted and tend to reject and categorize individuals on the basis of supposed aberrations. Gargiulo (1985:1) quotes the words of Gliedman and Roth (1980): "Handicapped citizens are frequently portrayed as deviant, incompetent or helpless. A disability label often leads to social isolation and assigns inferior status."

However, in the words of Ward and Reale (1972:28): "Understanding of these difficulties although grievously inadequate, is increasing. In fact, the concern for children who are handicapped or have special needs is all-time high." Gargiulo (1985:8) further states that in the past decade, a flurry of activity has arisen on behalf of handicapped children

and their parents. As a result, society has become increasingly observant of the unique characteristics and assets of its handicapped citizens.

The present section elaborates on the above observations:

First a brief historical review of attitudes towards the mentally disabled child is given. Next some basic concepts are clarified. Discussions then follow on the most important analytical variables identified during the analysis of relevant literature which relate to the needs of the mentally disabled child which must be fulfilled for its positive social functioning.

1.1.1 BRIEF HISTORICAL REVIEW

The recorded history and care of the mentally retarded follow a fairly logical sequence of development that spans many centuries. Even though unrecorded, the condition of mental retardation undoubtedly has simultaneously existed with the presence of man on earth.

The Greeks and Romans were the first to record official references to the condition of mental retardation. Both spoke of 'fools' and monsters' and alluded to their inability to provide for self or

family. Both, Athenian and Spartan city states are reported to have dealt severely with mental defectives because their interest was in developing a society free of defectives. Such persons were thrown of mountains, drowned in rivers or simply left to the elements to die. They were considered creatures incapable of human feeling and therefore undeserving of human compassion. Extermination was the rule of the day (Gearheart, 1975:1). In Rome, it was customary for the elite to keep fools and jesters for the amusement of the household and guests. Gearheart (1976) quotes the words of Kanner 1964 that many owners acquired greatness and fame as a result of their possessions. Unfortunately, all mentally retarded and deformed persons did not fare as well. Chains, cages or sentences of death were the fate of many.

The orient has been more humane than the Western world towards the mentally disabled, who have in general been tolerantly treated. The Koran specifies to "maintain them ... clothe them and speak kindly to them." A retarded child in a Brazilian family may be considered more a joy than a sorrow for he may be its sole support. A religious order in India is entirely financed by the receipts of the disabled children it trains to go out to ask for charity. Tradition has it that if you are not generous with these children, you

will be punished by having one born in your own family (Stern, 1963:187).

"However, the middle ages saw society's wholesale adoption of institutionalization as the answer to the care of the mentally retarded population. During this time, there were great movements for the formation of charitable organizations, legislation for the protection of the mentally disabled. However, the early Christian churches played a remarkable role in providing care and support for the poor and the disabled, and many asylums and hospitals were built for such people" (Talbot 1964, in: Gearheart, 1975:4).

Inherent in all of these was the worth and rights of individual human beings. It was believed that education and training suited to their aptitudes would make them effective citizens.

The early twentieth century was known as the era of education. Numerous special schools for the mentally disabled were built in large parts of Europe. However, the purpose was to develop the full potential of mentally disabled, and furthermore to see them as valued members of society. With the help of professionals and educators, many states throughout Europe began enacting compulsory school attendance laws. However, the first half of this century clearly

saw the emergence as well as the expansion of public school programs for the mentally disabled, both educable and trainable levels (Baumeister and Butterfield, 1970:6).

The 1970's have been the scene of the implementation of a principle of normalization. The principle of normalization has been documented as having its beginnings in services to the mentally retarded in Scandinavian countries (Wofensberger; 1972, in: Gearheart, 1975:12). The principle of normalization directs society to provide services and facilities that permit the individual to function in a manner that is as culturally normative as possible. The principle of normalization is one of the major underlying factors in much of the change in societal dealings with and provision for the retarded in the past several years.

Today, there has been an increasing interest among many people that the disabled have a right to have the same opportunities as his non handicapped counterparts, the right to work and earn a wage, a right to marry and have children, a right to give a fair trial for any alleged offense and most important, a mentally retarded person is entitled to the same civil rights as any other citizen.

However, the attitude and concerns among the enlightened, especially professionals and special educators at present find it a dire need to recognize the disabled person as a human being with the usual needs, inspirations and emotional experience. Practices which tend to dehumanize a disabled person should be eliminated. This applies to living conditions, working conditions, recreation, training and treatment. The atmosphere should be such that it recognizes the individuals worth and dignity, and makes provision for appropriate care, treatment and programming.

Especially in the United States, the enlightened feel that the mentally disabled should freely enjoy participation in every aspect of community life. The disabled are part of the community and they need to develop their potential to achieve maximum independence. This could enable them to become productive and gainfully employed.

1.1.2 DEFINITIONS OF GENERAL AND MEDICAL CONCEPTS RELATING TO MENTAL DISABILITY

1.1.2.1 General Concepts

Certain concepts are widely used when the phenomenon of mental disability is discussed. The following

discussion serves to clarify the meanings attached to these concepts in the present context.

(a) **Acceptance**

This refers to acceptance of the feelings given expression by behaviour and does not necessarily involve acceptance of unsocial behaviour. Acceptance involves positive and active understanding of these feelings and not merely a negative and passive refusal to pass judgement (Garrett, 1970:23).

(b) **Adjustment**

Adjustment may be defined in terms of adequacy in which the person responds to life situations. The adjusted person is generally effective in solving life's problems, while the maladjusted person is overwhelmed by lifes problems (Garrett, 1970:4).

(c) **Assessment**

An examiner's evaluation of the disease or condition based on the patients subjective report of the symptoms and course of the illness or condition and the examiner's objective findings (Brewer & Kakalik, 1979:57).

(d) **Handicap**

Referring to a person who has a congenital or acquired mental or physical defect that interferes with normal functioning of the body system or the ability to be self-sufficient in modern society (Brewer and Kaklik, 1979:159).

(e) **Exceptional Child**

The child who deviates from the average or normal child in (1) mental characteristic; (2) sensory abilities; (3) physical characteristics; (4) social or emotional behaviour; (5) communication abilities; and (6) multiple handicaps to such an extent that he requires a modification of school practices or special educational services in order to develop to his maximum capacity (Kirk, 1972:4).

(f) **Mental Retardation**

Significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behaviour and manifested during the developing period (Grossman, 1977, in: Myers; 1989:77).

(g) **Mental Deficiency**

Used synonymously with mental retardation. There are three major degrees of mental disability:-

i) **Mildly Mentally retarded**

A mildly mentally retarded child is a person who can develop social and communication skills and has minimal retardation in sensori-motor areas. Social and vocational skills may be adequate for minimum self support but guidance and assistance may be needed when unusual social or economic stress occurs (Kirk, 1972:27).

ii) **Moderately Mentally Retarded Children**

Such children can talk or learn to communicate. They have poor social awareness and a fair motor development. They can profit from training in self help and can be managed with moderate supervision. They may also achieve self maintenance in unskilled or semi-skilled work under sheltered conditions (Kirk, 1972:27).

iii) **Severely Mentally Retarded Child**

They have poor motor development. Speech is minimal, generally unable to profit from training in self help, have little or no communication skills. They may contribute partially to self maintenance under complete supervision, can develop self protection skills to a minimal useful level in controlled environment (Kirk, 1972:27).

(h) **Respite Services**

A short term care provided for children living at home while the parents spend time away, the service can be provided in the home or in a residential facility (Upshur, 1982, in: Marc and MacDonald, 1988:78).

(i) **Social Functioning**

"Social functioning refers, among others things, to activities that are essential to satisfying relationships in the variety of social experience of daily living. Interaction among individuals, groups and social systems is a continuous process and any obstacle to role performance creates a problem in social functioning. An individual functions in a socially acceptable manner when his or her activities result in satisfying experiences in daily living

(Garrett, 1970:22).

1.1.2.2 **Medical Concepts**

Cyril Burt, a British educational psychologist, once laid down the principle of multiple causation in relation to mental disability. He showed how in the background of the most mentally handicapped children there was more than a single causation factor. Some of these factors are discussed below.

a) **Asphyxia**

"The term asphyxia means either reversible or permanent damage to the tissue resulting from a lack of oxygen. Because of the high metabolic rate of the brain, it is this organ that suffers first and most seriously from a lack of oxygen. Many children who survive a severe lack of oxygen at birth are abnormal and have permanent neurological sequelae. They are often difficult to nurse and are generally slow in their developmental milestones" (Logue, 1972:11).

b) **Cretinism**

The complete functional failure of the thyroid gland in the new born infant leads to the condition known as cretinism. Cretinism may be of two types; the relatively rare endemic one which is the result of a low concentration iodine in the soil and water of a particular area and sporadic cretinism which is associated with an inborn dysfunction of the thyroid gland and of which the precise cause is not fully known. The early manifestations of cretinism usually include feeding problem, skin dryness, slowness and enlargement of both the tongue and abdomen. If medication is delayed, both marked retardation of mental and motor development will result (Logue, 1972:7-8).

c) **Cerebral Palsy**

Cerebral palsy may be defined as a motor handicap resulting from a damage to the brain before it is fully developed. Cerebral palsy can also occur from injury in early childhood as in the case of illness such as lead poisoning or severe physical trauma. The major descriptive characteristics of cerebral palsy include muscle weakness (Logue, 1972:16).

d) **Down's Syndrome (Mongolism)**

Mongolism is known to arise from a chromosomal defect. The most striking feature of mongoloids is their similarity. They are undersized, have small rounded heads, flat faces and narrow upward slanting eyes. The tongue is often large and protruding. The fingers are often soft, short and stubby and the little finger is curved upwards (Brewer and Kakalik, 1979:141).

e) **Kernicterus**

"Kernicterus is due to a blood incompatibility between the mother and the infant. Mental deficiency may follow from kernicterus or there may be neurological disturbances without retardation e.g. hyperkineses and disability variations in muscles tone" (Glanze et al, 1986:622).

f) **Phenylketanurea (PKU)**

PKU is a birth defect involving an inability of the body to metabolize an essential amino acid. This defect rarely occurs in Jewish, African and some Asian populations and is predominately a disorder affecting Whites. The inability of the body to metabolize phenylalanine results in an accumulation of the amino acid in the body. Some of its chemical derivatives

are excreted in the urine and sweat, and the accumulation of these amino acids leads to the damage of the central nervous system, especially the brain, and results in mental retardation (Darling, 1982:25).

g) **Wilson's disease**

A genetically transmitted abnormality characterized by a decrease of copper in the blood stream and an increase of copper in the liver, spleen and brain nuclei. Deposits in the brain eventually cause severe damage, including mental retardation (Gearheart, 1975:231).

1.2 DISABILITY AND THE CONCEPT OF SELF

Darling (1982:37) states that sociologists have shown that the self concept has a looking glass quality, that is, we are likely to see ourselves as others see us because we learn about ourselves through the communication and evaluations we receive in the cause of social interaction.

Pearlman and Scott (1981:147) state that a child's self image will also have tremendous impact on his overall success and happiness and a child who feels good about himself is an self motivated child. Similarly, Linkowski and Dunn (1974) state that:

"when a handicapped person has a positive self concept, it implies that an acceptable image toward society has developed. In contrast when a disabled person has a negative self concept, it implies that a dislike toward the person by society is developed" (in: Rotatori, et al, 1986:33).

But Boswell and Wingrove (1974:7) state that if a disabled child has a very poor self concept, it is important that he does not look upon his situation as a static one.

1.2.1 **The Relationship between the Self Concept and Adjustment**

Various studies have suggested that high self-esteem or having a positive attitude toward oneself, may be an index to adjustment. High-esteem among normal children and adolescents, for example, has been shown to be correlated with better school performance, fewer psychosomatic symptoms, less anxiety, and more participation with variety of activity outside the home (Coopersmith, 1967; Rosenberg, 1965; in: Darling, 1982:74).

James (1968) who supported this statement, states that experimental studies have shown that people with high self-esteem have a greater willingness to perform

(in: Darling, 1982:74).

Hewett (1970:204) states that adjustment is often defined in terms of "acting normally" in spite of one's handicap, yet society often denies handicapped individuals the opportunity to perform normally. This statement is further supported by Siegel (1974:22) that in many ways disabled people require more than the non-handicapped, yet they frequently receive less: less schooling, less legislation and fiscal attention, less opportunity, less success, less acceptance and less socialization. Darling (1982:73) state that expecting individuals to adjust to a society that does not adjust to them may be unrealistic. Waite (1971:6) states that disability creates problems in social adjustment, but when proper training is started, many of them can make good adjustment to life. Waite (1971:26) further states that life in general is geared to the average so-called normal individual and its' requirements and demands are intended for the average, while a retarded person will meet more problems in his daily living.

Boswell and Wingrove (1974:132) state that where physical excellence and skills are a sign of status, the handicapped child feels a failure. He may instead focus on his body and its' shortcomings and feel ugly, useless and in need of care from his mother.

Similarly, Bentovim (1972) states that frequent surgical or medical procedures or use of appliances may also provoke feeling of being damaged or mutilated and this may emphasize the feeling of being different, for example, a girl may feel she will never be a mother, and the boy never a father (in: Boswell and Wingrove, 1974:132). Rosen and Ross (1968:100) state in their study that a subjects' satisfaction with parts of the body correlate with their self concept only when body satisfaction is important to them. Thus disabled children who did not value physical prowess might still have high self-esteem.

All children including the retarded go through like phases of emotional growth according to levels of maturation. However, clinical evidence suggest that the retarded experience greater difficulty than normal children in giving up one mode of behaviour and progressing to another (Waite, 1971:26). Birenbaum (1979) states that in adulthood changed situations and expectations pose potential threats to self esteem. Normal adults are typically employed, married and have families. To the extent that a handicap prevents any of these activities; the disabled individual may be prone to a diminished view of the self (in: Darling, 1982:69).

Siegel (1974:17) states that because of this disability, the handicapped child remains dependent, thus he is rendered at once vulnerable and defenceless.

Literature indicates that most problems associated with the period of adolescence are pronounced and complicated, especially in the case of the mildly handicapped. Various studies have suggested that the mildly handicapped might have a lower self-esteem than normal persons. These children are most likely to attend regular schools and come into contact with normal persons. Although their difference from normal persons might be minimal, differences are likely to be magnified by the proximity of the comparison group (Collins, et al, 1970; Richardson et al, 1961, 1964; in: Darling, 1982:78). This is further supported by the findings of Meyerowitz (1962) that a group of educable mentally retarded children had a more negative self-concept than a normal group (in: Darling, 1982:77). In contrast, Krider (1959) stated that the disabled children attending special schools did not have significantly different self-concepts from a group of normal children (in: Darling, 1982:77). Similarly, Richardson, et al (1961) state that disabled children attending special schools are generally more sheltered. As a result, they may be less likely to compare themselves (unfavourably) with

normal children (in: Darling, 1982:78).

Collins, et al (1970:288) found significant differences between mildly retarded and non-retarded adolescents in self-criticism and ethnic self-concepts. However, no difference was found in self-satisfaction or in personal self-concepts. In general both adolescent groups had low self-esteem. The findings of Meyerowitz (1962) indicated that retarded children in regular classes had higher self-esteem (in: Darling, 1982:77).

Various studies of disabled children indicate that a disabled child receives less social and interpersonal experience, less responsibility and maternal nurturance and protection and thus has a lower esteem than the non disabled child (Barker and Wright, 1955 in: Boswell and Wingrove, 1974:195).

Bowley and Gardiner (1972:62) states that the disabled child's worth as a person, his capacities for ordinary thought, feelings and activities are assumed to be very reduced or lacking and consequently he is regarded as an outsider as far as social life is concerned. Siegel (1974:24) states that the feelings of frustration, disappointment, anger, failure and depression are all conducive to the poor self-concept.

According to Boswell and Wingrove (1974:7) psychological and sociological investigations show the impossibility of improving the individual resources of a person if he lacks stimulating contacts with other human beings. This is supported by the findings of Siegel (1974:17) that non-handicapped individuals who suffer from low self-esteem may still be able to develop and maintain meaningful and effective interpersonal relationship, while a handicapped individual is already rather ineffective socially and his low self-concept increases his problem.

However, Siegel (1974) further states that it is not unusual for a handicapped child to have the ability to make meaningful and fruitful interpersonal ties and to be totally effective in relating to individuals and groups of people. Kershaw (1973:8) states the child's disability may be a point of weakness in that too much of stress may actually increase the disability, thereby compelling the disabled to possess a low self-esteem.

Boswell and Wingrove (1974:201) state that the disabled are aware that they cannot live up to the expectation that stem from the high value placed on social and physical needs and activities. Kershaw (1973:11) states that therefore the handicapped child must have some essential things done for him by

others; he is dependent and must accept some measure of planned dependence.

1.2.2 The Relationship between Disability, Self Concept and Sex

The correlation between the degree of disability and the self-concept seems to have some relationship to sex. Studies indicate that disabled females had a significantly lower self-concept than disabled males (Smits, 1964, in: Darling, 1982:78).

Similarly, in another study, Meissner, et al (1967) found no general correlation between obviousness and impact of disability and self-concept. Females with the highest impact and most obvious disabilities had more negative self-concept than similarly disabled males (in: Darling, 1982:81).

Among the disabled children there is also the problem of finding an appropriate sexual identity. Bentovim (1972) indicates that long standing contact with the mother involving close body care over a prolonged period may mean that the boy may tend to adopt a feminine role rather than an assertive masculine one (in: Boswell and Wingrove, 1972:132).

1.2.3 **The Relationship between Disability and the Significant Others**

Literature in the field of child development indicates that children's most significant others are the parents. Parents are likely to convey to their children their feelings about many things and reward their children for accepting their views.

Several studies have been concerned with the kinds of parental attitudes and behaviour that are most likely to develop high self-esteem in children. A number of studies (Coopersmith, 1967; Rosenberg, 1963,1965) have shown that parents who show concern by talking with their children or by expressing interests in other ways tend to have children with high self-esteem (in: Darling, 1982:82).

Another factor that may be associated with children's self-esteem is parental warmth. Parents who relate to their children in an affectionate and nurturing manner seem to have children with higher self-esteem (Sears, 1970, in: Darling, 1982:85).

In a large family, for example, parents are less likely to be able to spend a great deal of time with each of their children individually. Sears, 1970 (in: Darling, 1982:283) stated that children from large

families do tend to have lower self-esteem than families with fewer siblings.

1.3 BASIC NEEDS OF THE MENTALLY DISABLED CHILD

Like the non-handicapped child, the mentally disabled have certain hopes and aspirations which determine the direction of their drives. Their basic needs are much the same as the normal child's, but their means of satisfying them must be different (Kirk, 1972:374). Waite (1971:28) states that mentally disabled children, like normal children, have numerous fundamental needs. A fundamental need of children is the feeling of accomplishment. The personality grows in security and maturity when it is able to accomplish and find joy in accomplishment. Similarly, the 1975 United Nations "Declaration of the Rights of Disabled People" states: "Whatever, the origin, nature and seriousness of their handicap and disabilities, they have the same fundamental need of their fellow citizens of the same age, which implies first and foremost the right to enjoy a decent life as normal and full as possible (para.3) (Mittler, 1979:2).

Disabled children need to be taught how to work and live together, how to get along with parents, playmates, co-workers and how to share in the common life of home and community. These children are in

need of socialization and training in acceptable social attitudes because many of them are not socially minded (Wallace, 1960:257).

Erikson (1955) sees the main needs of the disabled child as acquiring:

(a) a basic sense of trust in babyhood;
(b) a sense of autonomy in the toddler;
(c) a sense of initiative;
(d) a sense of industry; and
(e) a sense of identity in adolescence
(in: Gulliford, 1971:42).

According to Isaacson (1974:34) the disabled child needs love and security. They need attention and environment stimulation. The desire for security and belonging is strong in all children. It is perhaps greater in mentally retarded children because their security and sense of belonging have been challenged by failure in their social group. Therefore, according to Waite (1971:28) studies indicate that aggression in disabled children is a result of an unsatisfied desire for affection and security which result in frustration and aggression. In the light of the above, Mittler (1979:2) states that parents and professional staff must try to assess these needs in order to build a programme of training and activities

designed to meet them.

Gulliford (1971:42) states that parents must recognise the needs for love, security, belonging and activity, and meet them according to the methods of child rearing customary in their own society and sub-culture and also according to their personal capacity for providing materially and emotionally. However, Gulliford (1971) further states that the regularity and consistency with which bodily needs are met, as well as a continous, dependable mother-child relationship, develop a basic sense of trust which enables the baby to overcome the sense of mistrust involved in new experiences.

The disabled child needs to experiment and expand his world, growing as a person in his own right. As Erikson (1965) puts it, he has to develop a sense of autonomy as well as combating a sense of doubt and shame. He needs security of parental guidance and firmness as well as the freedom to experiment (in: Gulliford, 1971:43). Mittler (1979:68) supports this statement by saying that, the disabled child needs to learn about the outside world, to learn about properties and characteristics, he needs to come into contact with many different people and to learn from repeated experience how much people differ, not only culturally from him or his family, but in other

respects as well. Even more than the normal child, he needs to learn about the world beyond his family circle. But, this takes time and patience. In agreeing to the above statement Waite (1971:29) states that the adolescent's main task is to acquire a sense of identity while overcoming a sense of identity diffusion. For example, he needs to experiment with a wide range of roles; he needs to explore a variety of opinions, ways of behaving and ideals.

According to Gulliford (1971:49): "Teachers need to display an affectionate, sympathetic concern for the disabled child. Thus the need to feel accepted by the teacher communicates to the child that his situation is not hopeless. This realization itself often brings about initial improvement". Kirk (1972:137) states that acceptance should include a feeling of warmth and communicate to the child a feeling that he is valued as an individual.

Gulliford (1971:185) quotes the words of Gibbs (1958): "A point which applies to schools as well as homes is that children have a need not only for receiving but also for giving. The need for a playmate, friend and later for participation in group play activities is one through which normal children learn a great deal about how to relate to other people and how to win acceptance".

Another important set of needs are those of achievement, recognition and self-expression. To be able to do the normal things and to do some things better than other people is important for a child's self-esteem. An important issue for teachers and parents is how to promote and maintain good self-concepts.

1.4 SOCIAL STIGMA

Lemert (1967) defines stigmatization as: "a process of attaching visible signs of moral inferiority to persons, such as invidious labels, marks, brands, or publicly disseminated information" (in: Darling, 1982:104). Topliss (1982:109) argued that is often man-made barriers both physical and psychological, which deny disabled people the chance to use their residual capacities to the full.

However, it must be remembered that stigma is deeply ingrained in our society. Like other prejudices, it is learned early and reinforced often by our experiences with other people and with the media. Because many disabled children and adults were institutionalized or otherwise segregated from society, our conception of the disabled, have been shaped by myth and stereotype rather than being formed by direct experience. However, attitudes formed in

this way are difficult to change. In the light of the above, Topliss (1982:109) states that disabled people still complain about being stigmatized by public attitudes which label them as inferior, imputing a generalized inadequacy because of a particular and sometimes severe "functional loss". Bercovici (1983:7) states that mentally disabled persons have borne a heavy burden of stigma. Society, at times, has perceived them as less than human. This is not an inevitable response but attitudes are slow to change and despite progressive trends in our society, retarded persons are still seen as deviants and their social identities are generally discounted.

In the U.S.A., the "Committee On Restrictions Against Disabled People" (CORAD), was formed to investigate ways of reducing such discrimination. The committee focused on the need to change public attitudes, which it saw as posing the gravest threat to the full development and integration into society of disabled people. The Committee did not imply that the public in general lacks compassion for those who are disabled, but rather that the social and occupational patterns which predominate in our society are geared to rational strategies for the economic development and these favour the energetic, intelligent, independent and ambitious individual with vigorous good health.

Various studies have shown that almost all groups in the population have negative attitudes towards the disabled. For example, Richardson (1970) has shown children as young as six years old are likely to express preference for a picture of a normal child. Worthington (1974) found that normal children would talk to handicapped strangers, but would not stand as close to them as they would do other normal children (in: Darling, 1982:33).

Goffman (1963:14) has suggested that some handicapped children be 'discredited' whereas other are 'discreditable'. A 'discreditable' condition is one that is not readily apparent to a normal person. A child with a disfigurement hidden by clothing or disease might be able to 'pass' as normal and thus avoid stigma. A child with a more visible defect such as Down's Syndrome would be discredited, although the degree of discreditation may vary for different conditions.

Goffman (1963) further states that people hesitate to become close to the family of a stigmatized person because, they in turn, might be stigmatized. He further states that close associates of the stigmatized come to bear a courtesy stigma and may suffer similar reactions of avoidance, rejection and ridicule. It is for this reason that stigmatized

individuals and their families may choose their friends from what Goffman calls the "own -others", who already share the same stigma.

Society continues to insist that impairment is a mark of deviance thus maintaining differences and handicapping conditions (Wood and Shears, 1986:118).

Responding to the above statement, Topliss (1982:110) states: "Negative views of the disabled people affect their personal and social relationships as well as their opportunities to participate in the economic life of the community, since the stigma of disability devalues the disabled individual for the roles of friend or marriage partner. The extent to which social stigma creates problems of isolation and emotional frustration for disabled young people has been increasingly acknowledged in recent years, but effective social policies to help are still lacking".

Bercovici (1983:8) states that stigma attached to mental disability, and the perceptions as less than human, are not inevitable. Ideas, conceptions and beliefs about mental disability have been handed down to present generations, and they are created and recreated in the material provisions surrounding people with mental handicaps. Therefore, to eliminate such prejudices and stigma from the disabled, Boswell

and Wingrove (1974:7) state: "The only way to achieve the right attitude to the disabled is to accept him as a collaborator and fellow member of the community. A man who can take full responsibility for his life and his action".

2. THE INFLUENCE OF THE FAMILY AND THE HOME ENVIRONMENT

In this section the most important variables obtained from the literature analysis which relate to the family and its positive social functioning, viz a vis the child and educational environment are identified and discussed.

2.1 The importance of the family

In most Western societies, the family denotes a unit consisting of a husband and wife and their children. This unit is widely thought of a group based on marriage and biological parenthood, as sharing a common residence and united by the ties of affection, obligations of care and support and a sense of common identity (Elliot, 1986:4). According to Ross (1964): "A family is a dynamic system of interacting individual personalities who live together in a complex and changing society" (in: Gargiulo, 1985:42).

However, there are mainly two types of families to be found in modern society, namely, the nuclear family consisting of parents and children only, and the extended family consisting not only of parents and children, but also grandparents or other close relatives. The basic unit of social structure in our society is the nuclear family, and it is therefore within this family that the mentally disabled child receives care.

However, much of American research of the 1950's and 1960's was influenced by the theoretical perspectives of Talcott Parsons, who analyzed the nuclear family in terms of well-defined role relationships which promote stability and balance, where parents are more powerful than children, and fathers exercise 'instrumental' leadership and mothers 'expressive' leadership (Parsons and Bales, 1955, in: McConachie, 1986:28).

Schild (1976:459) states that if the family is considered as an interdependent system in which common needs and purposes are met by the interaction of members, then the problems of exceptionality can be treated as concerns of the entire family. In the light of the above, Gargiulo (1985:42) states that within the family constellation, the exceptional member should not be viewed as an isolated entity. He or she can only be seen and fully understood in the

context of the family unit. In contrast, Simeansson and Simeansson (1981) state that: "There is little doubt that the presence of a handicapped child significantly affects the structure, function and development of the entire family" (in: Gargiulo, 1985:43).

However, Bowley and Gardiner (1972:20) state that the family should be considered as a unit, and the handicapped child is not allowed to become a centre of attraction.

Bowlby (1953, in: Elliot, 1986:21) has argued that: "A warm, intimate and continuous relationship between parents and the disabled child is essential to healthy personality development and that physical, intellectual and emotional development are impaired where the child is without such a relationship". Bowlby (1953, in: Elliot, 1986:21) further states that studies show that children who experience residential care and who as a result have been deprived of a stable and close relationship with parents are unable to receive or give love, are compelled to adopt a career of destructive antisocial relationships and in extreme cases become psychopathic personalities.

Fletcher (1973:42) states: "The family is that group within which the most fundamental appreciation of human qualities and values takes place: the qualities of truth and honesty, of falsehood and deceit, of kindness and sympathy, of co-operation and forbearance and of tolerance, justice and impartiality".

Lillie (1981:97) states that the family is the foundation of society and the cornerstone of our social fabric.

2.2 Reactions of the parents to their handicapped child

When parents learn that their child is retarded, a series of intense and prolonged emotional reactions begin, regardless of how long after the birth of the child it takes place. Every member of the family will be affected. The emotional reactions may manifest themselves in many ways: though physical disorders, mental problems and even disruption of family life.

"Being parents of a handicapped child is not a role people choose for themselves. Parenting a disabled child is difficult, demanding and often a confusing and demoralizing task" (Wentworth, 1974, in: Gargiulo, 1985:14).

"Wolfensbergers' (1967) summary lists forty five initial or early reactions, all negative, including shock, denial, grief, guilt, rejection, rage and even impulses to kill the child, etc" (in: McConachie, 1986:44).

According to MacKeith (1973:25), the initial feelings of parents will be mixed ones such as feelings of inadequacy, feelings of shock, feelings of embarrassment which is a social reaction to what the parents think other people are feeling.

According to McConachie (1986:45) several authors have presented an analysis of parents' reaction in terms of stages: a state of shock at the initial disclosure, that is feeling of not being able to register or understand news and thus withdrawing, will be followed by a reaction stage, during which emotions of denial, sadness, anger, etc, may be felt in a rush. Similarly, the investigation of Kohut (1966) and Ross (1964) have suggested that parents display a variety of reactions when presented with the formal diagnosis that their child has a handicapping condition. Parent's reaction of shock, grief, disappointment and diminished coping abilities have been reported (in: Lynch and Staloch, 1988:77).

In the light of the above, McCormack (1978:34) stated that feelings of shame, embarrassment, inferiority and sometimes guilt, experienced by parents of handicapped children are well documented by psychiatrists and sociologists.

Reacting to the above, Faber (1960) suggests that: "The advent of a retarded child need not create a family crisis, while Chinn (1974) states that whether or not an event becomes a crisis depends upon three basic conditions:

(1) the nature of the event;
(2) the resources of the family; and
(3) how the family defines the event" (in: Chinn et al, 1975:139).

Schult (1975) states that: "When parents are told about their child being disabled; a period of irrational behaviour characterized by excessive crying and feelings of helplessness may be experienced. Many parents say that they were totally unprepared for the news of their child's handicap. For example: "We were first informed about her condition when Sally was twenty two months old. We felt that the bottom had dropped out of our world. We felt utterly alone, helpless and convinced that no one else had ever faced this particular tragedy" (in: Gargiulo, 1985:22).

In the light of the above, Cunningham and Davis (1985:165) states that it is clear that some of these strong initial reactions are affected by the manner in which parents are told: those parents who were told 'well' reported feelings of sadness rather than anger. Similarly Roskies (1972) and D'Arcy (1968) states that: "parents initial perceptions of their children are also influenced by their perception of the professional as sympathetic and understanding or abrupt and cold" (in: Gallagher, 1980:15).

Boswell and Wingrove (1976:139) recommends that parents need to be told bout their child's handicap in a way which helps them to accept the problem sufficiently; to provide a basis for taking the child home; and giving themselves time to establish a relationship with him. However, Boswell and Wingrove (1976) further states that although much has been said and written about the harm that can be done if the parents feelings are not sympathically understood, it is still not unusual for parents to be told of their child's handicap in a manner which intensifies their natural distress and leaves them shocked, alienated and misinformed. One doctor told a mother of a mongol child that mongols make nice pets about the house. Another told the mother to put her daughter away and forget you ever had her.

Greer (1975:519) states that in some families, having an exceptional child is a tragedy of the utmost magnitude, in other families it is a crises, but one that can be resolved, for others it is not considered a problem in itself, but rather one element in a daily struggle for survival. Greer (1975) reminds parents that their reactions are natural, and this does not indicate that they are bad parents.

2.2.1 Grief and Guilt of Parents

Roos (1978:17) states that many studies indicated that parents were disappointed about having a disabled son or daughter and are realistically concerned about the future. Roos further states that grief is a necessary and useful reaction and should not be avoided. It provides the parents with a transitional period whereby former dreams and fantasies about the 'perfect child' are readjusted to present day reality. On the other hand, Moses (1977:41) states that guilt is perhaps the most difficult reaction for parents of handicapped children to overcome. Moses (1977) further states that parents may believe that somehow they caused their child's handicap or that they are being punished for their past wrong doings. Bentovim (1972) suggested that the reaction of guilt is unrealistic, that is, the parents fix their feelings of responsibility for the child's abnormality on

imagined links with smoking or some unusual incident in pregnancy (in: Boswell and Wingrove, 1972:266).

According to Eden (1976:32) parents of mentally handicapped children experience quilt which is not a neurotic symptom, but a natural and legitimate reaction to a child who cannot meet any criteria by which parents are accustomed to judge their children. In contrast, Bowley and Gardiner (1972:19) state that mothers find it very difficult to accept the facts and to plan care and training constructively. Often they feel in some measures to blame, and feelings of guilt are very natural and fairly common in such cases. Similarly, Waite (1971:77) states that often people feel in some measure to blame and feelings of guilt are very natural.

2.2.2 **Shame, Embarrassment, Denial and the Self Esteem of Families**

Roos (1978:21) state that the love of parents is only partial protection against the feeling of shame that is produced when the son or daughter is laughed at or singled out as a defective. Roos (1978) further states that closely aligned with the feelings of shame and embarrassment is the loss of self-esteem. Since parents usually identify with their children and often perceive them as extension of themselves, a defect in

the child could easily be interpreted as a defect in oneself. A handicapped child is likely to threaten the parents self-esteem and may force them to radically modify lifelong goals.

Similarly, Waite (1971:77) states that when parents of a disabled child feel that their own personal inadequacy as a man or as a woman is the cause of the child's retardation it may be associated with the fear of loss of status and prestige which seriously threatens the parent's emotional security. The above is further supported by Roskies (1972) who noted that mothers who did not feel isolated also did not perceive their babies as extremely deviant, they did not feel that their own social status was implicated or threatened. Conversely, Walker, Thomas, Russel (1971) found that roughly three-quarters of the mothers studied felt isolated of the birth of a handicapped child (in: Gallagher, 1980:16).

In order to defend against the debilitating effect of the retarded child on the ego or self-concept, parents sometimes resort to the defense mechanism of denial (Chinn et al, 1975:139). However, Kanner (1963) suggests that this common reaction, especially during the initial stage of adjustment, provides a form of self-protection against powerful realities, while Begab (1966) suggests that this may explain their

child's limitations by implying laziness, indifference or lacking of motivation (in: Chinn et al, 1975:139-140).

The socio-economic and intellectual levels of the family may also be factors in the degree of impact in mental retardation. Begab (1966) in a discussion of the "limited family" suggests that there exist a number of "limited families" in which the retarded child's intellectual limitations do not set him apart from the rest of the family. In these families, parents as well as siblings have intellectual limitations. Begab states guilt, anxiety, ego threat or despair about the future are seldom evident. For families in which the parents are educated and goal oriented, the birth of a retarded child causes frustration and destruction of decisions and plans for the future (Chinn et al, 1975:138-139).

2.2.3 **Acceptance and Adjustment**

Wilkin (1975:35) states that most parents achieve a satisfactory adjustment to the emotional problems in a remarkably short space of time, as is evidenced by the large number of families who never seek or receive the support of professional workers who would identify and help them over their 'abnormal responses'. Conversely Waite (1971:27) states that a parent does

not parade his or her feelings easily, in fact, the parent struggles to repress them and hesitates to admit them, even to him or herself. But until the parent can obtain relief for feelings of guilt, inadequacy or humiliation, he or she cannot view reality with sufficient objectivity to develop emotional acceptance of the child. Bowley and Gardiner (1977:19) state that once parents have accepted the cruel fact that the child is permanently handicapped, the stage of adjustment has to follow, that is, coming to terms with long term implications in respect of family life, feeding, social activities, health and in short all aspects of the life of the whole family for many decades.

Several studies have looked at the relationship between social class and parental acceptance. Darling (1982:54) states that studies have suggested that in the case of mental retardation, lower class families are likely to be more accepting than their middle class counterparts. Holt (1958) has written: "The families who managed best were not those in the upper class. These parents were ambitious for their children and never overcame their frustration and disappointment. The ideal parents were those who, while sufficiently intelligent to appreciate the needs of the child, and to have insight into his difficulties, did not have great ambitions and so they

did not constantly display their disappointment. They looked upon the child as a gift for which to be thankful whatever his condition" (in: Darling, 1982:54).

2.3 EMOTIONAL FACTORS THAT PARENTS EXPERIENCE OVER THEIR DISABLED CHILD

2.3.1 The Effect of the Handicapped Child on the Marital Relationship of the Parents

The arrival of the handicapped child throws the parents relationship off balance. Instead of being two individuals or a couple, they become the parents of a time and energy consuming little person. This happens to some extent with normal children, but it is temporary. With a handicapped child, the need and the demands do not lessen with the passing years (McCormack, 1978:130).

Pieper (1976) points out that the family of a disabled child may even blame one another for "bad blood". These recriminations eventually take their toll on the stability of the marriage (in: Gargiulo, 1985:47). Research literature tends to support the clinical impression that the presence of a handicapped child greatly adds to the everyday stresses and strains of married life (Haring and McCormick, 1990:491).

Similarly, Telford and Sawrey (1967:47) state that a handicapped child may aggravate existing marital tensions or even precipitate conflict between husband and wife. The number of desertions and divorces in families with disabled children, far exceeds that found in the general population. McCormack (1978:129) states that the most common marital stumbling block is that the strain of the handicapped child is not evenly distributed between parents. McCormack (1978) further states that there should be a reorganization of roles, a redistribution of the workload and the emotional strains, a lot of talking out and shared decision making.

Abrams and Kaslow (1977:28) state that the child may also be viewed as the source and cause of all family problems, thus acquiring the role of the family scapegoat. On the other hand, as binding together the partners of an unhappy marriage. However, these cases seem to constitute a minority. McMichael (1971:113) has remarked: "In the face of such problems, the wonder is that so many marriages remain intact and are in fact, strengthened by sharing of anxieties about the handicapped child". Agreeing with the above statement, Darling (1982:61) states that in most cases, the marital relationship does not seem to be permanently adversely affected by the birth of a defective child. Although the child undoubtedly

places strain on a marriage, most couples seem to be able to adjust and some even feel that their marriages are stronger as a result. Conversely, McCormack (1978:130) state that there are people who simply cannot live with what they see as the shame and the stigma of a mentally handicapped child. When both parents feel this may happen and there is a residential place available, the dilemma may be resolved on the principle of "out of sight, out of mind".

However, researchers who evaluate families at risk report the following findings. Drotor, et al (1975) have reported that some couples claim to be drawn closer together by their exceptional child (in: Gallagher, 1980:3).

In contrast to the above, Friedrick and Friedrick (1981:153) found that mothers of handicapped children reported lower marital satisfaction than mothers of non-handicapped children.

McCormack (1978:133) has reported that there is the irony that whilst a handicapped child often contributes towards the near break up of a marriage, it may also be the factor that keeps it together. One of the father's explained: "We would probably be divorced now if it was not for our daughter. You

cannot walk out and split up a home with a mentally handicapped child in it, because it means she will end up in an institution. She does not make us any happier but she keeps us living together (McCormack, 1978:133).

Gath (1979) compared families with normal children to families with Down's Syndrome and found that the divorce rate was higher in the Down's Syndrome group. Gath (1979) further reports that all parents of Down's Syndrome infants stated that having such a child was a 'bitter blow' and all had experienced grief (in: Gallagher, 1980:90). Similarly, one American study looked at divorced rates in several groups of parents of young mentally handicapped or genetically impaired children, attending a genetic counselling service. In general, the authors found a lower divorce rate than in the general population, but suggested that young parents having a first born male child and mothers in their early thirties having a first child were grouped at greater risk for divorce (Roesel and Lawlis, 1973; in: Voysey, 1975:57).

2.3.2 The Effect of the Handicapped Child on the Siblings in the Family

Boswell and Wingrove (1972:132) state that the birth of a disabled child can become a factor of distortion of the general family relationships, while Grossman (1972:83) argues that a disabled child affects the entire family and there is a common belief that a handicapped child contaminates the family and generates considerable psychological stress. Grossman (1972:102) further states that a disabled child is very capable of having a disruptive influence in the levels of all family members, including brothers and sisters. However, researchers have consistly found that the effect of a handicapped child on his or her non-handicapped siblings is largely due to the parents attitudes and reaction toward the disabled child.

Many times non-handicapped siblings suffer from neglect or a lack of attention as both parents become overly involved with special needs of the exceptional child. Agreeing to the above, Boswell and Wingrove (1972:260) state that it is possible for the normal sibling to become deprived as so much attention is given to the handicapped child. The normal child may respond with aggressive attention seeking behaviour. The above statement is further supported by the findings of Michael (1971) and Kew (1975) that a

number of adverse affects such as attention seeking behaviour, jealousy, hostilities and aggression, embarrassment and reluctance to bring friends home may result (in: McConachie, 1986:61).

Waite (1971:78) states that the siblings age sequence becomes reversed, so that the retarded child functionally becomes the youngest sibling, while others, chronologically younger assume the role of older children. This also tends to impose an increased burden upon the oldest normal female child, since the mother tends to call upon her for assistance in coping for the younger children. Conversely, McMichael (1971:99) states that if family relationships are good, and the mother is able to meet the needs of her handicapped child, and still have time for her other children, the siblings are more likely to develop a friendly protective attitude and be more accepting of the limitations imposed by the handicap.

According to Chinn et al (1978): "Some of the reasons that normal children encounter decreased parental attention are:

1) The parents may be overwhelmed with the responsibility of caring for the special needs child.

2) The parents are filled with guilt, consequently all their time and energy is devoted to the handicapped child.

3) Sometimes parents attempt to escape from the entire family due to a threat to their self-esteem.

4) The parents may be operating under a false assumption that they are unfit to be parents because they have produced a defective offspring (in: Gargiulo, 1985:50).

Literature suggests that, in general, non-handicapped siblings experience a wide variety of problem. One of the problems encountered by these children is the unrealistically high expectations that some parents place upon them in an attempt to compensate for the limitations of the handicapped child (Schild, 1976; in: Gargiulo, 1985:53).

Michaelis (1977) relates that one daughter was told that she had to achieve for two in order to compensate for the parents disappointment. According to San-Martina and Newman (1974) some handicapped siblings believe that they need to overachieve, others may find their academic progress impeded, possibly as a result of feeling guilty about being normal. Poznansk (1973)

observes that: "Normal children in comparison with their handicapped siblings, frequently have more severe emotional problems. She attributes this to the decreased amount of attention given by parents to their normal offspring" (in: Gargiulo, 1985:53).

Cleveland and Miller (1977:39) state that siblings report having benefited through family cohesiveness and understanding of others.

2.3.3 **The Effects that the Handicapped Child has on the Financial Position of the Family**

Raising a handicapped child involves extra cost, not only for medical treatment and special equipment, but also for everyday items that must be adapted in several ways. For many families who do not live near the specialized facilities that their children need, transportation and overnight housing costs may be exorbitant, especially when a child requires long and frequent hospitalizations. "For most families, the financial problems associated with the care of their handicapped child are accepted as, but another continuing burden that they must bear. The following remark by the father of a severely handicapped child is typical: 'We are always in debt ... We just keep paying Children's Hospital a little bit every month'" (Darling, 1979:182; in: Darling, 1982:143).

Wilkin (1979:41) states that there are two ways in which the handicapped person may have an effect on the family's material standard of living. On the one hand, the earning capacity of either or both parents may be reduced, and on the other hand, meeting the needs of the handicapped person may cause the family additional expenditure. Hirman (1972:78) states that there are many ways in which a severely handicapped child can cause extra expense. For example, he has the same needs as any other child, for food, clothes, etc. But he may also need special clothes and appliances.

Wilkin (1979:42-43) states that apart from restrictions on their income many families with a handicapped member find that they have many additional expenses, special clothing, replacement of worn and damaged furnishings, special equipment and extra transport costs. The family with a handicapped member faces certain special problems and usually attempts to deal with those problems in the same way as would any other family, but the variety of these problems is almost as large as the number of families.

Financial difficulties contribute to stress on parents. Chetwynd (1985) showed that large heating accounts were highly predictive of stress in mothers of mentally handicapped children (in: McConachie,

1986:14). Similarly Hirman (1972:78) states that the family may spend more on heating in the care of a child with Down's Syndrome, who could be susceptible to cold weather. They may also have to buy special foods, as for a baby, where a backward child is unable to chew solids. A major factor would of course be loss of parental income.

Boswell and Wingrove (1976:144) state that there is no doubt that the family of a handicapped child suffers a serious disadvantage in a modern competitive community conditioned by costs and standards of living. However, there is no financial help given to parents to enable them to meet the cost of making the special arrangements that have to be made for the mentally handicapped child.

2.3.4 Stress and Practical Problems experienced by Families of a Handicapped Child

2.3.4.1 Stress

Wilkin (1979:33) states that it is recognized that families with a handicapped member are subject to strains and stresses. It is pointed out that a handicapped child is just like any other child to be born into a family with pre-existing strains and stresses. Wilkin (1979:36) further states that

parents of mentally handicapped children respond to stress in much the same way as any other parents, and in individual cases, the problems associated with such a child can place a severe strain on the mental health of the parents. Most parents of handicapped children suffer psychological and emotional damage for which they require the services of doctors and social workers. Davis (1986) found that parents of children with handicaps have more depressive symptomology than did a matched comparison group of parents of children who were not handicapped (in: Singer, Irvin and Hawkins, 1988:269). McCormack (1978:38) states that the strain of being with a handicapped child on a round-the-clock basis shows in the higher percentage of mothers who had, or came near to a nervous breakdown, during the early years. By contrast, husbands appeared on the surface to be calmer and more philosophical and to talk of their wives as having a naturally nervous temperament, or just being 'a born worrier'.

In light of the above, Singer, Irvin and Hawkins (1988:269) quote the following: "Parents experience sources of stress that are due to living with a child who is handicapped, such as extra care-giving demands, difficulties in obtaining child care, child behaviour problems and conflicts with professional service providers" (Gallagher et al, 1983; Pahl, 1985).

Psychological problems of stress, that is, anxiety and depression which can be outcomes of stressful life events will probably interact with coping resources in ways that make parents more vulnerable to environmental stressors (Crnic, Friedrick and Greenberg, 1983:552).

McCormack (1978:195) states that the strain is always worse in the mother. She is usually the one who feels most intensely about the child, both about not being able to cope with him at home and about not being able to send him away.

In light of the above, McCormack (1978:54) quotes the words of a mother: "Normal children are fairly restrictive when it comes to doing your own thing, but by the time they reach school age, they have developed some interests of their own to keep them occupied without help. A mentally handicapped child on the other hand can rarely be left to get on quietly with playthings". Lefley (1987) has listed a number of other factors that effect the family burden, including radical changes in household tasks, over time, excessive time commitment, neglect for needs of family members who are not handicapped, difficulties in maintaining stable marital relationships and limited independence (in: Rowitz, 1986:111).

With a handicapped child, it often becomes a lifetime concern for which caregivers or a series of caregivers are needed. According to Jenning (1987): "The stresses and demands increase as the child and parent age" (in: Rowitz, 1986:111).

Conversely, Gath (1978:116) in a study of families caring for a child with Down's Syndrome, reported that most families suffered degree of stress but concluded: "Despite the understandable emotional reaction to the fact of the baby's abnormality, most of the families in this study have adjusted well and two years later are providing a home environment that is stable and enriching for both their normal and handicapped children".

2.3.4.2 **Practical Problems**

Darling (1982:41) states that practical problems in caring for a handicapped child include extra work in routine child care tasks such as bathing and dressing, difficulties in obtaining equipment such as special wheel chairs, restricted social life, financial difficulties and restriction on freedom of movement. Similarly Mittler (1979:65) states that there are numerous problems which arise from having to care for a child who may be heavily dependent on the parents for the satisfaction of his basic needs, who may be

physical difficult to handle or carry, apparently unresponsive to praise or stimulation or subject to severe temper tantrums. Boswell and Wingrove (1976:132) state that all the normal work of housekeeping, washing, cooking, shopping and looking after other children becomes increasingly difficult when the mentally handicapped child needs constant attention. Hewett (1970:121) looked at the day to day problem of physical care, management and supervision of families with a cerebral palsied child and demonstrated their real meaning to the people most affected. She emphasized that although the problems faced by these families were different and more severe than those of families with only normal children, the approach adopted by the parents in dealing with these problems was the same.

Rotatori (1986:43) states that not only do the parents have problems in dealing with the fact that they have a retarded child, there also exist practical problems created by the child's physical appearance. A list of possible problems include:

a) financial demands relative to specialized medical care, transportation, diets, equipment, etc;
b) stress posed by providing constant attention and supervision;

c) diminished time of other family members;

d) limitation of normal family activities;

e) fatigue and exhaustion from constant demands;

f) neighbours and friends who are not understanding and may even be critical; and

g) troubling behaviour of the child.

In the light of the above, Wilkin (1979:37) states that it is the practical and material difficulties of caring for a disabled child that takes much longer to come to terms with and with which many parents would welcome professional help.

Faber (1968) states that: "As far as practical problems are concerned, the middle class families tend to be better equipped to cope with them because they are better off financially" (in: Wilkin, 1979:41).

Similarly, McMichael (1971:61) states that families with a handicapped child face a number of practical problems in the day-to-day living. This is inevitable, but what seems particularly unfortunate for the lower income groups is that the social problems they share with many other working class families, such as poor housing conditions, overcrowding and financial difficulties; bear more heavily on them when they have a handicapped child.

Faber (1968) states that evidences indicates that mothers find themselves more or less permanently restricted by the necessity of caring for a higher dependency child who will never grow up. He further states there are a number of ways in which this conflict can be dealt with. The problem can be removed by seeking long term residential care for the handicapped child, although this is a solution many mothers are unwilling to adopt. Some mothers feel forced to abandon their legitimate aspirations for life outside the family and devote their whole lives to child care (in: Wilkin, 1979:57). Bowley and Gardiner (1972:21) state that sometimes the handicapped child really benefits from being away for a period from the anxious and close concern of his devoted parents and on the other hand they may find relief from his constant care and be more able to live a full and normal life. However, literature indicates that many families have built up a very satisfying life while keeping a severely handicapped child at home and sharing his care and letting him join into family activities as much as possible.

2.3.4.3 **Housing**

Poor housing has frequently been cited as a major problem for families with severely handicapped children, e.g. overcrowding, damp (for children prone

to chest infections), stairs (for children who cannot walk), shared outside toilets (for children who are not toilet trained) (Tizard and Grad, 1961; McMichael, 1971; Butler, Gill, Dameroy and Fewtrell, 1978 in: McConachie, 1986:14).

Similarly, Boswell and Wingrove (1976:144) state that housing conditions which are normally acceptable can become appallingly difficult if other children have to live in one room with the handicapped child or if a very disabled child has to be carried up and down many flights of stairs and the normal problems imposed by poor housing are often vastly increased for these families.

Poor housing has direct effects in increasing the difficulties inherent in child-rearing; it also has indirect results in terms of child behaviour problems and of maternal ill-health (Carnegie United Kingdom Trust, 1964; Richman, 1974 in: McConachie, 1986:15). Conversely, the findings of Beckman (1983:155) indicates that one family in which the parents are no longer young or very fit, living in poor housing, with a severely mentally and physically handicapped child, seem to cope with any circumstances and welcome opportunities to do more for their child.

2.4 COUNSELLING PARENTS OF A MENTALLY DISABLED CHILD

2.4.1 Introduction

The concept of counselling according to Shertzener and Stone (1980) "ranges from the historical notion of advice giving, to test interpretation, to the traditional idea of psychotherapeutic relationship. Today, the most general concept associated with the term counselling is helping" (in: Gargiulo, 1985:119).

Siegel (1974:144) states that parent counselling is a vital ingredient in the emotional well being of a mentally handicapped child. Waite (1971:71) states that providing parents of a mentally handicapped child with suitable guidance is not a simple process. Each family will face new stresses and new problems at different stages in the development of a retarded child, and will need repeated professional help. Rotatori (1986:91) states that counselling the parents of a disabled child means not only to give advice on management, but to help them work through their shock, their unreasonable guilt and anxieties, and all of the emotional consequences of them having a retarded child. Darling (1982:193) states that counselling must be action-orientated, helping parents to know and to do, in addition to understand their feelings. The

role of the counsellor must be one of facilitation, that is, of educating parents in the process of effectively meeting and working to overcome societal constraints.

Waite (1971:89) states that the greatest single need of parents of mentally retarded children is constructive professional counselling at the various stages in the child's life, which will enable the parents to find the answers to their own individual problems to a reasonably, satisfactory degree. As one parent remarked: "We need guidance to help us decide upon and provide a training program for the child. In later years we need guidance and help in making plans which will provide permanent care for our child when we are gone. We look for the guidance that will enable us to make our own decisions in a way which will result in the greatest good for the child and the family which he is a part".

Wolfensberger (1967) suggests the following qualities of a counsellor for the families of the mentally handicapped:

"(a) knowledge of medical, social, educational behavioral aspects of retardation;

(b) knowledge of community resources etc.;

(c) competence in counselling principles and techniques;

(d) lack of bias;

(e) positive attitudes;

(f) orientation to community approaches"

(in: Rotatori, 1986:89-90).

Wolfensberger (1967) further states that: "Regardless of who performs the counselling service, that the individual should possess certain basic knowledge and develop minimal basic skills in counselling. This should provide knowledge of the retarded child on the family and knowledge of parent's comments and reaction regarding those who counsel them" (in: Gearheart, 1975:55).

Gearheart (1975:157) quotes the words of Levinson (1952) that: "Parents should get medical advice early, try to meet the child's emotional problems and help further the cause of the mentally retarded. Parents should not adopt a defeatist attitude, develop a complex of shame or guilt, neglect their normal children, be afraid to have other children and push the child beyond his capabilities".

Counselling parents of the Down's Syndrome child deserves special attention because this child represents the largest single group in the mental

retardation category. Because of a generally accepted concept of low abilities, early instutionalization becomes a standard recommendation. However, it should be noted that mongoloid children raised at home tend to develop more quickly and become more advanced in nearly all aspects than their counterparts placed in an institution (Kugel and Reque, 1961; Shatwell and Snipe, 1964 in: Gearheart, 1975:157).

Litton (1978) states that: "Counselling services might be summed up best as providing child management techniques and presenting realistic information and facts on mental retardation" (in: Rotatori, 1986:93).

Wolfensberger and Kurtz (1969) state that: "Parents need counselling to help them recognize the potential as well as the feelings of their child" (in: Rowitz, 1988:116).

However, Ehlers, Krishef and Prothero (1973) maintain that seven principles of counselling are of particular relevance for counselling parents of a mentally retarded child:

"These are:

1) involve both parents
2) provide support and understanding
3) stress the importance of feedback
4) give advice relating to needed community services
5) collect and understand the relevant facts on the child
6) maintain objectivity
7) preserve the counselling relationship"

(in: Gearheart, 1975:156).

2.4.2 Services and Support for Parents of Mentally Retarded Children

The services for the mentally handicapped people have traditionally focused on the handicapped people themselves; with policy making and professional giving, while limited attention was given to the role of the family and the community. Yet the main burden of caring for the mentally handicapped child is the family. Therefore adequate services and support should be provided to such families in order to relieve the stress and burdens of every day life.

2.4.3 Services for Parents of Mentally Retarded Children

Chinn et al (1975:145) states that one of the most fundamental needs of parents of retarded children is

to be made aware of the various services at their disposal. Many of these parents are in a state of confusion and find that many of the professionals they contact are unable to give them advice beyond their own area of expertise.

Wilkin (1979:45) states that there is a notable lack of attention to services provided directly to families, partly because the achievements of such services are less obvious and there are no convenient yardsticks which provide for evaluation. The most common failure in the evaluation of services has been that the recipients (the family) are not asked how they feel about the support (or lack of support) they receive.

Jaehnig (1974) noted that the marked lack of services, other than education which had impact only on day-to-day problems in the home, emphasized that where services were available to families they were oriented to crises intervention rather than the provision of long term support. He concluded that: "Professional workers expressed little interest in the situation as long as the child was at home and the parents were not complaining" (in: Wilkin, 1979:46).

Wilkin (1979:47) states that although the development of adequate community services is hindered by a general shortage of resources, there are also other factors which inhibit their development. Where resources are available they are not always used to provide the sorts of services that families want and need. Wilkin (1979) further states that professional and research workers have tended to focus on their own definition of the needs of families rather than being guided by felt needs of families, with the result, that the gap between what parents expect and what they want actually get widened.

Family services are really of two types: supplemental services are those that add to the resources based on the family so that they are enabled to enact independently. Supportive services enhance existing family capacity to cope with daily and emergency stresses, among these services would be information on programmes and services, recreational opportunity, counselling services focusing on family discord, perceptions of burden and understanding the needs of the family member who is disabled.

Research elicit some important findings:
Justice, O'Conner and Warren (1971) concluded from their findings that, although most parents reported that services which they contacted were indeed

helpful, they did not generalize the use of services in one problem area to services in other areas. A large proportion of parents reported that they did not know of any additional service that might help them, or they reported that no other services were needed.

Justice, O'Conner and Warren (1971) further state that the pattern of general lack of information about available services seems to prevail among parents of children with a variety of handicapping conditions. Richards and McIntosh (1973) noted that some parents attributed their child's delayed progress to lack of available services (in: Gallagher, 1980:18).

Ariel (1975) and Treestan (1971) both indicate that the task of helping parents and children with handicapping conditions is obviously a complex one. Parents report that many physicians do not have adequate training or knowledge to fulfil this task properly (in: Gallagher, 1980:18).

"The role of medical and educational services in influencing parents perceptions of their childs normality may seem to be paradoxical.
Walker, Thomas and Russel (1971) reported that many parents, particularly those of less handicapped children disliked the medical clinic because it brought them into contact with more severely

handicapped children. Roskies (1972) found that mothers who had previously perceived their children as seriously abnormal tended to judge that the rehabilitation program had increased their child's normality, while mothers who had previously considered their children to be relatively normal found that the process of rehabilitation had emphasized their childs abnormality" (in: Gallagher, 1980:18).

It is important for parents to have knowledge of the services that are available to handicapped children and the rights of handicapped children. They need help in locating and assessing services in the community region and the state that exists to facilitate the growth and development of the handicapped child. Parents also need training if they are to become effective advocates for the handicapped child throughout his or her life.

CHAPTER THREE

3. EDUCATION IN RELATION TO THE DISABLED CHILD

In this section variables obtained from the literature study and which relate to the formal school education of the disabled child and its positive functioning viz a vis the child and its family are identified and discussed.

3.1 Importance of education

Every society must provide ways and means of developing and refining the abilities of its members in order to sustain and perpetuate itself. Education is directed toward equipping a child mentally, physically, emotionally, morally, spiritually and socially toward becoming a responsible participating productive citizen of his community, his state and his nation (Waite, 1971:97). If education is concerned with everything that helps an individual to learn and to develop, then education begins at birth and never comes to an end (Mittler, 1979:75).

The function of education is to set conditions that are favourable for the continued mastery of knowledge, skills and acceptable social attitudes. This begins in the home during early childhood. Education is a

dynamic force whereby optimum individual social competence is furthered (Crow and Crow, 1963:5).

In the light of the above, education is in many ways perhaps the most effective therapeutic tool in the treatment of the handicapped. It teaches self-esteem and self-reliance like nothing else can" (Hamilton, 1973 in: Readings in Special Education, 1976:54).

Education has an important function to fulfil in providing handicapped children with appropriate degree of independence required to cope with open employment (Hutchinson, 1982:8).

The school is a powerful agent in the shaping of attitudes and expectations among children. Thus in the light of the above, education is seen as part of socialization itself, a process of social learning which centres upon the gradual internalization of values, norms and culture (Philip, 1982:11).

3.2 The objectives of education

Clarke (1951:152) states that the disabled child needs education for three vital reasons:

(i) he must acquire sufficient personal status to make his way through the world as independently as possible in spite of his handicap;

(ii) he will sometimes need the strength and consolation which comes from resources of the mind; and

(iii) he badly needs the self-confidence which educational ability engenders.

However, the reasons mentioned above for the mentally retarded child needing education is directly linked to the objectives of education. This is substantiated by Kirk (1972:197) who points out that the main objectives of education are:

"(i) self-realization;

(ii) human relationships;

(iii) economic efficiency; and

(iv) civic responsibility".

In the light of the above, Wallace (1960:249) states that the main objective of education is that it increases the childs' productive efficiency and social control so that they will as far as possible carry their own weight and not gravitate to the ranks of the dependent, paupers or delinquents.

Waite (1971:5) states that a mentally retarded child can grow up to be a good citizen in his community, can hold a job, raise a family and take active part in community affairs. He can do this if he receives proper education and training. This child requires a special education because he has special needs. In the light of the above, Dupont (1969:275-276) states that education can add an important dimension to the existing approaches to the mentally handicapped child. The methods of education address themselves to positive drives - drives towards knowing, learning, discovering and exploring. It is concerned with liberating and catalyzing positive energies, potentials and capacities within the human being.

However, the most important purpose of education is preparation for productive employment. In regard to this, Anderson (1963:172) states that employment signifies financial independence at a time when a person ought to be independent. Employment is a clear mark of adulthood, preventing the need for continuous and total parental assistance. The above is further substantiated by Bowley and Gardiner (1972:31) who state that the gradual learning of independence is of great importance for the handicapped child, both for his self-respect and his self-confidence in community life.

3.3 Pre-school education

3.3.1 Introduction

Within the last decade, interest in the education of young handicapped children has reached new heights. Educators have shown a keen desire to include pre-school education for the handicapped as part of their educational programs (Martin and Deutsch, 1974 in: Readings in Special Education, 1978:10).

School systems are beginning to develop clinical resources within the school setting to provide needed service. This willingness of the school to offer comprehensive services will be critically important if education is to have a chance to be the major source of pre-school and early childhood activities (Martin and Deutsch, 1974 in: Readings in Special Education, 1978:12).

For the handicapped child, formal education may begin shortly after birth. By the time the handicapped children are three years old, they are ready to attend a pre-school centre. In the pre-school centre, the child is usually placed in a small group of similarly functioning children under the supervision of a specially trained teacher. Mittler (1979:69) states that although mentally handicapped children are not

generally admitted to special schools before the age of five, educational authorities are increasingly aware of the need to make some form of educational provision for them before this. However, it is imperative to note that the education of young mentally handicapped children are similar to the education of pre-school children of average intelligence.

3.3.2 **The Major Goals of Pre-school Education**

According to Johnston (1951:140) the major goals of pre-school education are:

"(1) the pre-school should provide an environment for the child which will foster emotional health through providing a feeling of security and belongingness, and a feeling of accomplishment;

(2) the pre-school should provide opportunities for maturation through self-help throughout the day;

(3) the pre-school should offer opportunities for the development of motor skills;

(4) the pre-school should offer ample opportunities to develop intellectual abilities; and

(5) the pre-school should provide for special clinical education for special disabilities found in children".

Wallace (1960:247) states that pre-school education must give a handicapped child new orientation, focus, challenge and outlook to life. Wallace (1960) further states that special education should make it possible to relieve children of their dissatisfaction and insecurities and make them feel confident, happy and contented.

The most significant contribution that pre-school education can make to the education of all handicapped children can be summarized as follows:

(1) Pre-school programmes may be used to bring about a new spirit of co-operation and a system of interaction which can benefit all handicapped children.

(2) The school may be used as the central or co-ordinating link in such co-operative programmes (Martin and Deutsch, 1974:13 in: Readings in Special Education, 1978:13).

(3) The pre-school programme may be used as a relief for many parents. The released time often results in a greatly improved family morale.

(4) The pre-school may be an effective learning and training experience for the children.

(5) The pre-school may prepare the child for public school and for later life (Isaacson, 1974:139).

(6) The pre-school education may make possible the provision of an atmosphere and opportunity for renewal and revitalization of the education system (Martin and Deutsch, 1974:13, in: Readings in Special Education, 1978:13).

Isaacson (1974:136) states that specialized pre-school programmes for the disabled children are necessary, since these children often present special problems, for example, many are not toilet trained by the ages at which children typically enter a pre-school programme. Isaacson (1974) further states that pre-school programmes must be directed toward meeting the needs of each child. Each requires special training that will allow him to move into special education programmes in the public school system.

Caldwell (1970:720) states that the gains made by children in the school programmes are not maintained at later ages unless the children continue to receive special programming. Caldwell (1970) further states that children with special needs should have an enriched, individualized programme throughout school years.

In regard to the trainable mentally retarded (TMR) Waite (1971:71) states that such children have deficiencies in the language, self-help and socialization areas. The curriculum for the TMR should stress socialization and self-help skills. Skills needed for semi-independent functioning such as toilet training, dressing, using household equipment and engaging in socially acceptable public behaviour is an important part of the curriculum. Gulliford (1971:136) states that more specific teaching is required in language, in perceptual development and in acquiring fine motor skills, e.g. in dressing, feeding and other self-help skills. Gulliford (1971) further states that more guidance is needed because spontaneous activities tend to be more short lived and there is less experimental, constructive and imaginative play.

3.3.3 **Role of the Family in Pre-school Education**

Isaacson (1974:139) states that the most effective pre-school programmes are those in which the school situation is integrated in the life of the family. In such integrated programmes, the goals pursued in the pre-school programme are supplemented by training in the home. Grothberg (1968-1969:19), advocates valuable techniques that parents can utilize to encourage and stimulate learning in their children of pre-school years:

(a) recognizing the fact that they are educators;

(b) interacting with their children verbally;

(c) showing them that they care, proving to be dependable, reliable persons from whom children can learn;

(d) setting up goals for their children and rewarding them for their accomplishments;

(e) giving them toys that will help them become sensitive to shape, colour and other stimuli in their environment;

(f) teaching them to express themselves and to listen to others; and

(g) loving them.

Reynolds and Sylvia (1976) state: "Because of the extra-ordinary opportunities special educators have had to work with parents individually and in groups, they seem to be in the position to help lead the way to develop school-wide systems to provide for the participation of all persons affected by school decisions" (in: Readings in Special Education, 1978:7).

Martin and Deutsch (1974) states that: "Early education programs are leading to more recognition of the advantages and the necessity of having parents and other family members take part in instruction, because very young children spend more time at home that they do at school. In United States, the Kennedy Child Study Centre, help parents train their disabled children, guide visitors and encourage and help train other parents who are newer to the program. Thus, pre-school education, may lead the way toward further defining an active role for parents at all levels of special education" (in: Readings in Special Education, 1978:12).

Hamilton (1973) states that: "Parents often find that specific knowledge they acquire about their child helps them to accept weaknesses while maximizing the child's many strengths" (in: Readings of Special Education, 1978:51).

The family interest plays a vital role in the educational development of a pre-school child. Such parental interest also motivates the child to achieve a sense of confidence, independence and a good sense of self-esteem which is vitally important for the overall development of the well being of the handicapped child.

3.4 SPECIAL EDUCATION

Kirk and Gallagher (1972:24) defines special education as: "Special education are those additional services over and above the regular school programme, that are provided for exceptional children to assist in the development of the potentialities and or the amelioration of their disabilities".

The de Lange Report (1981:5) defines special education as follows:

"Special education means such education of a specialized nature including:-

(a) the psychological, medical, dental, paramedical and the therapeutic treatment (with the inclusion of the performance of operations);

(b) the provision of artificial medical aids and apparatus;

(c) the care in a hospital and school hostel;

(d) the provision of transport and physical care".

At present, provision of education for children with special educational needs in the R.S.A. is controlled by and is the responsibility of several educational authorities. Besides the four provincial education departments and the Department of National Education, which makes provision for some of the specific needs of white pupils with special educational needs, there are three additional educational authorities which see to the needs of the Coloureds and Indians, namely the Department of Internal Affairs (for Coloured and Indian Affairs respectively) and the Department of Education and Training for Blacks (de Lange Report, 1981:29).

However, the Indian Education Act No. 61 of 1965 defines a person needing special education as: "An Indian between the ages of three and twenty three years who in the opinion of a Head of Department is capable of deriving appreciable benefit from a suitable source of instruction but deviates to such an extent from the majority of children in body, mind or behaviour that:

(a) he cannot derive sufficient benefit from the instruction normally received in the ordinary course of education;

(b) he requires special education in order to facilitate his adaptation to the community;

(c) he should not attend an ordinary class in an ordinary school because such attendance may be harmful to himself or to other pupils in the class".

Stevens (1973:13) lists the important essentials of educational development:

"(a) To be considered as children, not types or cases.
(b) To have freedom of movement and activities in a specially structured environment.
(c) To receive continued praise and approval.
(d) To have a special kind of teacher.
(e) To have a varied and stimulating program of activities.
(f) To have a planned systematic individual teaching by the same teacher over a long period of time.

While four major provisions of education for the mentally disabled child are:

(1) All handicapped children are guaranteed a free, appropriate education.

(2) All handicapped children regardless of disability severity, must be identified, located and evaluated.

(3) Each handicapped child must be provided an Individualized Educational Plan (IEP).

(4) Special education must be provided in the least restrictive environment" (Dulfrey et al, 1978, in: Johnston, 1987:35).

3.4.1 Special Arrangements for the Mentally Disabled Child

The overriding aim of any form of organization is that children should receive the special treatment and education that they need in order to ensure their optimum development and to minimize their handicaps (Gulliford, 1972:8).

The report: Living with a Handicap (1970) points out that there are at least thirteen different ways of providing for handicapped children:

"(a) Full time residential special schools;

(b) Hospital schools;

(c) Residential special schools with provision on a five day week basis;

(d) Residential special schools serving as a base from which pupils attend appropriate ordinary schools in the neighbourhood, full time or part time;

(e) Residential hostels providing for tutorial help for pupils attending normal schools full time;

(f) Multi-purpose hostels providing for a variety of handicapped pupils and also providing short stay facilities for children in care, holiday facilities, relief in family crisis, etc.;

(g) Day special schools;

(h) Day special schools allowing some children to attend neighbouring ordinary schools on a part time basis;

(i) Special classes in ordinary schools and special units attached to ordinary schools;

(j) Peripatetic teaching e.g. remedial teacher;

(k) Resource centres in ordinary schools i.e. bases for material, equipment, remedial and other specialist teachers;

(l) Full integration in ordinary schools; and

(m) Home teaching".

3.4.2 **Advantages and Disadvantages of Special Schools**

3.4.2.1 **Advantages**

Malin (1980:105) lists the following advantages:-

"(1) Special schools have trained staff, very good teacher pupil ratios, specialist equipment and good outside support;

(2) Children attending special schools may be grouped according to age, ability, developmental level;

(3) Children usually have the same teacher for most part of the time, giving teachers a good opportunity to acquire a good knowledge of child development and to select appropriate activities to meet his needs;

(4) Most special schools have 'special' care groups catering for mentally disabled children, while in ordinary schools such service are absent".

Gearheart (1975:193) adds:

"(1) Special schools have a centralized program which reduces the cost of transportation

(2) Have specialized services such as provided by a speech therapist, nurse or behaviour therapists are more easily obtainable and justified;

(3) Has program visibility".

Gulliford (1971:10-11) adds:

"(1) Special schools have clearly defined aims and a well planned progression of education in all its aspects - including preparation for and supervision of transition to working life;

(2) Special schooling is a relief from the strain of trying to keep up and match up, it can be a relief from always feeling or being made to feel different".

Telford and Sawrey (1967:57) adds:

"(1) Special school simplifies the control and supervision of disabled children. The extra protection and supervision required by many handicapped children are more easily provided when all the children in the school are similarly handicapped".

3.4.2.2 **Disadvantages**

Malin (1986:105) lists:

"1 (a) the children may be isolated from their neighbourhood;

(b) have no non-handicapped children to serve as a model;

(c) may travel long distances to school and parent-teacher links may become weak because of this".

Gulliford (1971:111) adds:

"(1) Special schooling separates children from their fellows, missing the stimulation, interests and social learning from mixing with others".

Telford and Sawrey (1967:57-58) adds:

"(1) Since the handicapped, a minority are going to live their lives among the non-handicapped majority, some people think it is desirable for them to be educated with normal children. The over-simplified school life of the children in the special schools may not be the best preparation for life;

(2) There is often stigma attached to the children attending special schools. The families of exceptional children are often sensitive to the social implication of special schools and feel that special classes in regular schools are preferable because they do not label the child and cause his life to revolve so completely around his exceptional characteristics".

3.4.3 **The Advantages and Disadvantages of Residential Institutions**

3.4.3.1 **Advantages**

(1) A residential institution permits a more intensive approach to a childs needs through the creation of an environment and school community which is educational and therapeutic without disruption and discontinuity;

(2) This kind of institution is an advantage for many maladjusted children whose home environment are emotionally and culturally impoverished (Gearheart, 1975:201).

3.4.3.2 **Disadvantages**

Dunn (1973) lists disadvantages of the residential facility:

"(1) Dehumanizing, de-individualizing approach to treatment usually prevails;

(2) They are often orientated toward custodial care rather than intensive treatment;

(3) Much of the services is provided by trained attendants while professionals engage in administrative tasks;

(4) They are often unable to attract capable professional personnel;

(5) Funds are frequently spent on the physical plant at the expense of staff and services (in: Gearheart, 1975:202);

(6) Standards of living enforced on the grounds of the institution are considerably lower than standards outside the institution, and the training residents receive in institutions is inadequate and unrealistic. This obviously makes reintegration into the community quite difficult;

(7) The handicapped child often has limited (or no) opportunity for social interaction with non-handicapped children and he lacks the opportunity to prepare and steel himself for the demands of the normal working world" (Murray in: De Lange Report, 1981:165).

Some specific problems regarding special education may be referred to. Logue (1972:32-34) quotes the following: "G.Orville Johnson, Professor of Special Education, Ohio State University, reviewing research done on the efficacy of special classes for the educable mentally retarded produces weighty evidence that points to the great paradox in special education: It is indeed paradoxical that mentally handicapped children having teachers especially trained, having more money (per capita) spent on their education and being enrolled in classes with fewer children and a program designed to provide for their unique needs, should be accomplishing the objectives of their education at the same rate or at a lower level than similar mentally handicapped children who have not had these advantages and have been forced to remain in regular grades".

Lloyd, M. Dunn, Professor of Special Education and Past President of the Council for Exceptional Children, for the mildly retarded states: "I have logically supported and promoted special classes for the educable mentally retarded for most of the last twenty years, but with growing disaffection. In my view, much of our past and present practices are morally and educationally wrong. We have been living at the mercy of general educators who have referred the problem children to us and we have been generally ill-prepared and ineffective in educating these children. Let us stop being pressured into continuing and expanding a special education program that we know now to be undesirable for many of the children we are dedicated to serve".

The Hall-Dennis Report as cited by Logue (1972:33) indicates what the essence of special education is:

"(a) Except for the very severely impaired, every child is 'special' and each will benefit from special learning experiences, which should be an integral part of his learning.

(b) Schools for trainable retarded children should become a part of the total spectrum of public education and their programmes should include integrational experiences with children in

regular grades.

(c) Every child has a right to stand with dignity beside everyone else in the human parade. If we are truely to help the child who is different, we must be pre-occupied not with his handicap or with his weakness, but with his potential and his strength".

Gulliford (1971) discussing special educational needs, states: " The issue of special schools or special classes is often discussed on an either / or basis which is quite clearly unrealistic. Both are needed. As has been said already, more children could be educated in ordinary schools if special classes were well organized, staffed with specially trained teachers and well supported by health, psychological and advisory services. This would still leave many children whose handicaps are so severe that intensive special education would be needed".

There appears to be no single model for the organization and administration of special education for the mentally retarded. Each education authority is in the best position to determine its own organizational pattern on the basis of its own local needs, educational objectives, manpower and perceived priorities.

3.5 RELATIONSHIP BETWEEN PARENTS AND SCHOOL AUTHORITY

3.5.1 Nature of the Relationship

Karnes, et al (1972:85) state that parental involvement is a partnership in which both staff and family contribute not only to the formulation of an educational plan for the child, but to the implementation of that plan in flexible and individualized ways. Turnbull and Turnbull (1978) state that no longer is parent involvement considered a privilege for parents of a handicapped child, it is now considered a right (in: Gallagher, 1980:86). Wallace (1960:249) states that it is very difficult to achieve the objectives of special educational programmes without the whole-hearted co-operation of the parents.

Kroth (1975) states that: "Educators long resisted involving parents in the education process, and this was true of special educators as well" (in: Gallagher, 1980:85).

Gallagher (1980:86-87) states: "... parent or family involvement is still not extensive because:

1) professionals have not been trained to work with parents;

2) professional staff do not feel competent and comfortable in doing so;

3) most currently operated programs do not provide the in-service training necessary for staff to acquire the skills and knowledge that are needed if they are to work effectively with parents;

4) administrators often resisted any marked degree of parental participation for fear that it will have a negative effect upon the school;

5) professionals have little faith in parents ability to become good teachers for their children".

According to the De Lange Report (1981:174): "In South Africa, parent involvement in education of children with special education needs is of primary importance, but is not sufficiently encouraged. In cases where adequate provision is not being made for children with special educational needs, greater involvement on the part of parents in the formative education of these children must be encouraged". Smiches (1975:566) points out that: "In most European countries parents have successfully involved themselves in securing equal educational opportunities for handicapped children, ensuring the students' right

to process and establishing educational accountability".

Shearer and Shearer (1972:213) state that parents are interested in the growth of their handicapped children and can acquire new knowledge and skills to act as change agents. In the light of the above, Cunningham (1974) states that: "The last ten years have seen a number of highly innovative schemes in which parents have been helped to become involved in depth and detail in working with their handicapped child and in helping him to reach the next stage of his development" (in: Mittler, 1979:11).

Malin (1980:105) states that for the teaching programme to succeed it should involve the parents, careful assessment, planning, record keeping and continuous evaluation.

Wallace (1960:247) states that the programmes of parent education are always needed for the purpose of enlightening parents regarding the nature, causes and consequences of childhood handicaps. Cook and Cook (1974) state that: "There is a good rationale for involving parents in the educational program of their handicapped children and the literature in special education strongly supports the need for parental involvement" (in: Voysey, 1975:57).

Gulliford (1971:29) states that a feature common to kinds of special teaching is the need for the closest co-operation between home and the school.

Mittler (1979:11-12) states that not all parents are able or willing to be involved in working with their child and there is little doubt that many parents have been deeply frustrated. One result of this frustration is that some parents are willing to sacrifice a great deal of time and mainly seek treatment abroad which allow them to provide specialized exercises or other forms of treatment for their child.

The school also benefits from parental involvement. Parents can serve as assistants to teachers and other staff, thus enabling professionals to extend their expertise and to better meet the individual needs of handicapped children (Clements and Alexander, 1975:7).

Gallagher (1980:88) quotes the words of Lillie (1975): "Such involvement facilitates a parent's understanding of his or her handicapped child, and it puts parents of handicapped children into contact with one another. This contact often leads to supportive and mutually beneficial relationships".

Karnes, Teska and Hodges (1970:73) state that such involvement also allows parents to share information with professionals which helps the latter to programme more adequately for handicapped children. That parents can assume direct teaching responsibilities in the classroom without jeopardizing the learning of their own child or other children has also been documented. There can be no doubt that parent involvement helps children to sustain gains made at school and that children accomplish more when home and school work together. Calvert (1971:657) finds three major reasons for training family members- to enable them to help themselves, to help their handicapped child, and to further the programme as advocates.

According to Wilkin (1979:199) there are a number of ways in which communication between parents and teachers might be improved:

"(1) teachers should encourage parents to visit at any time during the ordinary school day and teachers should be prepared to discuss with parents their children's learning programme and progress;

(2) where parents have a telephone they should be encouraged to maintain contact with the school through this means and to discuss problems directly with the teachers;

(3) it would be of great help to both the teacher and parents if the teacher were to visit the family at home to discuss the childs progress".

3.6 Integration and Mainstream education

3.6.1 Introduction

It is important to state at the outset what we mean by 'integrated' education. The Report of The Snowdon Working Party (1976:12) defines 'integrated education' as: "A system which caters for the special needs of handicapped children within the ordinary school framework, and is supported by a range of facilities geared to meeting the needs of children suffering from different kinds and degrees of handicap, including such separate attention and protective arrangements as may be required". Booth and Potts (1983:1) define integration as: "The process of increasing participation of children and young people in their communities". 'Integration' is most commonly applied to the bringing of handicapped children from segregated special schools into ordinary schools and since they are an excluded group, it is appropriate that this should be so.

In Sweden, it is practical to educate handicapped children in ordinary classes wherever possible with the necessary special support (The Report of the Snowdon Working Party, 1976:15). The above is practicable in this country too, and fully in line with the trend in modern education of children, whether handicapped or not, within the ordinary school setting. Wood and Shears (1986:6) state that in London, integration of handicapped children into ordinary schools is put forward as a means to end the discrimination involved in providing special education in segregated settings. In most western countries, for example, Canada, Sweden, Denmark and the U.S.A., a great deal has been done to develop special provision through the use of specialist consultants, peripatetic teachers, resource centres, and special classes in ordinary schools. It is imperative to note, that it is these kinds of provisions which should be expanded in the R.S.A. as an alternative for many more handicapped children to be placed in special schools.

3.6.2 **Advantages of Integration and Mainstream Education**

Malin (1980:103) states the following advantages:

"(1) In ordinary schools, the presence of handicapped children can act as a constant challenge and stimulus to greater achievement;

(2) In the ordinary schools, the mentally handicapped child has 'normal' children to observe and model and non-handicapped children are familiarized with handicapped children".

The de Lange Report (1981:165-166) adds:

"(1) The child does not feel different - he attends an ordinary school just like his normal friends, brothers and sisters;

(2) The ties between parent and child do not have to be broken because the child does not have to leave his parental home to attend a special school;

(3) The child is afforded the opportunity of social interaction with non-handicapped people".

3.6.3 Disadvantages of Integrated and Mainstream Education

The de Lange Report (1981:166-167) lists the following:

"(1) The child does not learn to become independent oriented and mobile and is assisted in may ways and taken around;

(2) The costs of the aids that must be provided and sometimes used by only one person in the school set-up can be high.

(3) A dutiful teacher who cannot see to it that the handicapped child is merely a passenger in the class situation will have to pay attention to the individual handicapped child at the expense of the rest of the class".

According to Hamilton (1981:10-11, in: de Lange Report, 1981:167-168): "Certain circumstances peculiar to the R.S.A. make it difficult to include handicapped pupils in mainstream education. These include the following:

(a) Different educational and examining control bodies in white education, normally those of the four provinces and National Education;

(b) The relatively sparsely distributed handicapped population;

(c) The size of class groups in ordinary education which makes differentiation within the so-called school population difficult".

3.6.4 The Integration of the Disabled Child in Normal Schools

Jones (1983) states that the aim of integration is to enable children with special needs to maximize their opportunities, potential and personal fulfilment in their family life, in school and in the wide community (in: Booth and Potts, 1983:62).

Fish (1985:19) states that "Understanding the issues inherent in the process of integration is necessary in all schools regardless of the degree of disability or difficulty with which they may be prepared to cope". He further states that to increase participation is the objective of the process of integration. The process must begin within the ordinary school.

Special education in the ordinary school can provide good quality special education, but above all it can be a starting point for the process of integration. Bartlett (1977) states that: "Mainstreaming meets the needs of the educable mentally retarded in a less restrictive setting. The social and emotional needs of the individual can be met in the confines of the

'regular classroom' through the interaction that takes place with "normally cognitively functioning" children. He further states that the mainstreaming concept is further based upon the belief that the cognitive needs of the retarded child can be met through a combination of the skills of the 'regular education' teacher and the resource teacher" (in: Readings in Special Education, 1978:65).

Booth and Potts (1983:1) state the problems associated with integrated education is as follows:

"(a) It may imply that the job of involving handicapped children in the educational and social life of school is finished once they are within the ordinary school;

(b) It may be taken to mean that handicapped children have a greater right to participate in an appropriate education in ordinary schools than other children".

Mittler (1979:101) has suggested that: "The question of whether mentally handicapped pupils should be taught in special or ordinary schools should be seen as one of the reconciling of the child's educational and learning needs with the need to maintain contact with ordinary children in the community".

It is argued that special schools are not necessarily segregated, while children attending an integrated unit in an ordinary school can nevertheless be isolated from their able-bodied counterparts. The mere presence of the handicapped does not guarantee integration, which requires the fullest possible participation in the life of the school. It is sometimes said that non-handicapped children and staff will fail to accept handicapped children within ordinary schools and that either too much bullying and teasing will occur (Report of the Snowdon Working Party, 1976:14-15).

The attitude of school staff towards the disabled child is of utmost importance. The willingness of teachers to be flexible and helpful is sometimes more important than the degree of handicap. In this regard the handicapped child feels secure and accommodated, thus raising his self-esteem.

3.6.5 Counselling the Mentally Handicapped Child

Guidance to be effective must be a continuous process that starts when the child first enters school and is available for as long a period of time as necessary. It is not solely preparation for the future, its function is to help the child today as well as tomorrow.

Stan and Caughlan (1973:411) state that there are several factors necessary to establish a good counselling relationship with the mentally retarded individual:

"(a) The counsellor should accept the retarded individual regardless of his problems and conditions;

(b) A genuine respect for the dignity of human being and his personality is vital to maintaining a sound counselling relationship;

(c) It is the fundamental belief that the retarded individual has potential for growth and change. If this belief is not held by the counsellor then he will be ineffective;

(d) While maintaining a degree of optimism, it is equally well to remember the limitations of a particular individual. Self-determination or the right to participate in decisions that affect his circumstances should be allowed with discretion".

However, in the light of the above, Gearheart (1975:161) states that the goal of counselling is the development of an individual capable of satisfactory adjustment. The individual, as a result of

counselling, is then able to adjust himself to new situations as he encounters them. It should be remembered that the goals of counselling the mentally retarded are basically no different from the goals of counselling for the non-retarded. According to Lambert, Wilcox and Gleason (1974): "The aim of counselling is to allow the retarded child to view and experience themselves in performance roles that demonstrate their ability to perform. This may be especially important in the area of academic performance and negative self-concepts" (in: Rotari, 1986:33).

Anderson (1963:169) states that counselling can nurture feelings of self-esteem, even massive programmes in public relations, human relations and spiritual ethnical guidance may be instrumental in effecting a more accepting attitude by society toward those it perceives as different. Waite (1971:34) states that disabled children needs effective counselling services to prevent them becoming victims of their social emotional and academic environment. All efforts should be directed toward the promotion of optimal growth and adjustment to life as a whole. Conversely Anderson (1963:114) states that any system of guidance that is not based on a thorough understanding of the needs, potentialities and aspirations of the individual, is not only shallow,

but may be worse than worthless.

3.6.6 Conclusion

It is important to recognize that having a child with a handicap is a lifelong task for many families. Although certain families seem to cope well with the situation, there is evidence that the pressures of having a handicapped child take their toll. According to research, some theorists have attempted to develop models of stages or phases through which many families pass in the rearing of a child with handicaps (Haring and McCormack, 1990:499).

Gallagher and Bristol (in press) found that there were approximately twice as many divorces in families with young handicapped children as in families with children of similar age with no handicaps (in: Kirk and Gallagher, 1991:60).

To add to these difficulties, a handicapped child can be a serious financial drain on the family because of necessary medical, social and special services.

In regard to education, parents are concerned about obtaining the most appropriate education in the least restrictive environment as a right for their disabled family member.

Parents view education as central to the development of a disabled child, and crucially important in the life view of the child and his family. Parents also expressed concern about the inadequacy of appropriate support services for teachers with children in their classroom. All special schools should encourage a disabled child's development to his maximum potential within the family and community.

CHAPTER FOUR

THE EMPIRICAL FIELD STUDY: THE METHODS USED IN THE RESEARCH

4.1 Review of relevant literature

A literature survey is necessary if the link between theory and empirical research is to be maintained. In this regard, an extensive literature survey was conducted at the initial stage of the study.

The data used for this study was obtained from the following sources:

4.1.1 Journals

Reports and articles in journals provided a wealth of information for the research. The most significant journals consulted were the:

American Journal of Mental Retardation,

Psychology Today,

Exceptional Children, and

Mental Retardation

4.1.2 Non-scientific

In order to keep abreast with latest developments in the field of mental disability, the researcher found it necessary to follow closely articles in relevant newspapers and magazines.

4.1.3 Personal Communications

The researcher found it necessary to establish a source of verification of some of the information gathered from various types of literature. This was accomplished by personal interviews with people who are authorities in the field of mental retardation, such as social workers, researchers, academics and the principals and teachers of the three relevant schools. This type of discussion contributed greatly to the structuring of the questionnaire.

4.2 Methods of data collection

4.2.1 The Interview Schedule

The social survey is the most widely used method of data collection in the social sciences (Chadwick, Bahr and Albrecht, 1984:106).

There are three types of surveys available, namely the:

Objective Survey;

Descriptive Survey; and the

Projective Survey (Davis, 1971:80)

4.2.2 **Objective Surveys**

This presents a series of very specific questions that are to be read to the respondent, along with a set of pre-determined response categories. The respondent simply selects one of the answers provided and the interviewer records that response in the appropriate place on the interview schedule.

4.2.3 **Descriptive Surveys**

These present questions, but let the respondents answer in their own words.

4.2.4 **Projective Surveys**

These present abstract situations that require the respondent to analyse and comment on them.

The present study is an objective survey in which an interview schedule was utilized as a means of data collection. Although the cost in terms of money and

time was high, this was seen as the most practical technique, since the interview schedules were quite straight forward and easily understood. Further, within face-to-face situations, the researcher had an opportunity to check the certainty and the honesty of the respondent, as well as the exact meaning of the reply. When the respondent seemed uncertain, the researcher was able to ask for additional information.

The other techniques that were seen as suitable were:

(1) mailed questionnaire; and

(2) telephone interviewing

According to Moser and Kaltan (1977:261-262), the main problem with mailed surveys is that of getting an adequate response rate. Furthermore, with a mailed questionnaire, the surveyor cannot be sure that the right person completes the questionnaire.

Telephone interviews were seen as unsuitable. Some questions were difficult to ask on the telephone because of their complexity and sensitivity; if the respondent misses even a single word, the entire question may become unintelligible (Kidder and Judd, 1987:229).

It was necessary for the researcher to formulate two interview schedules, regarding how the family and formal education affects the social functioning of the mentally disabled Indian child.

Interview Schedule I was administered to the parents of the mentally disabled children. Interview Schedule II was administered to teachers of special schools.

Interview Schedule I was divided into three parts:

Part I: (question 1 - 2) identified the respondents from whom data were gathered.

Part II: (question 3 - 8) gathered background data on the respondents and the child.

Part III: (9 - 35) gathered data on the responses by parents on the social functioning of their disabled child.

Interview Schedule II was not divided into any sections. This interview schedule comprised questions 1 to 21 and gathered data on the formal educational effect on the social functioning of the mentally disabled child.

4.2.5 Construction of the Questionnaire

The ways in which the main variables identified during the literature survey and personal communications are related to the set questions are outlined below.

4.2.5.1 Self-Concept

A child's self image has a tremendous impact on his overall success and happiness, and a child who feels good about himself, is a self motivated child. Since the 'self concept' is important for understanding a mentally disabled child, three questions on this were included, namely, Questions 9, 10 and 22.

4.2.5.2 Family

Seven questions were included on this important variable, namely, Questions, 11, 12, 13, 14, 26, 27 and 29.

These were concerned with the aspect of how the mentally disabled child affects the family as a dynamic system of interacting individual personalities.

Question 11 measures the parent's perceptions of how often the child is willing to go out with family members.

Question 12 was included to test the child's preferences of any particular family member.
Question 13 was included to examine the extent to which the disabled children restrict the social activities of other family members.

Question 14 attempts to establish the degree to which disabled children feel comfortable in the care of family members.
Question 26 was designed in order to test the child's level of emotion due to the conflicts or problems between parents.
Question 27 examines the extent to which the disabled child could benefit, from appropriate family counselling.
Question 29 is aimed at testing the parents perceptions regarding the future of their disabled child.

4.2.5.3 **Siblings**

The disabled child is capable of having a disruptive influence on all family members, including brothers and sisters. Researchers have constantly found that the effect of a handicapped child on his or her non-handicapped sibling is largely due to the parents attitudes and reactions toward the disabled child (Trevino, 1979:49). In this regard six questions

refer specifically to such a situation, namely Questions 16, 17, 18, 19, 20, 21. Question 16 asks whether the disabled child demands more attention compared to the normal siblings. Question 17 ascertains the child's emotional level when he sees his demands are not met. Question 18 examines the disabled child's influence (both positive and negative) on the normal siblings. Question 19 tests whether the normal siblings suffer from neglect or a lack of attention as both parents become overtly involved with the special needs of the disabled child. Question 20 tests the attitude of the disabled child towards the normal siblings. Question 21 examines the extent to which the mother neglects the normal siblings.

4.2.5.4 **Practical Problems**

Practical problems in caring for a handicapped child include extra work in routine child care tasks. There are also numerous problems which arise from having to care for a child who may be heavily dependent on the parent for the satisfaction of his basic needs. In this regard five questions refer specifically to such a situation, namely, Questions 15, 23, 24, 25 and 28. Question 15 was included to test whether the disabled child is independent enough to cope adequately in the presence of non family members.

Question 23 attempts to establish the body responsible for taking the disabled children out on holidays.

Question 24 questions the extent in which parents are compelled to make special adjustment in the home in order to suit the needs of their disabled child.

Question 25 examines the extent in which financial expenditures bear more heavily on families due to a disabled child.

Question 28 was designed to test the extent in which a disabled child can cope independently with situations outside the home environment.

4.2.5.5 **Education**

Questions 30, 31, 32, 33, 34 and 35 are useful indicators regarding the child's education.

Question 33, in particular, examines the time which parents are prepared to spend with their disabled child.

4.2.5.6 **Health**

Questions 6 and 7 attempt to elucidate the potential etiology and subsequent magnitude of the disability.

Question 8 attempts to identify the sources of advice sought by the parents of the disabled child.

4.2.5.7 **Interview Schedule II**

The ways in which the main variables of formal education (i.e. interview schedule II) relate to the social functioning of the mentally disabled child were probed as follows.

Question 1, 2, 3, 4, 12 relate to special education. These measure teacher's perceptions whether special education allows for a greater degree of independence and gainful employment in the future.

Questions 6, 7, 8, 9 measure teachers perceptions of the disabled child's cognitive shortcomings.

Question 10 is an assessment of the teachers opinion regarding the benefits (or not) of integrated education on the future development of the disabled child.

Question 5 and 11 deals with the teacher's assessment of the potential influence of pre-school education on the disabled child.

Question 14 and 18 attempt to establish the degree of parental involvement in the educational requirements of the disabled child.

Question 19 and 20 examines the teacher's observations

of the disabled child's attitude towards extra-curricular activities.

Question 13 is an assessment of the teacher's views of external factors affecting the education of the disabled child.

Question 21 evaluates the teacher's opinion regarding the reasons why disabled children experience difficulties at school.

4.3 The Pilot Study

Before the survey proper begins, a pilot study should be undertaken. The pilot study is particularly useful for testing the adequancy of the instruments being employed, and for training the personnel who will assist in carrying out the survey (Behr, 1983:98).

Therefore, in accordance with the above, a preliminary study was conducted in order to test the suitability of the interview schedule. The pilot study comprised of ten interviews, which were conducted by the researcher. These interviews were arranged by appointments, the response rate being 100%. This successful completion was due to two reasons:

a) The parents of the disabled children were accustomed to discussing sensitive issues concerning their children, as a result of previous interviewing by social workers and other relevant health authorities. Therefore, participation in the social study was easily achieved.

b) The parents of the disabled children were of the opinion that the results and postulates of this research would contribute to significant and relevant improvements in the future quality of their children's lives.

The suitability of the chosen methods of data collection was proven during the pilot study. It became clear that the interview schedules worked in practice. It took approximately thirty minutes to administer each schedule, which was an acceptable time limit.

4.4 The Choice of Locale

The municipal boundaries of Durban and Westville were taken as the area of study. In this area there are three Indian special schools for the mentally disabled children, representing a student population of 315. This number represented a complete census and obviated

the need for a sample to be drawn. However, as noted later on, practical problems results in only 232 of the elements being interviewed.

4.5 Selection of Study Population

The selection of was done in terms of the following criteria:

a) The respondent had to be a parent of a disabled child.

b) The respondent had to be listed as a resident of the Borough of Durban.

The researcher concentrated on the Indian schools for the mentally disabled situated in the Durban and Westville municipal areas. The three (3) respective schools which cater for the mentally disabled Indian children of all ages, both at primary and at secondary levels are:

1) Golden Gateway Training Centre in Cato Manor
2) S Dass School in Phoenix
3) Westpark School in Westville.

These schools have a total population of three hundred and fifteen (315) students. The entire universe of three hundred and fifteen (315) parental couples was

established from the school records, and serves as a main data base.

However, two practical problems made it impossible to conduct all 315 interviews. In the event, only 232 interviews were conducted. Also not all of the interviews were conducted with parents. In certain cases significant other persons were interviewed, such as brothers, sisters, aunts or foster parents.

The reason for the above deviations are as follows:

1) Regarding the "missing" 83 elements, this was due to the inaccuracy of school records.

2) There were a significant number of parents who failed to keep the school informed in regard to the change of address.

Regarding conducting interviews with persons other than 'parents', the reasons were:

1) In some cases both parents were deceased. Persons 'other'- uncle, aunt, sister, etc. are now chief caretakers of the disabled child.

2) Both mother and father deserted the disabled child.

4.6 Data processing

Upon completion of the fieldwork, the 232 interview schedules were scrutinized for inaccuracies and completeness. All the schedules were found to be accurate and acceptable. Thereafter, a coding frame was drawn up. Each interview schedule was assigned a number and coded in accordance with the coding frame.

Researcher performed the task of capturing the data onto the computer using a data base programme called Debase III Plus.

The computer programme was developed with the assistance of a qualified programmer so as to tailor the programme in accordance with the requirements of the researcher. The computer analysis was performed by the researcher using the programme called Systat.

Frequency tables and percentages were drawn up and evaluated.

CHAPTER FIVE

5. EMPIRICAL FINDINGS

5.1 Influence of Familial and Home Background Factors on the Social Functioning of the Disabled Child

The ethics of kinship are such that parents and guardians of children generally feel they have a moral obligation to care for their children. Though humans display an immense capacity for love and caring as well as for adaptation and survival, there are psychological observations which supports the view that in the case of the profoundly retarded child, certain factors operate to distort, obstruct and even diminish the love and caring responses of the parent/guardian. In this regard, Lewis (1987:311) states that as with families, when the caring ceases, no intervention, however powerful, can keep society intact. Historically, families and societies have been torn apart when people no longer cared for others.

5.1.1 ***Persons interviewed***

TABLE 1: Identity of persons interviewed

	NUMBER	PERCENTAGE
MOTHER	124	53.5
FATHER	56	24.1
BOTH PARENTS	17	7.3
OTHER	35	15.1
TOTAL	232	100.00

The category 'other' includes brother, sister, aunt, foster parents or available relative. The reasons for interviewing these persons instead of parents were given in chapter three.

The analysis of Table 1 indicates that the majority of the persons interviewed consisted of mothers (53.5%). This may be compared to the low percentage of fathers interviewed which was (24.1%). The reason why fewer fathers were interviewed can be attributed to the fact that fathers were more often not at home than mothers.

5.1.2 *Age Range of Children*

TABLE 2: Age range of the children

YEARS	NUMBER	PERCENTAGE
3 - 7	15	6.9
8 - 12	63	26.9
13 - 18	106	45.5
19 - 21	48	20.7
TOTAL	232	100.00

From the above figures the following observations emerge:

1) The highest percentage of disabled children was found in the 13-18 (45.5%) year age group, compared to the lowest percentage of disabled children found in the 3-7 (6.9%) year age group. Such findings could indicate that the advancement in medicine in recent years in terms of pre-natal investigation, screening programmes and management of obstetric related problems have contributed to:

a) early diagnoses and management;

b) better counselling; and

c) appropriate reconstructive and rehabilitative surgical procedures.

All these factors have served to reduce the number of disabled children being born and in some cases the normalization of a disability.

5.1.3 ***Sex Ratio***

TABLE 3: Sex ratio among disabled children

	NUMBER	PERCENTAGE
MALE	136	58.9
FEMALE	96	41.1
TOTAL	232	100.00

From the above it would appear that there were 58.9% males as compared to 41.1% females disabled. A possible reason for the predominance of males is that mental handicap has a higher incidence in boys than in girls - probably due to the slower myelinization of the neurons which makes boys more susceptible to brain damage than girls (Kapp, 1991:294).

Similarly, more boys than girls are born with serious abnormalities, apparently because boys are more vulnerable to anoxia, prematurity and maternal infection. It has been speculated that genetic differences are involved or that the mother may develop an immunological reaction to male tissue which affects her fetus adversely (Mussen et al, 1979:95).

5.1.4 ***Types of Disability***

TABLE 4: Incidence of various types of disability

CAUSE OF DISABILITY	NUMBER	PERCENTAGE
DOWN SYNDROME	63	26.9
CRETINISM	42	17.9
CEREBRAL PALSY	23	9.8
ASPHYXIA	5	2.9
KERNICTERUS	6	2.6
OTHER	47	20.2
N/A	46	19.7
TOTAL	232	100.00

An examination of Table 4 illustrates that most children suffered from Down Syndrome (26.9%). The category 'other' indicates that a significant number

of children (20.2%) suffered from other ailments such as:

(1) POLIOMYELITIS, an acute illness of the central nervous system;

(2) CONVULSIONS, the contractions of the muscles on both sides of the body with loss of consciousness; and

(3) PHENYLKETONURIA, the transmission of a recessive gene.

5.1.5 ***Age at which Disabilities Commenced***

TABLE 5: Ages of children when disabilities were first manifested

	NUMBER	PERCENTAGE
BIRTH - 3 YEARS	188	80
4 - 7 YEARS	35	15.3
8 - 12 YEARS	9	3.9
13 - 18 YEARS	-	-
19 - 21 YEARS	-	-
TOTAL	232	100.00

The examination of Table 5 indicates that most parents first became aware of their children's disability when their children were between birth and 3 years old (80%). This finding could indicate that the advancement in the medical field, appropriate reconstructive and rehabitative surgical procedures and intervention programmes to prevent disability, increased the probability of an early diagnosis of a disability.

5.1.6 ***Extent of Disabilities***

TABLE 6: Extent of children's disability according to parents

EXTENT OF DISABILITY	NUMBER	PERCENTAGE
SLIGHT	130	56.1
MODERATE	69	29.7
SEVERE	33	14.2
TOTAL	232	100

According to Table 6, parents of the disabled child described their children's condition as either slight (56.1%) or moderate (29.7%). According to the researcher's observation of the children, most parents

were unwilling to admit the correct extent of their child's disability. These could be the reasons for this attitude:

(1) Parents learn that acceptance involves not only accepting the child, but also accepting themselves as they are, and acknowledging their individual strengths and weakness. The above is substantiated by the data in Table No.5, which notes that most parents first become aware of their children's disabilities when their children were between birth to 3 years old, which gave parents of disabled children time for the necessary adaptations and acceptance.

(2) Some parents attempt to escape the reality of the child's handicap and cushion its impact by denial, by refusing to recognize the child's disability, by rationalizing the deficiency or by seeking professional confirmation that there is nothing much wrong with the child. The above is further substantiated by Garguilo (1985:22) that denial which is a defensive posture; may be exhibited due to fear of the unknown, the uncertainty of the child's future potential and doubts about being able to cope with the added responsibilities brought about by the handicap.

5.1.7 ***Sources of Advice***

TABLE 7: Sources from which parent sought advice

	NUMBER	PERCENTAGE
GENERAL PRACTITIONER	116	49.9
HOSPITAL	51	21.8
CLINIC	47	20.4
FAITH HEALERS	1	0.4
OTHER (PRE-SCHOOL) (SCHOOL-PSCHOLOGIST)	17	7.5
TOTAL	232	100.00

Judging from the above figures, most parents of disabled children sought advice from the general practitioner (49.9%), as compared to a minority of parents who obtained advice from either the hospital (21.8%) or clinic (20.4%).

Valuable conclusions can be derived from the above figures.

Most parents sought advice from the medical and allied fields, as compared, to those that sought advice from cultural and/or traditional sources. Parents visited the general practitioner because, the general practitioner tends to be a family doctor, whom they

trust and confide in, regarding health matters. In contrast, a small proportion of parents visited the hospital/clinics probably on the basis that it is cheaper and capable of more extensive investigations into the child's problem.

5.1.8 ***Family Responses***

TABLE 8: Family responses towards the disabled child

	NUMBER	PERCENTAGE
PROTECTIVELY	38	16.4
NORMALLY	190	81.8
REJECTINGLY	2	0.9
DO NOT KNOW	2	0.9
TOTAL	232	100.00

It is clear from Table 9 that most families act normally (81.8%) towards their disabled child. A small percentage of the families responded either protectively (16.4%) or rejecting (0.9%) towards the disabled child.

However, a significant conclusion can be derived from the above. Table 8 illustrates that 80% of the parents react normally towards the disabled child. This could be attributed to an initial period of reorganization and acceptance with their being subsequently comfortable in their situation and confident in their parental skills.

Normalization is defined by Bengt Nirje (1976:231) as making available to all handicapped people patterns of life and condition of everyday living, which are as close as possible to the regular circumstances and ways of life of society (in: Kapp, 1991:50). This means that the handicapped person should, among other things, have the right to a normal daily routine, normal school and home circumstances, normal economic and environmental standards, etc.

These findings are in contrast to studies reported by Roessler and Bolton (1978: 135) which noted that most parents treat their disabled children as if they were sick which causes excessive concern with what is wrong with these children. This attitude is discrepant with that of other parents and lowers their expectation for disabled children's normal socialization.

From the above contrast, the present study suggests that over a period of 13 years, parental attitudes towards the disabled child has undergone a positive transformation. This could be attributed to:

(1) more information being available to parents;
(2) easier accessibility to support groups;
(3) greater social awareness and acceptance of the disabled child; and
(4) development of educational institutions to realize the potential of the disabled child.

The low percentage of families who reject (0.9%) the disabled child could be attributed to the following:

(1) Rejection can be a consequence of the parent's anticipation of the constant demands of lifelong emotional and financial responsibility. Faced with these burdens, parents can easily fall prey to resentment which leads to the rejection of the child.

(2) Rejection can also take the form of exclusion, whereby the handicapped child is denied participation in family activities.
The above is supported by the findings of Ricci (1970) that mothers of mildly and severely retarded children were found to be rejecting and

punitive (in: Crnic, Friedrick and Greenberg, 1985:120).

The intermediate proportion of parents who responded protectively (16.4%) to the disabled child, can be compared with the findings of Watson and Midlarsky (1978) who illustrate that overprotectiveness seen with mothers of retarded children may arise less from maternal guilt feelings than from the factually based perception that other non-retarded individuals have relatively negative attitudes towards retarded people (in: Crinic, Friedrick, Greenberg, 1983:127).

Similarly, another study conducted by Trevino (1979:49) clearly indicates that feelings of guilt, fear and shame which appear almost universally in parents of the disabled were reflected in overprotection and false light-hearted optimism.

5.1.9 ***Responses by Disabled Child to Others***

TABLE 9: Responses of the disabled child towards others

	NUMBER	PERCENTAGE
DEFENSIVELY	12	5.6
NORMALLY	117	50.2
AGGRESSIVELY	99	42.5
DO NOT KNOW	4	1.7
TOTAL	232	100.00

From the above figures the following observations emerge:

A large number of disabled children reacted normally (50.2%) toward others, as compared to the minority who either reacted aggressively (42.5%) or defensively (5.6%).

Certain conclusions can be derived from the above findings:

(1) Most children have a slight handicap (refer to Table 6, the extent of disability). Persons in this group are considered educable. With early diagnosis, parental assistance and special educational programmes, the great majority can adjust socially, master simple academic and occupational skills and become self-supporting members of their family and community. Therefore, the optimal realization of their potential (even though apparently limited) allows the disabled child to interact freely and with more confidence.

(2) That as many as 48.1% of the disabled children responded either aggressively or defensively can be compared to the fact that most disabled children are frequently described as aggressive, impulsive and unable to modulate their own behaviour. The above is supported by the findings of Goodman (1979:198) who described disabled children as overly responsive to, dependent on stimuli, unable wilfully to direct their own behaviour and function without strategies (in: Kapp, 1991:165).

It is also shown by Kapp (1991:165) that aggressive responding is more frequent among Down Syndrome children. Table 4 shows that 26.9% of the study

population are affected by Down's Syndrome.

5.1.10 ***Visiting by Disabled Children***

TABLE 10: Frequency of the disabled child's preference to go visiting

	NUMBER	PERCENTAGE
DAILY	41	17.5
2 - 3 TIMES A WEEK	33	14.3
OCCASIONALLY	143	61.6
DO NOT KNOW	2	0.9
NEVER	13	5.7
TOTAL	232	100.00

From the above figures certain observations emerge: A large percentage of disabled children prefer to go out visiting occasionally only (61.6%) with family members. In comparison, a small percentage of disabled children prefer to go out visiting with family members either daily (17.5%) or 2-3 times a week (14.3%).

From the above finding some deductions can be derived:

(1) In this study most children have a slight disability (refer to Table 6). This means that such children fall into a group who has the opportunity to develop social and communicative skills. Such skills allows the disabled child to become aware of the 'self'. Therefore, a label attached to him or her as being defective, inadequate or different compels the disabled child to develop a negative self-concept, thus preventing him from interacting and socializing freely with members outside his home environment.

Problems associated with the period of adolescence are pronounced and complicated, especially in the case of the mildly disabled (refer to Table 2). Because of this the disabled child displays an increasing unwillingness to venture out with family members. He consequently does not participate fully in family relationship formation. Because the disabled child is often ridiculed, the child becomes excessively self-centred, which in turn makes interpersonal contact more difficult.

Kapp (1991:308) also mentions that the poor self-concept and lack of involvement often makes the disabled child reluctant to venture out with family

members or toward new situations.

5.1.11 ***The Disabled Child and Companionship***

TABLE 11: The companionship the disabled child prefers

	NUMBER	PERCENTAGE
MOTHER	128	55.2
FATHER	42	18.1
SIBLING	40	17.2
SERVANT	-	-
OTHER (SPECIFY)	22	9.5
TOTAL	232	100

A study of the above table indicates that while most disabled children prefer the companionship of the mother (55.2%), a less significant percentage of disabled children preferred the companionship of either the father (18.1%) or sibling (17.2%).

The most obvious explanations for this are:

(1) Most Indian fathers, unlike mother, are employed, outside of the home, therefore, they were unable to fulfil the role of main caretakers of their children;
(2) Mothers are the chief source of emotional support;
(3) Mothers are the chief source of warmth and strength; and
(4) Mothers are generally more tolerant and patient.

In the light of the above, Akerly (1975) described mothers as having stubbornly resisted being engulfed by the handicap. They tend to regard themselves as positive elements in their child's life, as persons who have informed themselves about the nature of the child's handicap, and who undertake an objective, realistic, somewhat distant yet compassionate approach to the child (in: Reynolds, Walberg, Wang, 1989:298).

5.1.12 ***Restriction of Social Activities of Family Members***

TABLE 12: Restriction of social activities imposed by the disabled child

	NUMBER	PERCENTAGE
YES	50	21.6
NO	159	67.9
DO NOT KNOW	23	10.5
TOTAL	232	100.00

Table 12 clearly indicates that the majority of the respondents (67.9%) were of the opinion that the disabled child does not restrict the social activities of other family members. Similarly, Cunningham (1986:58) conducted a study where he compared families that have a disabled child with families with normal children. In this study, he did not find only major differences. Cunningham (1985) further states that most parents do not find themselves isolated and lonely because of the child. According to his study, many parents have claimed that they met more people and have wider contacts because of the child's condition.

Cunningham (1986:59) further states that parents may also find they spend a fair amount of time visiting clinics for treatment and advice, and attending lectures or parent groups. Again this can take up time, but only a few seem to find it a problem. Most find these outings and meetings actually extend their social life.

5.1.13 ***Child's Degree of Comfort with Family Members***

TABLE 13: Degree of comfort the child experiences in the care of family members

	NUMBER	PERCENTAGE
SOMETIMES	94	40.5
ALWAYS	93	39.9
NEVER	45	19.6
TOTAL	232	100.00

Table 13 is clear about the degree to which the disabled child feels comfortable in the care of family members. What it does illustrate is that more disabled children (80.4%) feel comfortable in the care of family members as opposed to being uncomfortable (19.6%).

5.1.14 ***Child's Coping with Visitors***

TABLE 14: The degree of appropriateness with which the child can cope, in the presence of visitors

	NUMBER	PERCENTAGE
SOMETIMES	113	48.7
ALWAYS	96	41.4
NEVER	23	9.9
TOTAL	232	100.00

The analysis of Table 14 indicate that most disabled children were sometime (48.7%) capable of coping appropriately in the presence of visitors at home. The percentage (41.4%) who could always cope, appears to be high.

The fact that disabled children at times were able to react appropriately may be attributed to the fact that in this study, most were mildly disabled (refer to Table 6).

Unfortunately, studies are not available to stipulate how the severely disabled children would react under similar circumstances. Possible explanation for the disabled child not coping appropriately, could be that there would be stronger anxiety, if the child is no longer surrounded by familiar and trusted faces, thus allowing for feelings of inadequacy, and lack of worth to surface. This manifests as anxiety, apprehension and other disruptive behaviour.

5.1.15 ***Amount of Attention Demanded by the Child***

TABLE 15: The amount of attention demanded by the disabled child

	NUMBER	PERCENTAGE
SOMETIMES	64	27.6
ALWAYS	68	29.3
NEVER	100	43.1
TOTAL	232	100.00

From the above figures the following observations emerge:

A large percentage of disabled children never (43.1%) demand more attention, in comparison to normal siblings. An small proportion of disabled children either 'sometimes' (27.6%) or 'always' (29.3%) seek more attention in comparison to their normal brothers and sisters.

From the above figures some conclusions can be derived:

(1) In this study most children have a slight disability (refer to Table 6). This prevents the disabled child from making excessive demands on the family as a whole.

(2) Table 8 illustrates that 81.8% of families responded normally, to their disabled child. In such environments, attention is equally distributed among the handicapped and non-handicapped. Both the normal and disabled siblings are given the opportunity for free participation and decision making within the home environment. Therefore, such opportunities prevent the disabled child from demanding unnecessary attention from both the parents.

In contrast to the findings mentioned above, the studies of Trevino (1979:49) have indicated that the amount of attention demanded by the disabled child, has caused the lives of normal siblings to be wasted or devastated. The findings of Trevino (1979) also indicate that the constant attention demanded by the disabled child, indicated that parents may have difficulty in controlling their hostile feelings towards the afflicted child and in turn may project this hostility and anger onto their normal children.

Similarly the findings of Kapp (1991:459) indicate that the handicapped child usually also requires a great deal of attention from his parents and from his mother in particular. Such a child may become demanding and when he gets older, he may expect others to make the same concessions for him as his parents do.

5.1.16 ***Behavioural Problems***

In the next table, data are provided on the type and frequency of problem behaviour presented by disabled children. Before this is presented, the following observations are appropriate.

In this discussion on behaviour of children (Kapp, 1991:115) states that behaviour disturbances are often traced to the child's situation at home. Disturbed family relationships can transform the child's emotional situation into a problematic one. A variety of errors, including rejection, lovelessness, overprotection and unreasonable discipline may contribute to the child reacting with anger and hostility toward others. Parents who are generally lax in disciplining their children, but are hostile, rejecting, cruel and inconsistent in dealing with misbehaviour are likely to have aggressive and delinquent children. Le Loux (1985:78-79) is of the opinion that many of the disabled children's behavioural manifestations such as tantrums, withdrawal and over compensation may be attributed to a poor self-image (in: Kapp, 1991:397).

According to McWhirter (1977:81) temper tantrums may be defined as a violent display of ill-temper. Hyperactive or restless behaviour he defines as: "disorganized, disruptive and unpredictable behaviour, usually involving an over-reaction to stimuli. The hyperactive child usually exhibits one or more of the following disorders as well as: short attention span and impulsivity".

Withdrawn behaviour occurs when children are slow or unwilling to involve themselves in social relationships, especially within their peer group. They reveal a lack of social interaction skills and become so preoccupied with themselves that their interest in matters outside themselves becomes inadequate (Kapp, 1991:118).

TABLE 16: Behavioural problems of disabled children

BEHAVIOUR MANIFESTED	USUALLY	%	SOME-TIMES	%	NEVER	%	TOTAL	
TEMPER TANTRUMS	86	37.1	80	34.5	66	28.4	232	1
RESTLESSNESS	12	5.1	70	30.2	150	64.7	232	1
WITHDRAWN BEHAVIOUR	109	46.9	90	38.9	33	14.2	232	1
OTHERS	-	-	-	-	-	-	-	

From the above data, the following deductions can be made:

(1) The attitudes and behaviour of disabled children bring to the surface strong feelings which are often experienced. Literature indicates that disabled children are not necessarily more aggressive and violent by nature as compared to normal children, but their display of temper tantrums shows that such children cannot release their anger in other ways (Haring and McCormack, 1990:204).

This points to the need for parents of disabled children who experience frequent temper tantrums, to be prepared for their own reactions to such behaviour.

(2) There is also a very high percentage of disabled children who display withdrawn behaviour usually(46.9%) or sometimes (38.9%).

Withdrawal is one of the most frequently used defense mechanisms of the disabled child. It is the direct avoidance of threatening situations or people. The withdrawal response temporarily removes the child from the feared situation but the tendency to withdraw becomes stronger each time the child practices this behaviour. This defense is often maladaptive for the following reasons:

(a) The child who refuses to cope with stressful situations may eventually become fearful of all problems and stresses and may never learn to handle adequately the crises that are inevitable in the cause of development.

(b) The child does not explore social situations or gain experience in coping with social relationships; this in turn may harm his growth towards independence.

(c) Withdrawal entails non participation of the child in the learning activity - active participation being essential for successful learning (Lovell, 1971:42).

5.1.17 *Influence on Psycho-Social Development of Normal Siblings*

TABLE 17: Disabled child's influence on the psycho-social development of the normal siblings

	NUMBER	PERCENTAGE
POSITIVELY	98	42.2
NEGATIVELY	26	11.2
NO EFFECT	108	46.6
TOTAL	232	100.00

The findings of Table 17 reflect that a large percentage of disabled children have no effect (46.6%) on the psycho-social development of the normal siblings. A significant percentage of disabled children have a positive (41.9%) influence regarding the psycho-social development of the normal sibling, possibly because the siblings are confronted with and must solve problems of social relations which other children do not experience.

5.1.18 *Jealousy and Resentment by Normal Siblings*

TABLE 18: Degree in which the normal children manifest resentment

	NUMBER	PERCENTAGE
OCCASIONALLY	192	82.8
FREQUENTLY	16	6.8
NEVER	24	10.3
TOTAL	232	100.00

The figures indicate that the special attention demanded by the disabled child cause normal siblings to display resentment or jealousy either occasionally (82.8%) or frequently (6.8%).

From the above data, certain deductions can be made: Resentment is a common and natural reaction on the part of a normal child with a retarded sibling. Resentment may develop because the disabled child might require a disproportionate amount of the parents attention. Jealously can easily develop from resentment, especially if the handicapped sibling perceives that he or she has lost 'favour' with the parents.

Similarly, Hunter, Schuman and Friedland (1972) suggested that a normal child in the family may develop feelings of anger toward the retarded sibling. Resentment may be felt because of the lack of personal attention received and the apparent favouritism shown toward the child with a handicap. Resentment may develop because the handicapped child prevents the family from going on certain types of outings, because of treatment, therapy, special schooling, and so on place financial constraints on the family; and because the normal child may have to assume certain types of unpleasant responsibilities such as babysitting. The normal child may even wish for the other child's death or at least that the retarded sibling would just go away (in: Chinn et al, 1979:384-385).

5.1.19 *Attitude Towards Normal Siblings*

TABLE 19: Disabled child's attitude towards the normal siblings

	NUMBER	PERCENTAGE
HOSTILE	17	7.3
INDIFFERENT	31	13.4
SUPPORTIVE	180	77.6
OTHER (SPECIFY)	4	1.7
TOTAL	232	100.00

Literature has constantly stipulated that the effect of a disabled child on his/her non-handicapped sibling is due largely to parents attitude and reaction towards the disabled child (Trevino, 1979:38). A child who enjoys the emotional nourishment, care and encouragement from his parents and siblings, is most likely to be protective and supportive of his family.

It is apparent in the present study, that most disabled children live in an environment which offers warmth, physical contact, intellectual, emotional and social stimulation, and help in positive learning. The above statement is supported by the data of Table 19 which show that most of the disabled children were

supportive to their normal brother or sister. An insignificant percentage displayed either hostile (7.3%) or indifferent (13.4%) behaviour.

It may be noted that some research show contradictory findings, for example an informal study by Holt (1974) of 138 families with mentally retarded children. This mentions that 'normal' children were reported to have suffered from unexpected, persistent physical attacks by their afflicted siblings (in: Trevino, 1979:49).

5.1.20 ***Neglect by Mother of Normal Siblings***

TABLE 20: The extent to which the mother neglects the normal siblings for the disabled child

	NUMBER	PERCENTAGE
A GREAT DEAL	3	1.2
IN SOME WAYS	161	69.3
NOT AT ALL	21	9.1
NO RESPONSE	47	20.3
TOTAL	232	99.9

From the above figures it appears that:

A large percentage of mothers neglect the normal siblings in some ways (69.3%). In comparison, a minority of mothers neglect the normal siblings either a great deal (1.2%) or not at all (9.1%).

From the above data, the following deduction can be made:

Child neglect appear to occur more often in families of the handicapped. The reason may be that parents, who are depressed or anxious regarding their retarded children, may be emotionally and physically unavailable to their normal children.

This deduction is supported by a similar study conducted in U.S.A. which shows that the neglect of normal siblings is reflected in hospitals, clinics, family service agencies and schools, where more often than not these children are excluded entirely from the diagnostic phase and treatment plan. Because mothers are so overwhelmed in caring for their disabled child, normal children are deprived of their childhood and even in some cases, normal children assume the role of substitute parents (Trevino, 1979:48).

According to Chinn, et al (1979:382) normal children are neglected for the following reasons:

1) Parents are overwhelmed with the responsibility of caring for the retarded child.

2) Normal children are neglected because parents may be filled with guilt, and they feel they must devote all their time to the retarded child.

3) Parents sometimes neglect their normal children because they operate under the assumption that they are unfit as parents because they have produced a child whom they view as defective.

5.1.21 ***Embarrassment Experienced by Disabled Child***

TABLE 21: The intensity of embarrassment experienced by the disabled child in comparison with normal children of his age

	NUMBER	PERCENTAGE
ALWAYS	18	7.8
SOMETIMES	117	50.4
NEVER	97	41.8
TOTAL	232	100.00

From the above figure it appears that:

A large percentage of disabled children experience the feelings of embarrassment or inadequacy either sometimes (50.4%) or always (7.8%). In comparison, a

significant number of disabled children never (41.8%) feel embarrassed or inadequate in the presence of normal children of his age.

It may be concluded that the disabled child is often poorly adjusted, social and critical. He thus functions inadequately on the asocial level. He experiences himself as a failure and thinks others hold the same opinion of him. This may result in him not easily integrating into a group or not being able to apply the finer nuances of social interaction with normal children of his own age.

The above statement is supported by various researchers.
Jellin and Turner (1985) state that retarded children become aware of their differentness and increasingly identify themselves as slow learners and feel inadequate (in: Levy-Shiff, 1986:547).

Richardson, Kaller and Katz state that mentally retarded adolescents' inadequate perceptual and intellectual abilities make it very difficult for them to develop a clear self image and body boundary, therefore such limitations prevent them from interacting freely with normal people of their own age group (in: Levy-Shiff, 1986:547).

Smith and Greenberg (1979) indicate that retarded children see themselves deficient, when compared with non-retarded persons, in both social skills and in interpersonal problem solving skills (in: Castles and Glass, 1986:36).

According to Shaw (1981) the disabled child's poor self-concept has a negative influence on his academic progress. This gives rise to poor social relationships and leads to those children having a lower sense of personal adequancy for social situations.

Disabled children feel inadequate in the presence of normal children of their own age because they experience an inability to process information from social situations and to integrate and react meaningfully to these (in: Kapp, 1991:397).

Furthermore, the significant number of disabled children who 'never' display feelings of inadequacy can be compared to the findings of Buddoff and Superstein (1978) that labels can help retarded children overcome at least some of the negative attitudes that usually accompany academic incompetence and physical stigmata, even though mingling with people of his or her own age group (in: Bak and Superstein, 1986:95).

5.1.22 ***Disabled Child and Holidays***

TABLE 22: Body that is responsible for taking the disabled children on holidays

	NUMBER	PERCENTAGE
WITH PARENTS	126	54.3
WITH INSTITUTION	29	12.5
WITH SCHOOL	6	2.6
WITH OTHERS	64	27.6
NOT AT ALL	7	3.0
N/A	-	-
TOTAL	232	100.00

42.7

The above table illustrates that the body responsible for taking the children out on vacations is mainly the parents (54.3%). This could be attributed to various factors:

(1) Disabled children are accustomed to the support and encouragement of their parents.

(2) Schooling environment helps the disabled child to develop social skills to various degrees, thus allowing the child to interact accordingly, also with parents.

(3) Society's increasing awareness and tolerance of disabled persons provides acceptance, enlightenment and adequate understanding on part of the parents. Therefore, parents do not feel ashamed to take their children on holidays, because a change in routine and meeting different people can stimulate development and learning.

It is interesting to note that many parents of disabled children preferred to send their children out on holidays with the institutions, school or 'other' (42.7%). This could imply several reasons.

(1) For many parents the greatest problem is using facilities, whereas in a school situation aides are available to assist the child if necessary problem arise.

(2) The disabled child tends to consume a lot of time and attention, and these breaks provide the opportunity to give attention to the other members of the family.

(3) According to parents, children must grow up to become independent and must learn to manage without their parents. By getting the child used to short separations and holidays, one can begin this preparation.

It could be contended that parents who are reluctant to go out with their affected child, create their own narrow prison. Ultimately, this rage accumulates and erupts and the frustrating cycle of resentment, guilt, over protectiveness and permissiveness begins, to the disadvantage of all. As a result, the disabled child who is caught in such a web, has little energy free for the adventure of learning.

5.1.23 *Special Adaptations in the Home*

TABLE 23: Are special adaptations required in a home, due to a disabled child?

	NUMBER	PERCENTAGE
ALWAYS	3	1.3
SOMETIMES	37	15.9
FREQUENTLY	5	2.2
NEVER	187	80.6
TOTAL	232	100.00

A large percentage of disabled children never (80.6%) require special adaptations to be made at home. In comparison, a small percentage of disabled children either sometimes (15.9%) or frequently (2.2%) require special adaptations.

The most obvious explanation for this can be attributed to the fact that most children in this study had a slight or mild disability (refer to Table 7).

5.1.24 ***Effect on Family Expenditure***

TABLE 24: The extent to which family expenditure is increased

	NUMBER	PERCENTAGE
ALWAYS	28	12.0
SOMETIMES	103	44.4
FREQUENTLY	5	2.2
NEVER	96	41.4
TOTAL	232	100.00

It is clear from the above table that the disabled child 'sometimes' (44.3%) imposes financial strains on the family. However, a significant number of disabled children do not increase the family expenditure at all (41.3%).

Raising a disabled child involves extra costs, not only for medical treatment, but also special clothes and appliances. In some cases special foods have to be purchased for the disabled, since he or she is unable to chew on solids. However, a major factor would of course be loss of parental income. Therefore, the wife may have to give up a job that

contributes a substantial amount of family income to stay at home with the child. Even if the mother is eventually able to return to gainful employment, the net income is still curtailed in most instances because of the expense of child care.

A similar study was conducted by Longsdale (1978) who interviewed 60 families of mentally handicapped children and found that one in six reported having a hard struggle financially. Some described their situation as adequate, while some commented that it would not be so without state financial help (in: McConachie, 1986:14).

5.1.25 ***Effects of Parental Conflicts***

TABLE 25: The extent to which the disabled child is affected due to conflicts at home

	NUMBER	PERCENTAGE
BECOMES WITHDRAWN	101	43.5
ANXIOUS	90	38.8
FEARFUL	30	12.9
OTHER (SPECIFY)	2	0.9
N/A	9	3.9
TOTAL	232	100.00

The figures indicate that most disabled children become either withdrawn (43.5%) or anxious (38.8%) due to parental conflicts and problems at home.

Some tentative conclusions may be drawn from this. The disabled child may withdraw socially, become more isolated and consequently develop an inability to communicate with peer groups and with adults. However, the intensity of anxiety and fearfulness prevents the disabled child to explore social situations or gain experience in coping with social relationships. This in turn may harm his growth towards independence.

The studies of Adamson and Adamson (1979:320) indicate that it is not clear which is more upsetting for a disabled child; chronic quarrels within the family or a mother who is often inaccessible because she is either physically or emotionally out of the home. When both parental dissension and an absentee mother are situational components, the effect on the child is disturbing. Harris (1961), who called this combination double disorganisation, found that the percentage of non-learners coming from such homes was almost three times as high as that for non-learners coming from families where this combination was not present. It stands to reason that, if both parents are out of the house most of the time and argue continually when there, the child will be preoccupied with frightening thoughts of abandonment, rejection, parental separations and disruption of the family unit. This is certainly not conducive to maximizing concentration ability or to mobilizing the child's energy for intellectual mastery (in: Adamson and Adamson, 1979:322).

5.1.26 ***Family Conselling Influences***

TABLE 26: The frequency in which family counselling will influence the life of the disabled child

	NUMBER	PERCENTAGE
A GREAT DEAL	82	35.3
IN SOME WAYS	83	35.8
NO EFFECT	29	12.5
DO NOT KNOW	38	16.4
TOTAL	232	100

It is evident from Table 26, that some parents feel that parental family counselling will influence the quality of life of the disabled child either a great deal (35.3%) or in some ways (35.8%).

Counselling which is available at an early stage, helps families to adjust better to the disabled child. Parent counselling serves as an emotional nourishment for the well being of the disabled child. The purpose of counselling is to help parents to cope with a painful situation and to accept the limitations of the disabled child. Family counselling helps the parents

to form more realistic expectations and to communicate with their disabled child, in which a major source of environmental stress on the child will be eliminated. This change will in turn help the child to form a more realistic self-image and reduce his emotional stress.

The study of Adamson and Adamson (1979:241) elucidate that the goal of parent counselling is to enable parents to function effectively in their role as parents to their child, e.g. to be able to support actively the child's growth and to feel satisfaction in doing so. They further state that counselling is a growth process. The parent counsellor can facilitate the growth of parents and through their growth in the child by skillfully working to interweave the parents' growth with that of the child.

5.1.27 ***Influence of Situations Outside the Home***

TABLE 27: The extent to which the disabled child has a problem in coping with situations outside the home

	NUMBER	PERCENTAGE
ALWAYS	23	9.9
SOMETIMES	107	46.1
NEVER	60	25.9
DO NOT KNOW	42	18.1
TOTAL	232	100.00

The above table indicates that disabled children sometimes (46.1%) have a problem in coping with situations outside the home.

The following reasons could be attributed to this:

(1) Outside the home, the child is away from its normal environment, which is designed to foster, protect and provide encouragement and support to which the child is accustomed. As a result, the absence of parental support and protection causes withdrawal and apprehensiveness.

(2) When disabled children meet normal children of their own age, they experience a feeling of inadequacy. This results in a lack of self confidence, and such a limitation seriously restricts interaction between the disabled child and normal people.

5.1.28 ***Parents' Attitude Towards Child's Future***

TABLE 28: Parents' prediction regarding the future of their disabled child

	NUMBER	PERCENTAGE
COMPLETELY INDEPENDENT	20	8.6
REASONABLY	61	26.3
DEPENDENT ON OTHERS	39	16.8
UNCERTAIN	112	48.3
TOTAL	232	100.00

3.

Many parents of the disabled children (34.92%) had a generally positive outlook about their child's future in that they held the view that their children would be either "completely independent" (8.62%) or be "reasonably independent" (26.3%).

A substantial percentage of parents stated that they were 'uncertain' (48.3%) about their child's future. This could indicate some degree of non-commitment, refusal to see beyond the immediate present as well as uncertainty or anxiety about further deteriorations in their children's condition.

The above table indicates that parents of disabled children experience more difficulty concerning the future of their children. In many cases they have serious doubts as to whether their child will be able to attain social and economic places in society and to maintain these, because he does not appear to progress in the direction of the future they envisage for him. For many parents of disabled children, there is little chance of their child integrating spontaneously into the social world.

Similarly, according to Chinn et al (1979:174-175), one of the greatest concerns of parents of a retarded child is what the future holds for their child, when they are no longer able or available to provide care. Parental concerns often centre around where and how the child's needs ultimately will be met. The thought of forcing the child into an institution after spending a large number of years in the community and family setting may be difficult for parents to accept.

In accordance to the all above mentioned factors, it may be in the best interest of the child if parents are able to make necessary arrangements for continued maintenance and other matters through carefully planned provisions, such as trusts that specify care. Whereas this view of maintenance focuses on providing funds, parents can at least have some assurance that their child will be adequately provided for when they are no longer able to do so.

5.1.29 ***Child's Interest in School***

TABLE 29: The parents' perception of the interest that the disabled child has in regard to his education

	NUMBER	PERCENTAGE
A GREAT DEAL (YES)	220	94.8
TO SOME EXTENT (NO)	12	5.2
NOT AT ALL (N/A)	-	-
TOTAL	232	100.00

The analysis of Table 29 clearly indicates that a majority of the disabled children have a keen interest in education and willingly attend school (94.8%).

It appears from this that parents view education as being of utmost importance for their disabled child. The following reasons may be given:

(1) Education allows the disabled child to be gainfully employed and productive in society.

(2) Education provides cognitively meaningful experiences that allow the children to learn and achieve academically.

(3) Education provide meaningful experiences that allow them to learn and achieve an understanding of themselves as individuals and as social entities.

(4) Education concentrates on providing the child with a positive attitude towards life. This provides him with opportunities to learn to accept responsibility, work persistently, take the initiative, work with others in good spirit, to be punctual, and to accept authority.

(5) Education provides the child with the opportunity to work independently, to create, to reason and to voice his opinions. In this way he is in a position to become a person with an own unique identity.

5.1.30 ***Forcing of Schooling on Child***

TABLE 30: The extent to which the disabled child is forced to go to school according to parents' perception

	NUMBER	PERCENTAGE
A GREAT DEAL	4	1.7
TO SOME EXTENT	35	15.1
NOT AT ALL	193	83.1
TOTAL	232	99.9

Judging from the above figures, most parents claim, that their disabled child is not forced to go to school at all. The reason for this can be correlated with the reasons mentioned in Table 29. It should be noted that a disabled child seldom has the ability to resist a parents insistence on attending school. But, the minority of disabled children forced to attend school either a great deal (1.7%) or to some extent (15.1%) can be attributed to the following reasons:

(1) The child's experiences school in a negative way because he feels that he cannot satisfy the set requirements and expectations of the school, as upheld by the teacher.

(2) The disabled child by nature, feels insecure, unaccepted and unworthy. He is not prepared to explore the living and learning world with which the school presents him. Instead he displays an escapist or avoidance attitude characterized by a lack of initiative, poor co-operation, poor concentration, withdrawal, anxiety and insecurity.

(3) He experiences the school's norms as threatening and meaningless and this can give rise to disobedience towards the teacher, early school leaving, truancy.

(4) Children, whose parents move around a great deal, may find it difficult to integrate into a new environment every time. The sequence and manner of presentation of the subject matter may also differ from school to school, with the result that gaps easily occur in the child's acquired knowledge. Because the child's mental capacity may be so limited, he may have difficulty in coping. He may thus view school as threatening

and as a burden.

The study of Kapp (1991:107) indicates that a child can only learn and study purposefully if the teacher in his lesson, planning and presentation, has a clear goal in mind and take steps to reduce and organize the learning content. If the instruction does not include the observance of didactical principles and the integration of appropriate teaching and learning media, the child will never learn to understand things adequately. Consequently, it does not really appeal to the child to get to know and master the learning content as such, because it does not make sense nor is it meaningful to him. He cannot easily comprehend it.

5.1.31 ***Responsibility for the Child's Education***

TABLE 31: Body responsible for the child's education according to parents

	NUMBER	PERCENTAGE
SCHOOL AUTHORITIES	24	10.3
PARENTS	10	4.3
COMBINED EFFORTS OF BOTH SCHOOL & PARENTS	195	84.1
OTHER (SPECIFY)	1	0.4
UNCERTAIN	2	0.9
TOTAL	232	100.00

The above table illustrates that most parents of disabled children accept the view that a child's education is the combined efforts of parents and school authorities (84.1%). This is a positive and enlightening attitude and makes apparent that not only do parents in this study realize the responsibility and importance of their roles in a child's education, but they are able to give due credit to educational authorities.

According to Berdine and Cegelka (1980:262) keen interest and co-operation between parents and school is necessary for the effective instruction of the child. The close link that is maintained between the school and parents, promotes the social functioning and school progress of the child. Parents are therefore not only co-educators but "valuable instructional partners".

Further, it is interesting to note that a small percentage of parents stated that the body responsible for the child's education was mainly the school (10.3%). A possible reason for this response can be attributed to the fact that parents see the school as providing an academic education, concerned with books, paper and pencils, something imposed upon the child. The tremendous opportunities existing in the home for casual, incidental learning may have been totally overlooked in favour of sitting down with pencils and paper.

A small percentage of parents claimed that the body responsible for the child's education were mainly the parents (4.3%). A possible reason for this response is that parents who are less informed about and less involved with their child's education show no interest in the functioning of education for their child. The lack of involvement can possibly be attributed to an

ignorance of the demands of the educational system - the parents themselves usually having had limited or no education.

5.1.32 ***Assistance Received by Child in School work***

TABLE 32: The degree to which parents assist their disabled child in school work

	NUMBER	PERCENTAGE
ALWAYS	54	23.3
SOMETIMES	146	62.9
NEVER	32	13.8
TOTAL	232	100.00

The above table illustrates that a high percentage of parents of disabled children assist their children with school work either always (23.3%) or sometimes (62.9%). From interviews with parents it was evident that "sometimes" often referred to times whenever their children expressed the need for parental assistance. Parental tuition at home may be seen as a manifestation of interest and concern about their children's schooling as well as involvement in the child's preparation for the future. This in turn, 'influences' the child's values, aspirations, and

social functioning.

5.1.33 *Parents Attendance at School Functions*

TABLE 33: Number of school functions attended by parents

	NUMBER	PERCENTAGE
REGULARLY	91	39.2
SOMETIMES	130	56
NEVER	8	3.4
N/A	3	1.3
TOTAL	232	99.9

The above figures reveal that most parents of disabled children attend school functions either regularly (39.2%) or sometimes (56%). This indicates that parents display an interest in their child's education. Such attempts made by parents to attend school functions show that many parents strive to establish or strengthen links with school authorities.

Most authorities agree that teacher/parent contacts are particularly vital in the case of disabled children and that when meaningful communication is established, it can enhance not only the child's education, but also social progress and development.

The minority of the parents who do not attempt to attend school functions at all (3.4%) can be attributed to the following reasons:

(1) Special schools involved in this study draw their pupils from a very wide geographical area, which makes communication with parents much more difficult than in ordinary schools with their local sources of pupils.

(2) Those parents of disabled children who are from lower socio-economic circumstances, do not have the educational background to deal with educational problems. They were reared in an environment in which education is not valued. Therefore, to initiate contact with school authorities remains meaningless.

5.2 FORMAL EDUCATIONAL EFFORT ON THE SOCIAL FUNCTIONING OF THE MENTALLY DISABLED CHILD

Education is a human activity which is usually seen as a means of promoting those aspects of humanity that are most highly valued. Education centres on the concept of 'growth'. Growth occurs through experience- and experience implies a transaction between the person and the environment. In this regard, Brindley (1979:26) states that special education should emphasize personal and social growth which includes developing creative personality, potential and satisfying social skills and behaviour to the point where each individual can obtain increased responsibility for his or her own path through life. Similarly Coetzee (1986:104) states that education can be seen as the most important avenue through which the child's potential can be developed. The more learning opportunities there are, the greater the possibilities of development (in: Kapp, 1991:124).

5.2.1 ***Necessity for Disabled Children to have Special Education***

TABLE 34: The extent to which special education is necessary for the disabled child

	NUMBER	PERCENTAGE
YES	21	77.8
NO	2	7.41
DO NOT KNOW	4	14.8
TOTAL	27	100.01

Analysis of the above table indicates that most teachers agree that it is necessary for the disabled children to have special education as compared to normal children (77.8%).

In comparison, an insignificant percentage of teachers indicate that disabled children do not require special education as compared to normal children (7.41%).

During discussions with teachers the following emerged:

The appropriate functions of special education were described by many teachers as the equipping of the

retarded children with 'life skills'; a principle that goes far beyond the goal of imparting academic skills.

Special education is provided to the disabled children based on programmes that are appropriate to the needs and capacities of each child.

Special education for the mentally disabled strives for the achievement of independence and self-control by the child as a result of interaction with an environment suited to the child's developmental levels. The emphasis in special education is upon the intelligent problem solving process in which an individual achieves success through learning to adapt appropriate materials and methods to meet his needs, and to achieve his goal.

Special education has been predicated upon the philosophy that to fully meet the needs of the disabled child, there is a requirement for developing an educational procedure whereby the teacher can give equal emphasis to all aspects of the child's development.

In full agreement to the above, Budoff and Gottlieb (1976) have argued that the critical issue for special education is selecting or designing the appropriate

match between the handicapped child's attributes and needs, and the educational program elements required to maximize the child's personal and educational growth (in: Readings in Special Education, 1978:67).

5.2.2 ***Embarrassment for having to Attend Special Schools***

TABLE 35: The extent to which disabled children are embarrassed to attend special school

	NUMBER	PERCENTAGE
YES	12	44.4
NO	11	40.7
DO NOT KNOW	4	14.8
TOTAL	27	99.9

Judging from the above table it can be concluded that a significant proportion of teachers felt that disabled children did feel embarrassed to attend a special school (44.4%), while 40.7% of the teachers felt that disabled children did not feel embarrassed to attend special school at all.

Valuable conclusions can be derived from the data. Society has to be blamed for assigning an inferior status to people who are different to the normalized. If society successfully propagates respect for human worth, human rights and dignity, it would be impossible for people to look down upon people that are little different. Contrary, society that embraces the normal person, and when an individual does not correspond to society's standards for normalcy, there is a tendency to reject and categorise the individual. A disability label often leads to social isolation and assigns inferior status.

5.2.3 ***Special Education and Greater Independence***

TABLE 36: The extent to which special education allows for greater independence

	NUMBER	PERCENTAGE
YES	15	55.6
NO	7	25.9
DO NOT KNOW	5	18.5
TOTAL	27	100.00

The table clearly illustrates that most teachers believe that special education does permit the disabled child greater degree of independence later in life (55.6%).

A small percentage of teachers feel that disabled children do not earn independence, due to special education (25.9%), while 18.5% of teachers were uncertain in this regard.

Judging from the above figures, it is explicit that special education internalizes certain values and skills, thus encouraging and assisting the disabled to develop their abilities to their maximum potential. These skills that are successfully internalized by the disabled, by means of special education allows them to manipulate their environment.

5.2.4 *Special Education and Employment and Productivity*

TABLE 37: The extent to which special education allows for employment and productivity in the future

	NUMBER	PERCENTAGE
YES	19	70.4
NO	3	11.1
DO NOT KNOW	5	18.5
TOTAL	27	100.00

The above table indicates that a large proportion of teachers believed that special education offers for the disabled employment and productivity in the future (70.4%). In contrast 11.1% of teachers disagreed to the above statement, while 18.5% of the teachers were uncertain in this regard.

From the above analysis it can be concluded that disabled children can learn certain trades and a number of them will be educated sufficiently to be able to earn their living in society. In many cases the work they do will be of a routine kind, hardly competitive and requiring supervision. In the light

of the above Villeneuve (1970:62) states that their disability prevents them to profit from normal schooling, but they can learn with special training to look after themselves. However, they will always need a protective environment.

According to Fish (1987:173), an international study already showed that education and training in real employment well into the twenties was very effective, particularly where supported employment programmes were also available. Many individuals who had been previously condemned to trivial activity in centres could maintain themselves in open employment.

Similarly, as with able-bodied applicants for work, disabled persons should be considered for the widest possible range of jobs, preferably in open employment, in line with their qualifications and capabilities. In contrast to the above, the International Labour Office (1984:VI) state that even in times of full employment, no country has yet succeeded in providing employment for all its disabled citizens. When unemployment is widespread, the disabled suffer more than most, and in recent years the unemployment rate for the disabled persons in many industrialized countries has been twice or even three times that of the rate for the non-disabled. The situation is unlikely to improve in the immediate future, as shifts

in the age structure of the working population, strains on social support systems and changes in the nature of work occur. In such circumstances, selective placement takes on a new meaning and must be closely linked with measures aimed at creating socially and economically viable work opportunities for the disabled.

5.2.5 ***Adjustment by Pre-school Children to the Formal Schooling Environment***

TABLE 38: The extent to which pre-school children adjust to formal schooling environment

	NUMBER	PERCENTAGE
SOMETIMES	14	51.9
ALWAYS	11	40.7
NEVER	2	7.4
DO NOT KNOW	-	
TOTAL	27	100.00

The above table illustrates that most teachers agreed that children who have attended a pre-school adjust either sometimes (51.9%) or always (40.7%) to a formal schooling environment.

In the case of the disabled child, pre-school education is of cardinal importance. Each learning experience serves as a foundation on which new experiences can be built. Bach (1981) (in: Kapp, 1990:62) writes that: "The later education is begun, the greater the handicap can be expected to grow". Bach (1981) further gives reason for the necessity of early education for the handicapped, namely to prevent them from acquiring wrong learning habits.

Similarly, Papolid and Olds (1978:269) state that the purpose of pre-school education is: "ideally helping to promote and maintain the child's health and physical development, providing the opportunity to broaden social contacts, offering a rich environment for living and learning, providing the opportunities for the expression of language as a means of communication and experience, broadening the child's understanding of the social and scientific world and providing opportunities for children to develop a sense of responsibility" (in: Kapp, 1991:132).

The Plowden Report (Central Advisory Council for Education, England, 1967) argued that pre-school provides opportunities for constructive play, a more richly differentiated environment and the access to medical care that a good pre-school can provide (in: Chazan, 1973:19). This view was reinforced by the

Gittins Report (Central Advisory Council for Education, Wales, 1967) which stressed that the stimulating experiences provided by the pre-school should enable more children to take full advantage of educational opportunities offered at later stages of their development (in: Chazan, 1973:19).

According to Stanley (1972), experiments in the U.S.A. have suggested that pre-school programmes which are carefully planned and supervised, have clear cut objectivities and pay attention to language development and parental involvement are likely to prove of most benefit to disabled children (in: Chazan, 1973:21).

5.2.6 *Reaction to Inability to understand Basic Concepts*

TABLE 39: The reaction of the disabled to their inability to understand basic concepts

	NUMBER	PERCENTAGE
EMBARRASSED	19	70.4
INDIFFERENT	5	18.8
DEPRESSED	3	11.1
OTHER (SPECIFY)	-	-
TOTAL	27	100.00

Table 40 shows that most teachers agree that disabled children reflect either embarrassment (70.4%) or indifferent behaviour (18.8%) due to their inability to understand certain basic concepts. In contrast an insignificant proportion of disabled children indicate depressive behaviour in this regard.

In this study, teachers reported that disabled children who had a comparatively higher functioning became embarrassed, due to the fact they seem particularly unable to think divergently. Due to their inability to think divergently, such children have little confidence in their own abilities. Due to

their repeated disappointment and embarrassments, mar disabled children may refuse to try a task due to fea of embarrassment or failure.

5.2.7 ***Reaction to Education***

TABLE 40: The reaction of the disabled in regard to education

	NUMBER	PERCENTAGE
VERY INTERESTED	5	18.5
AVERAGE INTEREST	12	44.4
LITTLE OR NO INTEREST	10	37.0
TOTAL	27	99.9

Analysis of the above table clearly illustrates tha most disabled children either display an averag interest (44.4%) or little or no interest (37.0%) i regard to being educated.

This data could possibly indicate the following:

a) The reaction of the disabled child, in bein educated, depends on the effectiveness of specia education, which is determined by th appropriateness of the educational purposes an the quality of teaching.

b) The correctness of relevant literature whic clearly indicates that a childs' reaction towar education depends on the teachers knowledge an perceptions. If the teacher expects and demand too little from the child, it could cause feeling of being incapable of doing anything an this may paralyse his will to try.

c) The child who is under the impression that h cannot do anything and that he will never amoun to much, will be discouraged and a feeling c inability will predominate. Therefore, most c the time, disabled children show gross emotiona and learning difficulties and they fail t appreciate education.

The above is supported by Vrey's (1979:234-235 contention that by his conduct, in the teachin situation, the teacher exercises great influence o the pupils' motivation and willingness to learn.

5.2.8 *Maintenance of Concentration in Classroom*

TABLE 41: The extent to which the disabled child can maintain concentration in the classroom

	NUMBER	PERCENTAGE
ALWAYS	-	-
SOMETIMES	27	100
NEVER	-	-
TOTAL	27	100

Study of the above table elicits that disable children can only sometimes (100%) maintain thei concentration in the classroom.

In this regard certain conclusions can be made. Concentration problems are often the result o inadequate motivation for study. Under suc circumstances a person's thoughts wander easily fro the study task as in day dreaming or replacing th task by more pleasant and less strenuous activities.

Disabled children have a particularly short attentio span. They do not only have problems in selecting th important and discarding the irrelevant, but i

sustaining attention for any length of time. Spec (1970:54) ascribes this to the child's meagre menta energy and feels that the levels of energy maybe s low in these children that their attention only las for a few minutes (in: Kapp, 1991:309).

The findings of Dolloway, Epstein and Culliain (1985 state that mentally retarded pupils also exhibit mor attention deficit problems than their non handicappe peers. They tend to be more distractible, inattentiv and easily flustered and to have a shorter attentio span. In fact, well over half of the mildly retarde pupils were found to have problems is indicative of a attention - deficit disorder (in: Kirk and Gallagher 1986:133).

If a teacher does not clearly identify the learnin and teaching goals for the presentation of particular lesson, his preparation and planning of th lesson will be haphazard. The pupil's attention which is essential for the study, will be seriousl restricted on account of the poor appeal made by th teacher as the initiator of the subject matter.

Factors such as fatigue, poor general health an nutrition will play an essential part in determinin the span of attention and vitality in young children In current studies it becomes apparent that a majo

factor is noise level and lack of privacy so that th child is sensorially over-loaded and over-stimulate by a chaotic and unstructured environment. This lead to fatigue and intolerance to factors such as noise with resulting poor attention and inability t concentrate.

5.2.9 *Coping with Criticism*

TABLE 42: The ability of the disabled child to cop with criticism

	NUMBER	PERCENTAGE
TEND TO BECOME RESENTFUL	9	33.3
TEND TO BECOME MISERABLE OR WORRIED	16	59.3
TEND TO SHOW NORMAL ATTITUDE TO CRITICISM AND PUNISHMENT	2	7.4
TOTAL	27	100.00

The above table indicates that a significan percentage of disabled children either reflec resentment (33.3%) or become miserable or worried whe criticized or punished by teachers (7.4%).

Harsh criticisms and punishment lead to th development of underlying doubts of worthiness an competence on the part of the child and may block th development of self-esteem, acceptance and assurance

Van Niekerk (1982:13-14) notes that derogator remarks, unsympathetic criticism or merely ignorin the child are extremely powerful to the child's self concept and the meaning he gives to his situation Van Niekerk (1982) further states that the teache should take care not to exert injudicious pressure o children, for example, through consistently hig demands and admonitions that all children shoul achieve equally well and within the same time limit Disabled children who achieve poorly in the subjec are often criticized, belittle and humiliated, an this again leads to affective instability, resistanc and ultimately rejection of learning.

Punishment and criticism may arouse resistance an rebelliousness. In this regard, Heward and Orlansk (1980:135) directed the following message at teachers "Have a fair attitude for individual differences i interest and abilities, do not force every child t fit a narrow mould". Heward and Orlansky (1980 further state that criticism instills fears and non acceptance an the disabled child. Such a child feel disappointed, dissatisfied, and even inferior an

becomes tense and frustrated.

The child may need re-assurance and praise and may respond to punishment and stress by many mechanisms, such as withdrawal, refusal, etc. When the child is discouraged and feels insecure he may resort to coping mechanisms such as attracting attention, demonstrating his power to defeat the teacher and parent, to punish the teacher and parent (by not learning), to convince the teacher that he cannot learn in order to be left alone and that pressure should be removed from him (Muller, 1972:2).

5.2.10 ***Extent of Benefits from Integrated Education***

TABLE 43: The extent to which the disabled child will benefit from integrated education

	NUMBER	PERCENTAGE
YES	13	48.1
NO	11	40.7
DO NOT KNOW	3	11.1
TOTAL	27	99.9

Judging from the table, a majority of the teachers agree that disabled children would benefit from integrated education (48.1%), while (40.7%) teachers disagreed that disabled children will benefit from integrated education and (11.1%) of the teachers were uncertain in this regard. There is this considerable confusion in this regard.

Integrated education may have both advantages and disadvantages for the mentally disabled. The advantages may be as follows:

a) Normal classes come into contact with one or more disabled children. In some instances, this could constitute the initial contact and therefore a learning experience for non disabled persons.
b) Promote the socialization of the handicapped.
c) Influence the attitude of the non-handicapped.
d) Give the disabled child confidence in their own ability to function independently outside the narrow world of home and special classes.
e) Parents of disabled children may feel less isolated and apprehensive as they see their children participate in the universal rite of public schooling.

Contrary to the advantages, Gottlieb, Rose and Lessen (1983) commented that a "... considerable amount of research has already indicated that merely placing retarded children in regular classes does not improve the social acceptance of them by non-retarded peers. Retarded children in regular classes who misbehave or cannot conform to the standards of the classroom are apt to be socially rejected, regardless or whether or not they are labelled as mentally retarded" (in: Kirk and Gallagher, 1986:146).

Furthermore, disabled children could profit more from a programme emphasising the practical and vacational skills needed for independent living.

Haring and McCormack (1986:30) are of the opinion that: "The popular model of integration into the regular classroom does not necessarily mean better educational opportunities. It may remove stigma of segregated education, but if it fails to meet the individual needs of the exceptional person it can also, like the segregated classroom, be detrimental to the student difficulty in adjusting socially".

5.2.11 *Relative Advantages and Disadvantages of Pre-school Education*

TABLE 44: The Extent to which the advantages of pre-school education outweigh the disadvantages, according to teachers' perceptions

	NUMBER	PERCENTAGE
YES	20	74.1
NO	2	7.4
DO NOT KNOW	5	18.5
TOTAL	27	100.00

Most teachers believe that the advantages of pre-school education outweighs the disadvantages (74.1%). In comparison, an insignificant proportion of teachers disagree that pre-school education has advantages at all (7.4%).

According to the teachers, this could be because a pre-school education for disabled children means that they are easily adapted (fitted into) a school situation. They also do not need a transition period in their school life as pre-readiness skills are already taught. The pupil is better able to adjust to

organized classroom routine. It also helps in socialization, communication and gives the child a headstart in perceptional skills, gross and fine motor skills. Pre-school prepares the child emotionally and socially. By the time the child finishes pre-school he has adjusted to routine and school life. Pre-school education permits the child to receive instruction from teachers effectively.

5.2.12 Relative Advantages and Disadvantages of Special Education

TABLE 45: The extent to which the advantages of special education outweigh the disadvantages, according to teachers' perceptions

	NUMBER	PERCENTAGE
YES	25	92.6
NO	2	7.4
DO NOT KNOW	-	-
TOTAL	27	100.00

A large proportion of teachers agreed that the advantages of special education outweighs the disadvantages (92.6%).

Teachers indicated that this may be due to the fac the disabled children are trained according to thei level of functioning. These children are not expose to the frustration of coping with academic work, whic they are not intellectually capable of doing. Th child can be meaningfully occupied and trained to b productive and independent to meet life's demands Children are assisted by aides (specially traine people to assist them), while the curriculum and pac set in special school prove to be more effective i positively shaping pupil's adaptive behaviour pattern Tone and pace set in special school help the chil gain greater confidence in his/her ability. Thi boost in confidence contributes to an all roun development. A further advantage is that teachers ca concentrate on the child's special needs, thu progress can be noted in a training programme.

5.2.13 *Effect on School work by Factors outside the School*

TABLE 46: The extent to which the school work of the disabled child is affected by factors outside school

	NUMBER	PERCENTAGE
ALWAYS	13	48.1
SOMETIMES	14	51.9
NEVER	-	-
DO NOT KNOW	-	-
TOTAL	27	100.00

The above table illustrates that most teachers agree that disabled children either always (48.1%) or sometimes (51.9%) are affected by factors outside school, for example home circumstances.

According to Kapp (1991:30), in some instances the child's problems are associated with the environment or the circumstances in which he grows up. Poor socio-economic circumstances and an environment which is culturally poor and lacks opportunities may hamper the child's development and learning to such an extent that his potential cannot develop fully.

Pretorius (1979:171) states that some children grow up in good homes, under sound economic circumstances and receive adequate guidance, but nevertheless develop learning and behaviour problems at school owing to adverse influences from their own sub-culture and peers (in: Kapp, 1991:30).

A child's environmental background can restrain him to such an extent that he is unable to succeed in satisfying the demands made on him by the school. To clarify this, reference is made to Kok's (1970:12-13) distinction between two kinds of educational environment, namely a supportive and non-supportive environment. In a supportive environment a world is opened to the young child by reading to him, travelling with him, and teaching him to use modern communication media and technical aids. In a non-supportive environment, the child does not experience a healthy relationship with the family. Poverty and its accompanying problems are often general factors responsible for inadequate environment (in: Kapp, 1991:124). Therefore, in this regard, teachers should purposefully create a climate in which the child can be affectively supported, in which he can feel safe because he knows that he is completely accepted, and in which he knows that his helper has time for him and believes that he will rise above his problems.

5.2.14 *Interaction between Teachers and Parents*

TABLE 47: The extent to which teachers interact with parents regarding the child's education

	NUMBER	PERCENTAGE
YES, BOTH	23	85.2
YES, MOTHER ONLY	4	14.8
YES, FATHER ONLY	-	-
NEITHER	-	-
TOTAL	27	100.00

Most teachers interact constantly with either both parents (85.2%) or the mother only (14.8%), regarding the child's progress at school.

Progress of children can often be enhanced when teachers discuss the child's education with parents, this allowing parents and staff members to work as partners in serving children. Parental contact is seen as a critical component for generalization of acquired skills to the community and for the continuing maintenance of these skills. According to teachers, reasons for contacting parents in the education process include:

a) Parents, especially the mother, are the primary teacher for the child during the early years of life.

b) If programmes are to be successful, there must be consistency in programming between home and school.

These two dimensions are essential in planning parent programmes if staff members are to provide parents with the information and the skills they need to be effective members of the child's education team.

Duncan and Fitzgerald (1969) found that contacts with parents served to prevent or reduce attendance problems, the number of dropouts and disciplin problems (in: Mercer, 1987:101).

5.2.15 *Extent of Parents' Interest in the Child's Education*

TABLE 48: Extent of parents' interest in the child's education

	NUMBER	PERCENTAGE
VERY INTERESTED	3	11.1
AVERAGE INTEREST	17	63.0
LITTLE OR NO INTEREST	7	25.9
NOT AT ALL	-	-
TOTAL	27	100.00

Only a small number of parents seem to be very interested on their child's educational progress (11.1%). However, a large percentage of parents show an average interest to their child's education (63%) while 25.9% of parents display either little or no interest regarding the education of their child. This is according to the perception of teachers.

Parents are perhaps the most important members of their child's education team. Most parents are interested in what their children are doing, and in what they can do to help their children learn. In this study most staff members indicated that there is

a strong need for parents to be involved in the direct instruction of their children. They further stated that staff members should be responsive to the desires and concerns of parents and to teach parents the skills they want and need to teach their own child.

According to Topping (1986) and Wolfendale (1985) teachers have become increasingly aware of the need to work more closely with parents of children with special educational needs. Two of the most widespread ways in which parents are participating are through reading programmes and behavioural training (in: Horby, 1989:161).

Parents displaying a keen interest in their child's education, can contribute valuable information about their child with special educational needs and about the family. Information on the child's strengths and difficulties, likes and dislikes, and medical circumstances can be gathered by teachers at parent-teacher meetings. Making full use of parents knowledge of their children helps to improve professional practice and makes parents aware that they have been listened to and that an active interest has been taken in their child.

With regard to parental interest in the administration of school teaching methods and programmes, Pocklington (1980:22) states that parents should be granted extensive rights by mandate viz. the right to attend various planning meetings, for their views to be actively consulted; access on request to all school records, etc. Weatherly and Lipsky (1977) state that greater parental participation, has led to most parents making substantial contributions to the assessment or planning processes (in: Pocklington, 1980:23).

Similarly, Yoshida et al (1978) point out that schools may view the parents as active participants and encourage parents to assist in making judgement about their program. They note that this latter approach "May increase parental support for their child's special education program and promote closer co operation between school and home in implementing that program" (in: Mercer, 1986:107).

5.2.16 ***Parent's Interest in School Administration***

TABLE 49: Parental interest in the administration of the school

	NUMBER	PERCENTAGE
A GREAT DEAL	2	7.4
IN SOME WAYS	12	44.4
NOT AT ALL	13	48.2
TOTAL	27	100.00

The above figures illustrate that few parents displa a great interest in school administration (7.4%). considerable percentage participate in some way (44.4%) but nearly half show no interest at al (48.2%).

5.2.17 *Parent's Interest in Teaching Methods*

TABLE 50: Parental interest in the teaching methods of the school

	NUMBER	PERCENTAGE
ALWAYS	-	-
SOMETIMES	8	29.6
NEVER	19	70.4
TOTAL	27	100.00

The same pattern can be seen regarding interest i teaching methods, although even more (70.4%) neve show an interest. Literature shows that although th assumption that parent participation in their child' educational programme has inherent appeal and logic the formal involvement of parents has not been easy o necessarily productive. The results of Turnbul (1986) indicate that extensive parent involvement i both administration of the school and educationa planning is not likely, and on occasion mee opposition. Many parents end up as observers onl (in: Mercer, 1986:107).

Yoshida et al (1978) point out that school, may view the parents as active participants and encourage parents to assist in making judgements about their child's programme. They note that this latter approach: "... may increase parental support for their child's special education programme and promote closer co-operation between school and home in implementing that programme" (Mercer, 1986:107).

According to Haring and McCormack (1990:192) many parent- involvement efforts have been unsuccessful because of the conflicting attitudes of parents and staff members and because of their lack of skill in working with each other.

Thomas (1982) has argued that there is an "uneven balance of power" between individuals in a parent-professional encounter. Professionals are experts in their own field, which gives them legitimate authority in their own eyes and may lead them to reject the expertise of parents (in: Sandow and Stafford, 1981:19).

5.2.18 ***Parents and Extra-curricular Activities***

TABLE 51: Parents' helpfulness in extra-curricular activities

	NUMBER	PERCENTAGE
ENTHUSIASTIC	8	29.6
HAVE TO BE PERSUADED	18	66.7
NOT INTERESTED	1	3.7
TOTAL	27	100.00

The above table indicates that most parents have to b persuaded (66.7%) to participate in extra-curricula activities, while (29.6%) of the parents ar enthusiastic helpers. A small minority are no interested at all (3.7%).

According to teachers, the major reason why mos parents display a lack of interest or even have to b persuaded to participating in extra-curricula activities, is a major fault on part of th educational system. A lack of a solid educationa system could probably propagate systemic rules, thu allowing educators to manipulate the situation to sui and meet their own needs.

5.2.19 ***Participation in Extra-curricular Social Activities***

TABLE 52: The participation of disabled children in extra-curricular activities

	NUMBER	PERCENTAGE
MEANINGFULLY	17	63
HESITANTLY	5	18.5
INADEQUATELY	5	18.5
NOT AT ALL	-	-
TOTAL	27	100.00

According to the preceding table:

Most disabled children (63%) participated in extra curricular activities, whether they consisted o games, plays or activities engaged by the school, fo example, athletics, gardening, sewing or physica education.

It is important to note that some disabled childre were either hesitant (18.5%) or inadequate (18.5%) i participating in extra-curricular activity.

The circumstances under which this situation could have arises include:

i) Poor health;

ii) Medical certificate exempting children from participating in sports;

iii) Lack of appropriate sporting equipment to meet the needs of the disabled child concerned; and

iv) Lack of motivation and encouragement on the part of physical education teachers.

Extra-curricular activities is essentially a personal and direct form of educational experience.

According to Boswell and Wingrove (1974:7) extra-curricular activities provide skills, satisfactio discovery and achievements to enliven and enrich th life of man. Inherent in recreation, is a chivalrou code of sportsmanship, which fosters a spirit of co-operation without loss of identity. Boswell an Wingrove (1974:7) further state that: "from psychological point of view it is essential for th disabled to share activities with older people Interest in, and practice of sports or differen cultural activities are specially useful. Trainin for such activities is often necessary. They not onl afford the disabled stimulation, but also give hi training and exercise for his limited abilities.

5.2.20 *Change in Extra-Curricular Social Activities over Time*

TABLE 53: The extent to which participation of the disabled child in extra-curricular social activities change as they progress at school

	NUMBER	PERCENTAGE
IMPROVES MEANINGFULLY	19	70.4
IMPROVES SOMEWHAT	8	29.6
DOES NOT CHANGE	-	-
DETERIORATES	-	-
TOTAL	27	100.00

The participation of disabled children in extra curricular activities change meaningfully as the progress at school (70.4%). While only a smal percentage of the disabled children's progress a school improved 'somewhat' (29.6%) in this regard.

5.2.21 *Difficulties experienced at School*

TABLE 54: Difficulties experienced by the disabled child at school

	NUMBER	PERCENTAGE
DUE TO HEALTH REASONS	21	77.8
TRANSPORT DIFFICULTIES	0	-
LACK OF HELP	1	3.7
LACK OF SPECIAL CLASSROOM APPARATUS	4	14.8
OTHER (SPECIFY)	-	-
N/A	1	3.7
TOTAL	27	100.00

The table indicates that 77.8% of the disable children experienced difficulties at school due t health reasons. Poor health results in a substantia percentage of disabled children being absent fro school, thus school work is adversely affected.

A lack of special classroom apparatus (14.8%), an lack of help (3.7%) are relatively minor difficultie experienced.

CHAPTER SIX

CONCLUSIONS, RECOMMENDATIONS AND SUMMARY

6.1 CONCLUSIONS

The following conclusions follow logically from th data analysis. They are discussed in terms of th theoretical perspectives outlined in Chapter Two.

The fact that a family has a child with a disabilit usually means that family life will be very differen from what was expected. The nature and the intensit of the effects vary according to many factors including child characteristics, famil characteristics, family support systems and communit resources. Almost, inevitably, however, having child with a disability means that the family wil experience unique relationships with schools and othe public service agencies.

Every family has certain basic functions that it mus fulfil. For example, Turnbull, Summers and Brotherso (1984) have described nine basic family functions economic, physical, rest and recuperation socialization, self-definition, affection, guidance educational and vocational. In addition, a famil that has a disabled child may compel parents to spen much time on any one function resulting in them havin

less time for others. In the area of needs some families, may require information, financial assistance and help in teaching their child at home (in: Haring and McCormick, 1990:497).

When seeking to understand families, it is important to recognize that having a child with a handicap is a life long task for many families. For many parents of disabled children, the early childhood years are difficult; during this period many children with moderate to severe handicapping conditions are identified. Some children are identified at birth, particularly those with obvious physical impairments. Other children are not identified until they show delays in attaining developmental landmarks.

Parents undergo a series of five stages of parental reaction and adjustment to the awareness of the child's handicap. The first stage is that of shock, followed by a period of denial. During these two stages, parents may be confused and disorganized. They may not accept the fact that the child is not handicapped. In the third stage, the inevitability of the handicap becomes apparent, and families often experience intense feelings of danger, anxiety and sadness about the future. Parents worry about the happiness of the child, and the possibility of permanent caretaking responsibilities. The fourth

stage is a gradual adaptation to having a child with disabilities, and the fifth stage represents reorganization and long term acceptance of the situation.

As the disabled child grows older, parents encounter specific problems. Parents are excessively concerned about the areas of employment, independent living, social recreation outlets and planning for the future Because adults in our society are expected to work and contribute to the economy, one major responsibility of parents is to help their children seek and secure appropriate opportunities for employment. Many parents have mixed feelings about the option what is best for their handicapped child.

Parents are also concerned about their child's long term social development. Dating, marriage, and child bearing and normal transitions that often pose difficulty for the family of an adolescent or young adult with a handicapping condition.

As parents begin to realize that their handicapped child will probably outlive them, they are faced with the issue of who will be responsible. This anxiety can be particularly traumatic, especially for parents who have had to take an active and involved role in the care of their child. Their fundamental concern is

whether anyone else would devote their time and energy necessary to ensure a life of as high a quality as possible. However, unless another family member volunteers to assume this role, parents often hesitate to ask anyone to accept such a lifelong responsibility. Thus, this decision can be a very difficult one for parents and calls for much support and assistance.

Education serves as a therapeutic tool for the disabled child to overcome his limitations. Special education shapes the direction of the growth of the disabled child. Presently, the field of special education underwent additional changes as parents and families began to demand increased involvement in the education of their children. In a special class, specially trained teacher provides a distinctive curriculum for a small group of children. The curriculum may include exercises in personal grooming safety, or any subject appropriate for the disabled child, whose cognitive development is half or less of the age of normal children.

A major goal of special education is to help the disabled child to interact with his environment and people around him.

Special education teachers must be skilled in workin with children who have mental disabilities. They must be skilled in family involvement activities, assessment of environmental demands and co-ordinatin efforts with agencies such as vocational an rehabilitation services.

Effective training is an important skill. Specia educators need to be able to identify family needs fo training and to design acceptable strategies to hel family members acquire needed skills. These skill include self-help, work, recreation and leisure - al are necessary to function independently in the hom and community environment.

Vocational training provides students wit opportunities to generalize. Skill training in othe settings exposes students to a variety of wor experiences to help them make decisions about jo preference.

Disabled children require special education an related services to develop their maximum capacity Teaching a disabled child requires that a regula curriculum be modified with regard to one or more o the following: objectivities, content, method o teaching, teaching media, parental guidance, etc.

Special education makes it possible for the educators to make proper contributions to the handicapped child's education; if he is in the position to identify the child's particular educational needs. Special education strives to make the disabled child economically independent. The basic idea here is that the school should also assist the child to develop independence in his accepted task, as well as his future occupational life.

6.2 ADDRESSING THE WORKING HYPOTHESES

It is evident from the content of this report that the aims of the study were realized. With respect to the two working hypotheses (in 1, paragraphs 2.2 and 2.3) it is also evident that these are confirmed by the research.

6.3 RECOMMENDATIONS

6.3.1 Services

Services for the mentally disabled should be comprehensive, accessible and within the means of all income levels. It is essential that services start with diagnosis and ascertainment of disabled individuals and will therefore involve hospital and community paediatricians and other hospital

specialists. Services must involve free medica treatment forthe disabled child and as well as for his/her parents, since parents encounter an enormou amount of stress in caretaking their disabled child It also includes genetic counselling, counselling o parents, support groups, social workers, communit nurses, occupational therapist, speech therapist physiotherapist, and child psychiatrists.

6.3.2 **Preventive Services**

There are three requisites for reducing the number o handicapped in our community.

(a) Every pregnant women should undergo a procedur called amniocentesis. A procedure for drawin some of the amniotic fluid from the pregnan woman. Fetal cells found in that fluid are the analyzed for chromosomal abnormality. Such earl diagnosis allows parents to decide whether th pregnancy should be terminated.

(b) The state should provide effective system c health, housing, nutrition and education.

(c) The public should be educated about menta disabilities. Such actions compels parents t give immediate attention regarding their child' future.

6.3.3 Implementation of Laws

In U.S.A. referral laws, legislative laws and public laws are implemented. Such laws protect the needs and interest of each and every disabled child. Therefore, such laws should be implemented in South Africa in order to safeguard the rights of disabled children. Laws of such kind permits disabled children to earn respect and become worthwhile members in their community.

6.4 AREAS FOR FUTURE RESEARCH

More research needs to be conducted with regard to ascertaining the predisposing and causative factors of mental disability so that preventive or therapeutic measures could be instituted to alleviate this problem.

6.5 SUMMARY

The present study was undertaken to analyze and ascertain attitudes of the family and formal education on the social functioning of the mentally disabled Indian child.

The study was carried out in three phases, viz. literature survey, informal interviews with people who have authority in the field on mental disability, and

a full-scale empirical investigation of adults an teachers within the study area. The construction o the interview schedule was based on the informa interviews and literature relevant to the study. Th interview schedule was used as the principle method o data collection. A preliminary survey was conducte in which the interview schedule was pretested fo shortcomings.

The entire universe of 315 respondents was selecte for the study, thus constituting a census and avoidin a sample being drawn. Upon completion of th fieldwork, the data was processed with the aid of computer. Percentages and frequency tables were use to analyze the data.

The findings of the empirical study revealed tha majority of the respondents were protected an positive in their attitudes towards their mentall disabled children. Such parents also displayed a hig degree of willingness to care for their disable child. This could be attributed to the stron traditional values that Indians still appear to hold The findings also revealed that disabled children, i provided with adequate special education, can b gainfully employed and productive in society.

The findings were explained in terms of the variou: theoretical perspectives. A number of recommendation. were made.

Finally, future research possibilities emanating fro: the present study were indicated.

BIBLIOGRAPHY

1. Abrams, J. and Kaslow, F. 1977 : Family Systems and the Learning Disabled Child Interventions and Treatment Journal of Learnin Disabilities, Vol.10 (2):27 31.

2. Adamson, W.C.and Adamson, K.K. 1979 : A Handbook for Specifi Learning Disabilities, Ne York: Gardner Press Inc.

3. Anderson, C.J. 1963 : My Brain Damaged Daughter, Porthand: Durham Press.

4. Bak, J.J. and Superstein, G.N. 1986 : Protective Effects of the Label 'Mental Retarded' o Children's Attitude Toward Mentally Retarded Peers American Journal of Menta Deficiency, 91 (1):51-56.

5. Barlett, R.H. 1977 : Politics, Litigation an Mainstreaming: Specia Education's Demise? I Readings in Specia Education, 1978 Connecticut: Specia Learning Corporation, 64-67

6. Baumeister, A.A. and Butterfield, E.C. 1970 : Residential Facilities for the Mentally Retarded Chicago: Oldine, Atherto Inc.

7. Beckman, P.J. 1983 : Influence of Selected Chil Characteristics on Stress i Families of Handicappe Infants, American Journa of Mental Deficiency, Vol.2 (3):87-94.

8. Behr, A.L. 1983 : Empirical Research Metho for the Human Sciences Second Edition, Durbar Butterworths.

9. Bentovim, A. 1972 : Handicapped Pre-school Children and their Families: Effects on the Child's Early Emotional Development. In Boswell, D.M. and Wingrove, J.M. (ed.) 1974, The Handicapped Person in the Community, London: Open University Press, Tavistock.

10. Bercovici, S. 1983 : Barriers to Normalisation - The Restrictive Management of Retarded Persons, Maryland: University Park Press.

11. Berdine, W.H., and Cegelka, P.T. 1980 : Teaching the Trainable Retarded, Columbus: Merril Publishing Co.

12. Booth, T. and Potts, P. 1983 : Integrating Special Education, England: Basil Blackwell Publishers Ltd.

13. Boswell, D.M. and Wingrove, J.M. 1974 : The Handicapped Person in the Community London: Open University Press, Tavistock.

14. Bowley, A.H. and Gardiner, L. 1972 : The Handicapped Child: Educational and Psychological Guidance for the Organically Handicapped London: Sangman Group Ltd.

15. Brewer, G.P. and Kakalik, J. 1979 : Handicapped Children Strategies for Improving Services, U.S.A.: McGraw Hill Book Company.

16. Brindley, A. 1979 : A Preparation for Passivity Special Education. Forward Trends, Vol.6: 24-28.

17. Budoff, M. and Gottlieb 1976 : Special Class EMR Children Mainstream: A Study of an Aptitude (Learning Potential) x Treatment Interaction. In Readings in Special Education, 1978 Connecticut : Special Learning Corporation: 67-71

18. Caldwell, B.M. 1970 : The Rationale for Early Intervention. Exceptional Children, 36.717-726.

19. Calvert, D. 1971 : Dimension of Family Involvement - Exceptional Children, 37.655-658.

20. Castles, E.E. and Glass, C.R. 1986 : Training in Social and Interpersonal Problem Solvin Skills for Mildly an Moderately Mentally Retarde Adults. American Journal o Mental Deficiency, Vol. 9 (1):35-42.

21. Chadwich, B.A., Bahr, H.M. and Albrecht, S.L. 1984 : Social Science Research Methods, New Jersey Prentice-Hall Inc.

22. Chazan, M. 1973 : Disadvantages and Nurser Schooling:Special Education 62 (3) : 18-23.

23. Chinn, P.C., Drew, J.C. and Logan, R.D. 1975 : Mental Retardation: A Life Cycle Approach, U.S.A.: Th C.V. Mosby Company.

24. Chinn, P.C., Drew, J.C. and Logan, R.D. 1979 : Mental Retardation: A Life Cycle Approach. St. Louis The C.V. Mosby Company.

25. Clark, J.B. 1951 : Disabled Citizens, London: Allen and Unwin.

26. Clark, T., Lobato, D. and Brand P. 1989 : What Mentally Retarded and Non Retarded Childre Expect of One Another American Journal of Menta Deficiency, 93 (4) :396-405

27. Clements, J.E. and Alexander, R.N. 1975 : Parent Training: Bringing it all Back Home Exceptional Children, 7.7 12.

28. Cleveland, D.W. and Miller, N. 1977 : Attitude and Life Commitments of Olde Siblings of Mentall Retarded Adults, Menta Retardation, 15(3):38-41.

29. Collins, H., Burger, G.H. & Doherty, D. 1970 : Self-Concept of ENR and Non Retarded Adolescents, America Journal of Menta Deficiency, 75 (3):285-289.

30. Crnic, K.A., Friedrich, W.H., & Greenberg, M.T. 1983 : Adaptation of Families with Mentally Retarded Children: A Model of Stress, Copin and Family Ecology, America Journal of Mental Defiency Vol. 88 (2):125-138.

31. Crow, L.D. and Crow, A. 1963 : Educational Psychology, New York: Litto Educational Publishers Inc.

32. Cunningham, C.C. and Davis, H. 1985 : Early Parent Counselling, London: Balhere-Tindall.

33. Cunningham, C. 1986 : Down's Syndrome: A Introduction for Parents Great Britain: Souveni Press (Ltd.).

34. Darling, J. 1982 : Children who are Different: Meeting the Challenges o Birth Defects in Society London: C.V. Mosby Company

35. Davis, J.A. 1971 : Elementary Survey Uses, New Jersey : Prentice-Hall Inc.

36. De Lange, J.P. 1981 : Report of the Wor Committee: Education fo Children with Specia Educational Needs, Huma Sciences Research Council.

37. Dupont, H. 1969 : Educating Emotionall Disturbed Children, Ne York: Holt Rinehart an Winston Inc.

38. Eden, M. 1976 : Mental Handicap, London George Allen and Unwin Ltd.

39. Elliot, R.F. 1986 : The Family: Change o Continuity? London MacMillan Education Ltd.

40. Fish, J. 1985 : Special Education: The Wa Ahead, Great Britain: J.W Arrowsmith Ltd.

41. Fish, J. 1987 : Questions we Need to Ask British Journal of Specia Education, Vol. 14 (4):171 175.

42. Fletcher, R. 1973 : The Family and Marriage in Britain, 3rd ed., Harmondsworth: Penguin.

43. Friedrick, W.N. and Friedrick, W.L. 1981 : Psycho-social Assets of Parents of Handicapped Now-Handicapped Children, American Journal of Mental Deficiency, Vol.85 (5): 551-553.

44. Furey, E.M. and Haber, M. 1989 : Protecting Adults with Mental Retardation :A Model Statute, American Association of Mental Retardation 27 (3) : 135-140.

45. Gallagher, J.J. 1980 : Parents and Families of Handicapped Children, London: Jossey-Bass Inc.

46. Gargiulo, M.R. 1985 : Working with Parents of Exceptional Children: A Guide for Professionals, Boston: Houghton Mifflin Company.

47. Garrett, A. 1970 : Interviewing, Its Principles and Methods, Family Service Association of America, U.S.A.

48. Gath, A. 1978 : Down's Syndrome and the Family, London: Academic Press.

49. Gearheart, R.B. 1975 : The Trainable Retarded U.S.A.: The C.V. Mosby Co.

50. Glanze, W.D., Anderson, K.N., Urdang, L and Swallow, H.H. 1986: Mosby's Medical & Nursing Dictionary. St.Louis: C.V. Mosby Co.

51. Goffman, E. 1963 : Stigma: Notes on the Management of Spoiled Identity, Englewood Cliffs Prentice-Hall, Inc.

52. Greer, B. 1975 : On Being the Parent of Handicapped Child.Exceptional Children Vol.41:519.

53. Grossman, F. 1972 : Brothers and Sisters o Retarded Children, Psychology Today, 82-88.

54. Grothberg, E.H. 1969 : "Role of the Parent i fastering Early Learning": Education, A Magazin devoted to the Science, Art Philosophy and Literature o Education, Bobbs Merrill Vol.89.

55. Gulliford, R. 1971 : Special Educational Needs London: Routledge and Kegan Paul.

56. Hallahan, D.P. and Kauffman, J.M. 1982 : Exceptional Children: Introduction to Specia Education, Second Edition U.S.A.: Prentice-Hal International.

57. Hamilton, A. 1973 : Teaching Handicappe Children and their Parents, American Education. I Readings in Specia Education, 1978 Connecticut: Specia Learning Co., p.52-57.

58. Haring, N.G. and McCormick, L. 1990 : Exceptional Children and Youth: An Introduction t Special Education, Fift Edition, Columbus: Merri Publishing Company.

59. Heward, W.L. and Orlansky, M.D. 1980 : Exceptional Children: An Introductory Survey t Special Education, Columbus Ohio: Charles E. Merril.

60. Hewett, S. 1970 : Who will Help? The Famil and the Social Services Statutory and Voluntary The Family and th Handicapped Child, London George Allen and Unwin.

61. Hirman, B.H. 1972 : The Mentally Handicappe Child, Great Britain Northumberland Press.

62. Horby, G. 1989 : A Model for Parent Participation, Britisl Journal of Specia Education, Vol. 16 (4):156-163.

63. Hutchinson, P. 1982 : Work Preparations for th Handicapped, London: Groo Helm Ltd.

64. Isaacson, R. 1974 : The Retarded Child, A Guid for Parents and friends U.S.A., Argu Communications.

65. International Labour Office 1989 : Employment of Disable Persons, Geneva: Universal Copyright Convention

66. Johnston, B.R. 1987 : Learning Disabilities Medicine and Myth: A Guid to Understanding the Chil and the Physician, U.S.A. Little, Brown and Co. Ltd.

67. Johnston, K. 1951 : Educating the Retarde Child, U.S.A.: Houghto Mifflin Co.

68. Justice, R.S., O'Conner, G. and Warren , B 1971 : Problems Reported by Parent of Mentally Retarded Children: Who Helps American Journal of Menta Deficiency, Vol. 75 (6):685-691.

69. Kapp, J.A. 1991 : Children with Problems: Orthopedagogica Perspective, Pretoria: J.L Van Schaik Ltd.

70. Karnes, M.B. and Zenrback, R.R. 1972 : Flexibility in getting Parents involved in School Exceptional Children, 197 5(1): 6-19.

71. Karnes, M., Teska, J. and Hodges, A. 1970 : "The Successful Implementation of a Highly Specific Pre-schoo Instruction, Program b paraprofessional Teachers" Journal of Specia Education, Vol.4: 69-80

72. Kershaw, J.D. 1973 : Handicapped Children in th Ordinary School: Stresse in Children, London University of London Press

73. Kidder, H. and Judd, M. 1987 : Research Methods in Social Relations, Hong Kong: CE Publishing, Japan Ltd.

74. Kirk, S.A. 1972 : Educating Exceptiona Children, U.S.A: Houghto Mifflin Co.

75. Kirk, S.A. and Gallagher, J.J. 1979 : Educating Exceptional Children, Boston: Houghto Mifflin Co.

76. Kirk, S.A. and Gallagher, J.J. 1986 : Educating Exception Children, Fourth Editio Boston: Houghton Muffl Co.

77. Kirk, S.A. and Gallagher, J.J. 1991 :Educating Exceptional Children, Fifth Edition, Boston: Houghton Muffl Co.

78. Levy-Shiff, R. 1986 : Mother-Father-Chil Interactions in Famili with a Mentally Retard Young Child. Americ Journal of Menta Deficiency, Vol. 91 (2) 141-149.

79. Lewis, H. 1987 : Forum in Social Case Wor The Journal of Contempora Social Work, Vol. 8: pp.29 311.

80. Lillie, D. 1981 : Educational an Psychological Strategies f Working with Parents. Paul J. (ed) Understandi and Working with Parents Children with Speci Needs, New York: Hol Rinehart and Winsto pp.89-118.

81. Logue, G. 1972 : The Slow Learning Chil Durban: Phoeni Publications.

82. Lovell, K. 1971 : The Growth of Basic Mathematical and Scientific Concepts in Children, 4th Ed., London: London University Press.

83. Lynch, E.C. and Staloch,E 1988 : Parental Perceptions of Physicians Communication in the Informing Process, American Association on Mental Retardation: Vol.26 (2):77-81.

84. Malin, N. 1980 : Services for the Mentally Handicapped in Britain, Great Britain: Redwood Burn, Ltd.

85. Marc, L. and MacDonald, L. 1988 : Respite Care - Who Uses It, American Association on Mental Retardation, Vol.26 (2) :93-96.

86. Martin, D. and Deutsch, C.P. 1974 : Intelligence, Heredity and Environment: The Critical Appraisal of an Outmoded Controversy, In Readings in Special Education, 1978, Connecticut: Special Learning Co., pp.29-40.

87. MacKeith R. 1973 : The Feelings and Behaviour of Parents of Handicapped Children. Exceptional Children, Vol. 17:24-7.

88. McConachie, H. 1986 : Parents and Young Mentally Handicapped Children, London: Croom Helm Ltd.

89. McCormack, M. 1978 : A Mentally Handicapped Child in the Family, A Guide for Parents, Great Britain Constable and Company Ltd.

90. McMichael, J. 1971 : Handicap: A Study of Physical Handicap Children and their Families, Pittsburg: University of Pittsburg Press.

91. McMichael, J.K. 1971 : Handicap, London: Staples Press.

92. McWhirter, J.J. 1977 : Treating Children with Learning Disabilities, Social Casework, Vol. 91 (2) : 279-281.

93. Mercer, C.D. 1987 : Students with Learning Disabilities, Third Edition Columbus: Merril Publishing Co.

94. Mittler, P. 1979 : People not Patients: Problems and Policies in Mental Handicap, London: Methuen & Co. Ltd.

95. Moser, C.A. and Kalton, G. 1977 : Survey Methods in Social Investigation, London: Heinemann Educational Books.

96. Moses, K. 1977 : Effects of the Developmental Disability on Parenting the Handicapped Child. in: Rief, M. (ed.). Patterns of Emotional Growth in the Developmentally Disabled Child, Morton Grove: Julia S. Molloy Education Centre, pp. 31-52.

97. Muller, F. 1972 : Factors Influencing the Results of Therapy, Die Phoenix Joernaal Boek 5, No.4.

98. Mussen, P.N., Conger, J.J. & Kanner, J. 1979 : Child Development and Personality; 5th ed., New York: Harper and Row Publishers.

99. Myers, B.A. 1989 : Misleading Cues in the Diagnoses of Mental Retardation and Infantile, Autism with the Pre-school Child, Mental Retardation, 27 (2) : 85-90.

100. Pearlman, L. and Scott, L.A. 1981 : Socialization within the Family Unit, Raising the Handicapped Child, U.S.A.: Prentice-Hall Inc.

101. Philip, G. 1982 : Children and Schooling, London: George Allen and Unwin.

102. Pocklington, K. 1980 : Integration: A Lesson from America? British Journal of Special Education Vol. 7 (3) : 20-25.

103. Reynolds, M.C. and Sylvia, W.R. 1978 : Special Education: Past, Present and Future. In Readings in Special Education, 1978, Connecticut: Special Learning Co., pp.3-10.

104. Reynold, M.C., Walberg, H.J.& Wang, Y. 1989 : Handbook of Special Education New York: Pergamon Press.

105. Roessler, R. and Bolton, B. 1978 : Psycho-social Adjustment to Disability, Baltimore: University Park Press.

106. Roos, P. 1978 : Parents of Mentally Retarded Children: Misunderstood and Mistreated, In Turnbull, A. and Turnbull, H. (eds.), Parents Speak out, Columbus: Charles Merrill, pp.12-27.

107. Rosen, G.M. and Ross, A.O. 1968 : Relationship of Body Images to Self-Concept, Psychology Today, pp.97-104.

108. Rotatori, A.F., Gerber, D.J., Litton, F.W. & Fox, R.A. 1986 : Counselling Exceptional Students, New York: Human Sciences Press, Inc.

109. Rowitz, L. 1986 : The Forgotten Adolescence and Mental Retardation, Mental Retardation, 26(3):115-118.

110. Sandow, S.A. and Stafford, P. 1982 : Parental Perceptions and the 1981 Education Act, Research Supplement: British Journal of Special Education, Vol. 13 (1) : 19-21.

111. Schild, S. 1976 : The Family of the Retarded Child. In Koch, R. and Dobson, J. (eds.), The Mentally Retarded Child and his Family, New York: Brunner/Mazel, pp.454-465.

112. Shearer, M.S. and Shearer, D.E. 1972 : The Portage Project: A Model for Early Childhoo Education. Exceptiona Children, Vol.39: 210-217.

113. Siegel, E. 1974 : The Exceptional Child Grow Up: Guidelines fo Understanding and Helpin the Brain Injured Adolescen and Young Adult, New York Dutton and Co. Ltd.

114. Singer, G.H.S., Irvin, L.K. and Hawkins, N. 1988 : Stress - Management Trainin for Parents of Children wit Severe Handicaps, Americ Association on Menta Retardation, 26(5):269-277.

115. Smiches, R. 1975 : The Parent - Professiona Relationship. Exceptiona Children, 41:565-566.

116. Stan, S. and Coughlan, P.M. 1973 : Four Process variables in Counselling with Mentally Retarded Clients, Americ Journal of Menta Deficiency, Vol. 77 (4 :408-414.

117. Stern, M. 1963 : Mental Retardation. Th Encyclopedia of Menta Health, Vol. IV, U.S.A., Franklin Watts Inc.

118. Steenkamp, E. and Steenkamp, W. 1981 : The Mentally Handicapped Child: A Manual for the Da Centres, Pretoria, Sigm Press.

119. Stevens, M. 1973 : The Educational Needs o Severely Subnormal Children, London: Edward Arnold Ltd.

120. Telford, C.W. and Sawrey, J.M. 1967 : The Exceptional Individual: Psychological and Educational Aspects, London: Prentice-Hall, Inc.

121. Topliss, E. 1982 : Social Responses t Handicap, U.S.A.: Longma Group Ltd.

122. Trevino, F. 1979 : Siblings of Handicapped Children: Identifying those at Risk, Social Casework, Vol. 60 : 48-53.

123. Van Niekerk, P.A. 1982 : The Teacher and the Child in Educational Distress, Stellenbosch: University Publishers.

124. Villeneuve, P. 1970 : Education for Handicapped Children, Unesco. USA: Georges Thone.

125. Voysey, M. 1975 : A Constant Burden: The Reconstitution of Family Life, London: Routledge and Kegan Paul.

126. Vrey, J.D. 1979 : The Self-Actualizing Education: Pretoria: Unisa.

127. Wallace, J.E. 1960 : Education of Mentally Handicapped Children, New York: Harper and Brothers.

128. Waite, K.B. 1971 : The Educable Mentally Retarded Child, Guidance and Curriculum, U.S.A.: Charles C. Thomas.

129. Ward, S. and Reale, G. 1972 : Survey - Exceptional Children, Vol. 2:28-29.

130. William, P. and Gruber, E. 1967 : Responses to Special Schooling, Great Britain: Western Printing Services, Ltd.

131. Wilkin, D. 1979 : Caring for the Mentally Handicapped Child, Great Britain, Biddles Ltd.

132. Wood, S. and Shears, B. 1986 : Teaching Children with Severe Learning Difficulties, London: Croom Helm.

133. Report of the Snowden Working Party, 1976. Integrating the Disabled. Horsham: Survey Fine Art Press Ltd.

A P P E N D I C E S

Republic of South Africa
Republiek van Suid-Afrika

ADMINISTRATION: HOUSE OF DELEGATES
ADMINISTRASIE: RAAD VAN AFGEVAARDIGDES

Department of Education and Culture
Departement van Onderwys en Kultuur

☎ (031) 37-2351 ⚡ 622344 SA Fax: (031) 374261

Esplanade Government Offices
Esplanadestaatskantore
Stanger Street
Stangerstraat
Private Bag X54323
Privaatsak
DURBAN
4000

Ref. No. / Verw. No. A 10/29/2/20

Enquiries / Navrae S. Pillay

Miss I. Govender
62 Belmont Road
Red Hill
DURBAN
4051

Madam

REQUEST FOR PERMISSION TO CONDUCT RESEARCH
Your letter dated 1991-01-07 has reference.

1. Permission is hereby granted to you to conduct your research at the schools as indicated in your letter provided that :

1.1 prior arrangements are made with the principals concerned;

1.2 participation in the research is on a voluntary basis;

1.3 completion of questionnaires is done outside normal teaching time;

1.4 all information pertaining to parents and teachers is treated confidentially and used for academic purposes only;

1.5 the prior permission of the Chief Executive Director is obtained if any of your findings are to be published.

2. Kindly produce a copy of this letter when visiting schools.

3. The Department wishes you every success in your research and looks forward to receiving a copy of the findings.

Yours faithfully

CHIEF EXECUTIVE DIRECTOR (ACT.)

910205/belmont/rn

QUESTIONNAIRE 1

QUESTIONNAIRE TO DETERMINE THE FAMILY'S EFFECT ON THE SOCIAL FUNCTIONING OF THE MENTALLY DISABLED INDIAN CHILD

PLEASE TICK IN APPROPRIATE BLOCK

A. RESPONSES BY INTERVIEWER

1. PERSONS INTERVIEWED:

MOTHER	FATHER	BOTH PARENTS	OTHER (SPECIFY
1	2	3	4

2. ADDRESS: _____

_____

B. RESPONSES BY PARENTS ON BIOGRAPHICAL INFORMATION

3. AGE OF THE CHILD:

3-7 YEARS	8-12 YEARS	13-18 YEARS	19-21 YEARS
1	2	3	4

4. SEX:

MALE	FEMALE
1	2

5. WHAT WAS THE CHILD'S AGE WHEN PARENTS FIRST BECAME AWARE THAT THE CHILD WAS DISABLE.

BIRTH-3 YEARS	4-7 YEARS	8-12 YEARS	13-18 YEARS	19-21 YEARS
1	2	3	4	5

HEALTH

6. CAUSE OF DISABILITY:

MONGOLISM (DOWN'S SYNDROME)	1
CRETINISM	2
CEREBRAL PALSY	3
ASPHYXIA	4
KERNICTERUS	5
OTHER (SPECIFY)	6
N/A	7

7. EXTENT OF Disability

SLIGHT	1
MODERATE	2
SEVERE	3

8. TO WHOM DID PARENTS GO FOR ADVICE

G.P.	1
HOSPITAL	2
CLINIC	3
FAITH HEALERS	4
OTHER (SPECIFY)	5

C. RESPONSES BY PARENTS ON SOCIAL FUNCTIONING OF CHILD

9. How does the family react towards the disabled child?

PROTECTIVELY	1
NORMALLY	2
REJECTINGLY	3
DON'T KNOW	4

10. HOW DOES YOUR CHILD ACT TOWARDS OTHERS?

DEFENSIVELY	1
NORMALLY	2
AGGRESSIVELY	3
DON'T KNOW	4

11. DOES THE DISABLED CHILD PREFER TO GO OUT WITH FAMILY MEMBERS?

DAILY	1
2-3 TIMES A WEEK	2
OCCASSIONALLY	3
DON'T KNOW	4
NEVER	5

12. DOES THE DISABLED CHILD PREFER THE COMPANIONSHIP OF ANY PARTICULAR FAMILY MEMBER?

MOTHER	1
FATHER	2
SIBLING	3
SERVANT	4
OTHER (SPECIFY)	5

13 DOES THE DISABLED CHILD RESTRICT THE SOCIAL ACTIVITIES OF OTHER FAMILY MEMBERS?

YES	1
NO	2
DON'T KNOW	3

14. DOES THE DISABLED CHILD FEEL COMFORTABLE IN THE CARE OF FAMILY RELATIVES?

SOMETIMES	1
ALWAYS	2
NEVER	3

15. IS THE DISABLED CHILD ABLE TO COPE APPROPRIATELY IN THE PRESENCE OF VISITORS AT HOME?

SOMETIMES	1
ALWAYS	2
NEVER	3

16. DOES THE DISABLED CHILD DEMAND MORE ATTENTION COMPARED TO OTER SIBLINGS?

SOMETIMES	1
ALWAYS	2
NEVER	3

17. HOW DOES THE DISABLED CHILD REACT WHEN HIS DEMANDS ARE NOT MET?

	USUALLY	SOMETIMES	NEVER
TEMPER TANTRUMS	1	2	3
RESTLESSNESS	1	2	3
WITHDRAWN BEHAVIOUR	1	2	3
OTHER (SPECIFY)	1	2	3

18. DOES THE DISABLED CHILD INFLUENCE THE PSYCHO-SOCIAL DEVELOPMENT OF THE NORMAL SIBLINGS?

POSITIVELY	1
NEGATIVELY	2
NO EFFECT	3

19. DOES THE SPECIAL ATTENTION DEMANDED BY THE DISABLED CHILD, CAUSE OTHER SIBLINGS TO BE JEALOUS OR RESENTFUL

OCCASSIONALLY	1
FREQUENTLY	2
NEVER	3

20. WHAT IS THE ATTITUDE OF THE DISABLED CHILD TOWARDS THE NORMAL SIBLING?

HOSTILE	1
INDIFFERENT	2
SUPPORTIVE	3
OTHER (SPECIFY)	4

21. DOES THE DISABLED CHILD FEEL THAT THE MOTHER NEGLECTS THE SIBLINGS FOR HIM?

A GREAT DEAL	1
IN SOME WAYS	2
NOT AT ALL	3
NO RESPONSE	4

22. DOES THE DISABLED CHILD FEEL EMBARASSED, OR INADEQUATE IN THE PRESENCE OF NORMAL CHILDREN OF HIS AGE?

ALWAYS	1
SOMETIMES	2
NEVER	3

23. DOES THE DISABLED CHILD GO ON HOLIDAYS?

WITH PARENTS	1
WITH INSTITUTION	2
WITH SCHOOL	3
WITH OTHERS	4
NOT AT ALL	5
N/A	6

24. DOES THE PRESENCE OF THE DISABLED CHILD REQUIRE ANY SPECIAL ADAPTIONS IN THE HOME?

ALWAYS	1
SOMETIMES	2
FREQUENTLY	3
NEVER	4

25. DOES THE DISABLED CHILD INCREASE FAMILY EXPENDITURE?

ALWAYS	1
SOMETIMES	2
FREQUENTLY	3
NEVER	4

26. DO PROBLEMS BETWEEN THE PARENTS AFFECT THE DISABLED CHILD?

BECOMES WITHDRAWN	1
ANXIOUS	2
FEARFUL	3
OTHER (SPECIFY)	4
N/A	5

27. WILL APPROPRIATE PARENTAL FAMILY COUNSELLING INFLUENCE THE QUALITY OF LIFE OF THE DISABLED CHILD?

A GREAT DEAL	1
IN SOME WAYS	2
NO EFFECT	3
DON'T KNOW	4

28. DOES YOUR DISABLED CHILD HAVE A PROBLEM IN COPING WITH SITUATIONS OUTSIDE OF THE HOME?

ALWAYS	1
SOMETIMES	2
NEVER	3
DON'T KNOW	4

29. ACCORDING TO PARENTS/GUARDIANS, WHAT WILL BE THE FUTURE OF THE DISABLED CHILD?

CHILD WILL BE COMPLETELY INDEPENDENT	1
REASONABLY INDEPENDENT	2
DEPENDENT ON OTHERS	3
UNCERTAIN	4

30. DOES THE DISABLED CHILD WILLINGLY ATTEND SCHOOL?

YES	1
NO	2
N/A	3

31. IS THE DISABLED CHILD FORCED TO GO TO SCHOOL?

A GREAT DEAL	1
TO SOME EXTENT	2
NOT AT ALL	3

32. WHO IS MAINLY RESPONSIBLE FOR CHILD'S EDUCATION?

SCHOOL AUTHORITIES	1
PARENTS	2
COMBINED EFFORTS OF BOTH PARENTS AND SCHOOL	3
OTHER (SPECIFY)	4
UNCERTAIN	5

33. HOW MUCH TIME DO YOU AS A PARENT SPEND WITH THE DISABLED CHILD

PARENT	MUCH	OCCASIONALLY	SELDOM	NEVER
FATHER	1	2	3	4
MOTHER	1	2	3	4
OTHER (SPECIFY	1	2	3	4

34. DO PARENTS/SIBLINGS ASSIST THE DISABLED CHILD WITH SCHOOL WORK?

ALWAYS	1
SOMETIMES	2
NEVER	3

35. DO PARENTS ATTEND SCHOOL FUNCTIONS?

REGULARLY	1
SOMETIMES	2
NEVER	3
N/A	4

QUESTIONNAIRE 2

QUESTIONNAIRE TO DETERMINE FORMAL EDUCATIONAL EFFECT ON THE SOCIAL FUNCTIONING OF THE MENTALLY DISABLED CHILD:

NAME OF SCHOOL: _____

PLEASE TICK IN APPROPRIATE BLOCK:

1. DO DISABLED CHILDREN BELIEVE THAT IT IS NECESSARY FOR THEM TO HAVE SPECIAL EDUCATION COMPARED TO NORMAL CHILDREN?

YES	1
NO	2
DON'T KNOW	3

2. ARE DISABLED CHILDREN EMBARRASSED TO ATTEND SPECIAL SCHOOLS?

YES	1
NO	2
DON'T KNOW	3

3. DO DISABLED CHILDREN BELIEVE THAT SPECIAL EDUCATION WOULD ALLOW THEM A GREATER DEGREE OF INDEPENDENCE LATER IN LIFE?

YES	1
NO	2
DON'T KNOW	3

4. DO DISABLED CHILDREN BELIEVE THAT SPECIAL EDUCATION WOULD ALLOW THEM TO BE GAINFULLY EMPLOYED AND PRODUCTIVE IN THE FUTURE?

YES	1
NO	2
DON'T KNOW	3

5. DO CHILDREN WHO HAVE ATTENDED A PRE-SCHOOL ADJUST BETTER TO A FORMAL SCHOOLING ENVIRONMENT?

ALWAYS	1
SOMETIMES	2
NEVER	3
DON'T KNOW	4

6. HOW DO DISABLED CHILDREN REACT WHEN THEY ARE UNABLE TO UNDERSTAND CERTAIN APPARENTLY BASIC CONCEPTS?

EMBARRASSED	1
INDIFFERENT	2
DEPRESSED	3
OTHER (SPECIFY)	4

7. HOW DO DISABLED CHILDREN REACT TO BEING EDUCATED?

VERY INTERESTED	1
AVERAGE INTEREST	2
LITTLE OR NO INTEREST	3

8. ARE DISABLED CHILDREN ABLE TO MAINTAIN THEIR CONCENTRATION FOR ANY DURATION OF TIME IN THE CLASSROOM?

ALWAYS	1
SOMETIMES	2
NEVER	3

9. DO DISABLED CHILDREN SHOW THE CAPACITY TO COPE WITH PUNISHMENT OR CRITICISM?

TEND TO BECOME RESENTFUL	1
TEND TO BECOME MISERABLE OR WORRIED	2
TEND TO SHOW NORMAL ATTITUDE TO CRITICISM AND PUNISHMENT	3

10. WOULD THE DISABLED CHILD BENEFIT FROM BEING INTEGRATED INTO NORMAL SCHOOL?

YES	1
NO	2
DON'T KNOW	3

IF YES OR NO GIVE 2 MAIN REASONS FOR YOUR ANSWER:

_____

_____

11. DO THE ADVANTAGES OF PRE-SCHOOL EDUCATION OUTWEIGH THE DISADVANTAGES?

YES	1
NO	2
DON'T KNOW	3

IF YES OR NO, GIVE 2 MAIN REASONS FOR YOUR ANSWER:

_____

_____

12. DO THE ADVANTAGES OF SPECIAL EDUCATION OUTWEIGH THE DISADVANTAGE?

YES	1
NO	2
DON'T KNOW	3

IF YES OR NO, GIVE 2 MAIN REASONS FOR YOUR ANSWER:

_____

_____

13. DO YOU CONSIDER THE SCHOOL WORK OF THE DISABLED CHILD TO BE EASILY AFFECTED BY ANY FACTORS OUTSIDE SCHOOL (E.G. HOME CIRCUMSTANCES).

ALWAYS	1
SOMETIMES	2
NEVER	3
DON'T KNOW	4

14. DO YOU DISCUSS THE CHILD'S EDUCATION WITH EITHER OF HIS/HER PARENTS

YES, BOTH	1
YES, MOTHER ONLY	2
YES, FATHER ONLY	3
NEITHER	4

15. TO WHAT EXTENT DO THE CHILD'S PARENTS SHOW INTEREST IN HIS/HER PROGRESS IN SCHOOL?

VERY INTERESTED	1
AVERAGE INTEREST	2
LITTLE OR NO INTEREST	3
NOT AT ALL	4

16. DO PARENTS TAKE KEEN INTEREST IN THE ADMINISTRATION OF THE SCHOOL?

A GREAT DEAL	1
IN SOME WAYS	2
NOT AT ALL	3

17. DO PARENTS INTERFERE WITH SET TEACHING METHODS OF THE DISABLED CHILD?

ALWAYS	1
SOMETIMES	2
NEVER	3

18. ARE PARENTS HELPFUL IN EXTRA-CURRICULAR ACTIVITIES (E.G. SPORTS DAYS, FUND RAISING FOR SCHOOL).

ENTHUSIASTIC	1
HAVE TO BE PERSUADED	2
NOT INTERESTED	3

19. DO THE DISABLED CHILDREN PARTICIPATE IN EXTRA-CURRICULAR SOCIAL ACTIVITIES.

MEANINGFULLY	1
HESITANTLY	2
INADEQUATELY	3
NOT AT ALL	4

20. DOES THE PARTICIPATION OF THE DISABLED CHILDREN IN EXTRA-CURRICULAR ACTIVITIES CHANGE OBSERVABLY AS THEY PROGRESS AT SCHOOL?

IMPROVES MEANINGFULLY	1
IMPROVES SOMEWHAT	2
DOES NOT CHANGE	3
DETERIORATES	4

21. DO YOU THINK THAT THE DISABLED CHILD EXPERIENCES DIFFICULTIES AT SCHOOL?

DUE TO HEALTH REASONS	1
TRANSPORT DIFFICULTIES	2
LACK OF HELP	3
LACK OF SPECIAL CLASSROOM APPARATUS	4
OTHER (SPECIFY)	5
N/A	6