Problems of Mentally Handicapped Children

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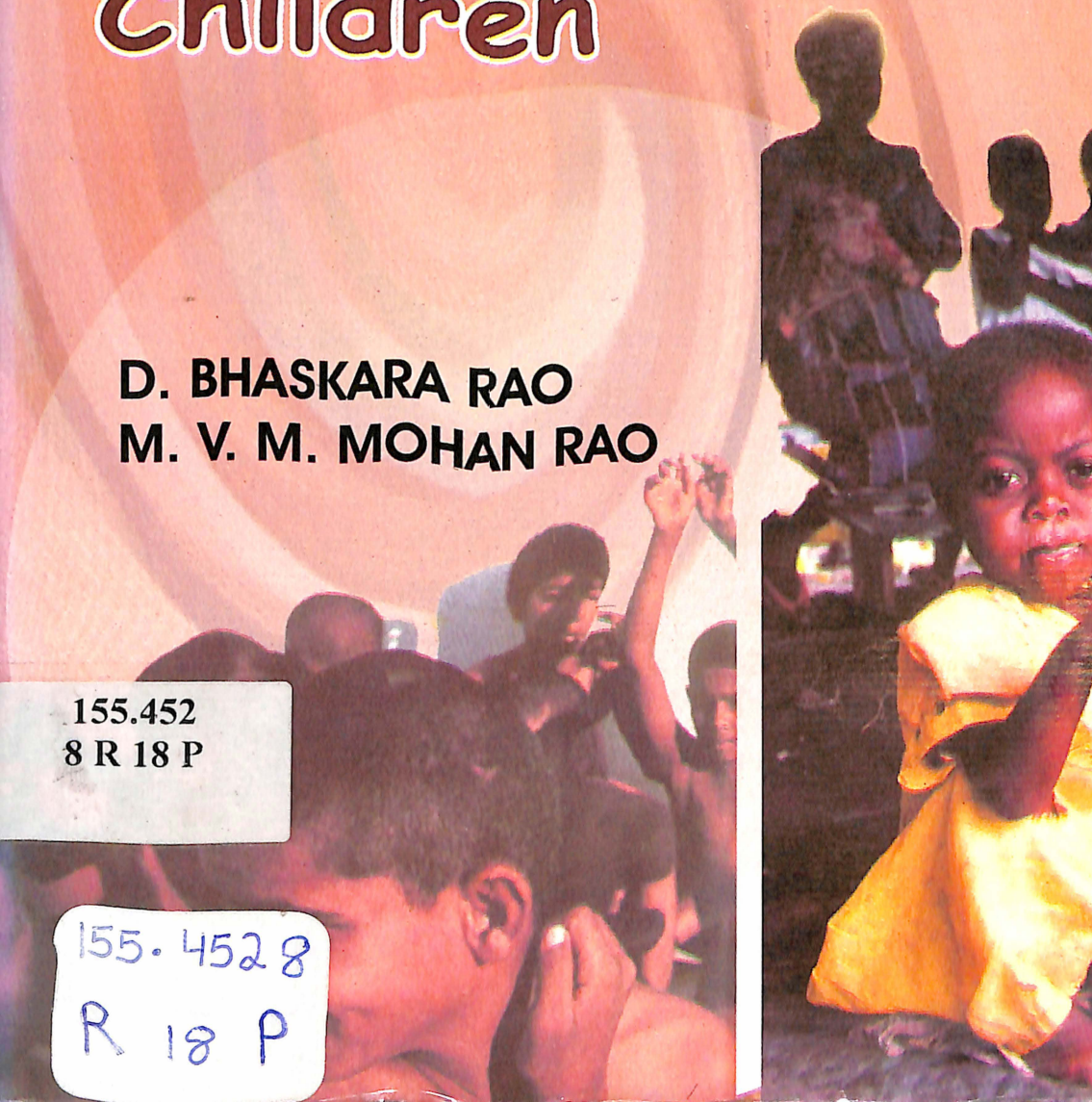

PROBLEMS OF MENTALLY HANDICAPPED CHILDREN

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Dedicated
to the
Mentally Handicapped
and to their
Parents and Counsellors

Preface

Mental handicap refers to the deficiency in mental power, and the individuals who are incapable of managing their lives on their own due to mental weakness or deficiency are called mentally handicapped.

Mental handicap is a matter of concern to parents, guardians, doctors, psychologists, psychiatrists, and educationists as it is a challenge to mankind.

The present study intended to identify the family history, motor problems, behaviour problems, assets problems of mentally handicapped, and programmes that are to be required for mentally handicapped individuals identified several problems and programmes. The teachers associated with mentally handicapped have suggested certain possible programmes which help in their day-to-day activities.

The researchers convey their blessings to the mentally handicapped children and thanks to the personnel and management of Dakshinya Institute for the Mentally Handicapped, Guntur who were the sources of this study.

The researchers are thankful to the authors, researchers, publishers, and the National Institute for the Mentally Handicapped (Secunderabad) for utilising their ideas, literature and resources in the study.

—**Bhaskara Rao**

Contents

1. Introduction

Mental handicap is a challenge to human race. This is a matter of concern to guardians, educationists, doctors, psychologists and psychiatrists. Educationists, psychologists, sociologists, and doctors have been doing researches for the last fifty years or so to develop their normal abilities.

Many times, children with mental handicap show behaviours that are considered as problematic because of the harm or inconvenience they cause for others or to the child himself. The persons of problem behaviour give strain to teachers, parents and others concerned. Besides this, they may interfere with activities in home/class room settings. These problems could be due to a number of reasons like deficits in adaptive behavioural skills, cognitive capabilities or problems solving skills. About sixty per cent of the mentally handicapped and reported to have problem behaviours. However, one has to bear in mind that children with normal intelligence also show problem behaviours. In fact, to some extent, exhibition of problem behaviour is a normal developmental phenomenon. Generally, with the advancement of age, normal intelligence children learn to behave appropriately in the given situations. This may not be achieved by the children with less intelligence. Hence, it is necessary to draw some guidelines to call a behaviour as problem behaviour.

— Behaviour which is harmful to oneself.

— Behaviour which is harmful to others.

— Behaviour which interferes with the learning tasks.

— Behaviour which is not socially accepted.

— Behaviour which is age inappropriate.

The above characteristics may be observed in everybody. Rare occurrence of these patterns cannot be qualified as problem behaviours. The main requirement for that is

— the intensity or severity of the behaviour;

— the frequency or number of times of occurrence of the behaviour; and

— the duration or length of time of the behaviour.

Nearly 50-69% of mentally handicapped individuals have behaviour problems. Presence of behaviour problems is known to produce great amount of stress and management difficulties to parents and other family members. At times, wrong advice given by well wishers to be over strict or to tolerate bad behaviours and to fulfil all demands of mentally handicapped individuals in order to keep them happy makes worse. Due to the presence of behaviour problems mentally handicapped children may find difficult to get admission in schools, and may cause embarrassment to the parents and family members. Mentally handicapped individuals may also find difficult to retain jobs or adjust to work setting if behaviour problems persist. No wonder, controlling problem behaviour is a priority for many parents.

Mental handicap (retardation) occurs among children throughout the world; in its most severe forms, it is a source of great hardship to parents as well as an economic and social

burden on the community. The incidence of mentally handicapped seems to increase markedly at ages 5 to 6, to peak at 15, and drop off sharply after that. For the most part, these changes in incidence reflect changes in life demands. During early childhood, individuals with only a mild degree of intellectual impairment, who constitute the vast majority of mental handicaps, appear to be relatively normal. Their subaverage intellectual functioning becomes apparent only when difficulties start with school work. When adequate facilities are available for their education, children in this group can usually master essential school skills and achieve a satisfactory level of socially adaptive behaviour. Following the school years, they usually make an acceptable adjustment in the community and thus lose the identity of mentally handicapped.

STATEMENT OF THE PROBLEM

"A Study of the Problems of Mentally Handicapped Children".

NEED OF THE STUDY

Behaviour disturbances are reported to be four to five times more in mentally handicapped children as compared to intellectually normal children. The stress on the family members tends to increase with the presence of behaviour or other problems in the mentally handicapped children. They impose extra caretaking demands and burden to the parents in their educational process, reduce their social acceptability and may also result in the threat of harm to themselves or to others. Therefore, it is no surprise that one of the most sought after area of service by parents of mentally handicapped children is the management of problems.

It is important for the service providers to know what are the various problems posed by mentally handicapped children to their parents for which they seek professional help. The present study attempts to analyse such problems and also try

to find, how these are related to age and sex of mentally handicapped children studying in Dakshinya Institute for the Mentally Handicapped, Guntur.

OBJECTIVES OF THE STUDY

The following are the objectives of the present study.

1. To find out the family history of the mentally handicapped children.

2. To find out the motor problems, behavioural problems, and assets problems of the mentally handicapped children.

3. To find out the difference between boys and girls with regard to motor problems, behaviour problems and assets problems.

4. To find out the difference between below 12 years and above 12 years old children with regard to motor problems, behaviour problems and assets problems.

5. To identify the programmes suggested by the concerned teachers to the mentally handicapped children.

SCOPE OF THE STUDY

The present study is confined to the mentally handicapped children attending the programmes organised by Dakshinya Institute for Mentally Handicapped located in Guntur city. Sex and age are taken as variables to identify their role. Only motor problems, behaviour problems, assets problems, family history, and suggested programmes are considered for the study.

2. Review of Related Literature

Any worthwhile research in any field of knowledge requires an adequate familiarity with the word which has been done already in the same area. A summary of the writings of recognized authorities and or previous research provides sufficient evidence that the research is familiar with what is already known and what is still unknown. Since effective research is based upon previous knowledge this step helps to eliminate the duplication of what has been done besides helping in the fixation of useful objectives, formulation of appropriate hypotheses, drawing of meaningful conclusions and making commendable suggestions.

Citing studies that show substantial agreement and those that seem to present conflicting conclusions helps to sharpen and define understanding of existing knowledge in the problem area, provide a background for the research project and makes the reader aware of the status of the issue. Parading a long list of annotated studies relating to the problem is ineffective and inappropriate. Only those studies that are plainly relevant, competently executed and clearly reported should be included in the review of related research.

The search for related literature is a time consuming process. Even then, it is necessary for a good research. Hence,

this chapter is meant for the study and citation of information and research studies related to the present study on mentally handicapped children.

MEANING OF MENTAL HANDICAP

Many terms are used to define mental retardation or handicappedness. In 1955, the term "subnormal mind" was used by British psychologists like Cyril Burt, Clerk and by the W.H.O. (World Health Organisation). In the recent revision (ICD-9), W.H.O. has preferred the term "retardation". The American Psychiatric Association (APA) uses the term "mental deficiency", commonly used term that is synonymous with "mental deficiency" or "feeble-mindedness", "amentia" and "oligophrenia". The term "amentia" is generally used to differentiate individuals with low intelligence from individuals who are mentally ill (dementia). Oligophrenia is the accepted term in continental countries. But professionals working in this area use terms like "exceptional individuals" or "typical individuals". The popular term "feeble—mindedness" is no longer used. The psychiatrists and contemporary psychologists use the term "mentally retarded" or "mental deficiency" or "mentally handicapped".

NATURE OF MENTAL HANDICAP

Mental handicap refers to the weakness or deficiency in mental power. People who are incapable of managing their lives at their own are included in the category of mentally handicapped. Wolman aptly remarked in this context, "The field of mental deficiency is concerned with individuals whose adjustments, achievements and happiness are thwarted or rendered inadequate by conditions or influences which produce a level of intellectual development markedly below normal or average".

Actually, mental handicap itself is not a personality problem and at first appears out of place as a topic in a book dealing

with abnormal psychology. There is no evidence that mental retardation and personality disturbance are synonymous or necessarily related. However, there are parallels and in some areas there is an important overlap. This overlap is seen most clearly in the relationship between mental handicap and brain syndromes.

According to Heer, mental handicap or retardation refers to "Sub-average general intellectual functioning which originates during the developmental period as associated which impairments in adaptive behaviour".

"Mental retardation refers to significantly sub-average general intellectual functioning resulting in or associated with concurrent impairment in adaptive behaviour, and manifested during the developmental period". (Grossman, 1983).

As it is seen, the definition includes essentially three components to call a person as mentally retarded.

1. Significantly sub-average general intellectual functioning.

2. Deficits/impairment in adaptive behaviour.

3. Manifested during developmental period.

Average general intellectual functioning is considered to be an Intelligent Quotient (IQ) between 90 and 110 on a standardized intelligence test. The two commonly used standardized tests in India to measure the IQ are the Indian adaption of Stanford Binet and Wechsler Intelligence scale for children. As per the definition two standard deviations below the average is considered significantly sub-average. As can be seen in figure—1, depending on the IQ score of a person, the level of retardation is determined, and are classified accordingly as borderline, mild, moderate, severe or profound.

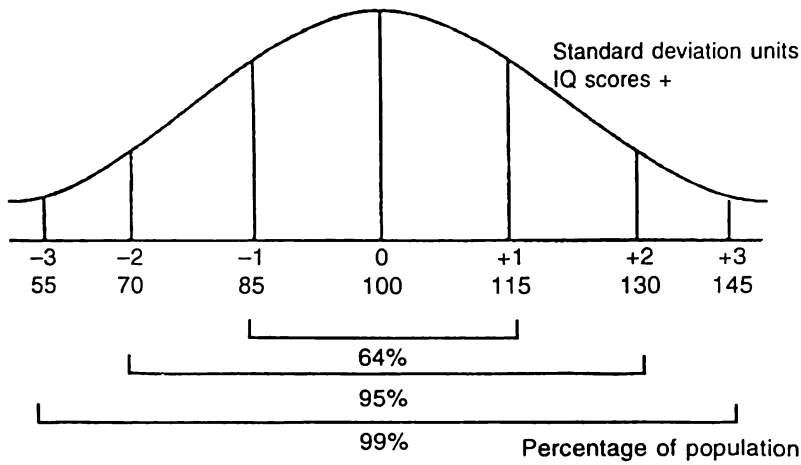


Fig. 1

The second component of the definition points to deficits in adaptive behaviour. Adaptive behaviour is defined as the effectiveness with which a person meets the standards of personal independence and social responsibility expected of his age and cultural group. These reflect the development of sensory motor skills, communication skills, self-help skills, and socialization in early childhood, application of reasoning and judgement in mastery of environment, social skills in childhood and adolescence, and vocational and social responsibilities in adult life; any deficiency in these aspects will be considered as a deficit in adaptive behaviour. For instance, if a 3-year-old child with physical defects does not walk or a 10-year-old child does not have toilet control or a 18-year-old boy does not identify a five rupee note or 50p coin, it is considered to be deficit/impairment in their adaptive behaviour.

The third component of the definition focused on the onset of condition—the developmental period, which is considered to be below the age of 18 years. In short, a person to be diagnosed as mentally handicapped should essentially have its intellectual functioning significantly below average, which results in or is associated with impairments in adaptive behaviour and should have acquired the condition before the age of 18 years.

DIFFERENCE BETWEEN MENTAL HANDICAP AND MENTAL ILLNESS

Mental handicap is different from mental illness. Mental handicap is a condition which generally leads to a handicap, where as mental illness is a disease. Mentally handicapped children are slow in learning and development. Their mental age or mental development is below their actual age. For example, a seven-year-old mentally handicapped child may act, talk and behave like a three-year-old normal child. Thus, he may show a developmental delay of four years. On the other hand, mentally ill persons do not show any developmental delay. They may show disturbances in behaviour, such as, being extremely moody, sleepless, withdrawn, seeing or hearing things which others do not see or hear, reduced appetite, etc. In rare circumstances, however, a mentally handicapped child can also have mental illness.

CLASSIFICATION BASED ON THE DEGREE OF THE MENTAL HANDICAP

The foilowing table shows the levels of retardation/ handicap:

Level of Retardation	Intelligence Quotient	
	Stanford Binet	Wechsler Scale
Profound	under 20	under 25
Severe	20—35	25—39
Moderate	36—51	40—54
Mild	52—67	55—69

In view of their typical sub-normal intelligence and deficient adaptive behaviour these categories are described below.

Mild Handicap

A majority, approximately 85 per cent, of handicapped belong to this category in adult life. These individuals attain intellectual levels comparable to that of an average ten-year-old child. Their social adjustment may be compared with that of the adolescent. They show signs of delayed development early in life and learn to walk, talk, feed and toilet themselves an year later than the average. They may be identified in schools as slow learners and are frequently required to repeat early grades. Speech disturbances are common among them.

In comparison with normal individuals, the mildly handicapped exhibit immature behaviour, have poor control over their impulses, lack judgement, and fail to anticipate the consequences of their actions. Their sexual behaviour and adjustment, in spite of the normal sexual development and fertility, is unpredictable and leads to a variety of problems and difficulties.

The mildly handicapped individuals generally do not show any organic pathology and require little supervision. They are considered to be educable. With early diagnosis, parental assistance, and aid of special classes, they can be expected to reach a reasonable degree of educational achievement and to make an adequate social and economic adjustment in the community.

Moderate Mental Handicap

Approximately 10 per cent of the total mentally handicapped belong to this category. In adult life, these individuals attain intellectual level similar to that of the average six-year-old child. Physically they appear clumsy, suffer from motor inco-ordination and present and affable, dull and somewhat vacuous personality. Because of their inadequate development and deficient capacities and abilities they are regarded as 'trainable' instead of being 'educable' like the mildly

retarded. From early infancy or childhood, they show signs of retardation in almost all areas of development; and though they manage to speak, their rate of learning is too slow. They are unable to do any work that requires initiative, originality, abstract thinking, memory or consistent attention, and cannot be expected to acquire the basic skills of reading and writing.

However, with early diagnosis, parental help and adequate training and support, most of the moderately handicapped can achieve considerable independence in all spheres of life. Nevertheless, they require constant supervision and support and need institutionalization depending on their general level of adaptive behaviour.

Severe Mental Handicap

Nearly 3.5 per cent of the total handicapped individuals—mostly children and adolescents—belong to this category. They never attain an intellectual level greater than that of the average four-year-child. They are grossly retarded in development from birth or infancy onwards and show severe motor and speech retardation. Sensory defects and motor handicaps are common. Majority of them display relatively little interest in their surroundings and many of them never master even the necessary skills and functions like feeding and dressing themselves, or bladder and bowel control. The severe mentally handicapped are neither "educable" nor "trainable" and the majority of them remain dependent on others throughout their lives. They need care and supervision of others with a great need for institutionalization. They may profit with proper care, timely treatment and specialized training in managing their own physical well-being and doing manual labour.

Profound Mental Handicap

This group make 1.5 per cent of the total mentally handicapped population. It is characterized by the most severe symptoms of mental handicappedness. The individuals

belonging to this category never attain in adult life an intellectual level greater than that of the average two-year-old child. They are severely deficient both in their intellectual capacities and adaptive behaviour. The symptoms associated with them are retarded growth, physical deformities, pathology of the central nervous system, severe speech disturbances, motor incoordination, deafness, and convulsive seizures. They are unable to protect themselves against common dangers and are unable to manage their own affairs, and satisfy their physical needs. Their life span, as a result of their low resistance, is too short. Such individuals are completely dependent on others and need the care and supervision given to an infant. Essentially, they need to be institutionalized as their condition deteriorates on account of the biased attitude of the parents.

CLASSIFICATION OF MENTALLY HANDICAPPED ON THE BASIS OF THE RATE OF LEARNING AND EDUCABILITY

There has been a movement by the professionals and parents regarding the issue of classifying and labeling the mentally handicapped persons. It is considered to be stigmatizing them with a label and would also restrict the teacher in concentrating on specific abilities only. Currently there is a trend towards delabeling (not referring to them by their level of retardation). But, let us see the classification of mentally handicapped on the basis of the rate of learning and educability.

Dull (IQ 75—80/90)

Capable of competing in school in most areas, except in the strictly academic areas in which performance is below average. Social adjustment that is not noticeably different from the larger population, although in the lower segment of adequate adjustment. Occupational performances will be satisfactory in non-technical areas, with total-support highly probable.

Educable (IQ 50—75)

Second to fifth grade achievement in school academic areas. Social adjustment will permit some degree of independence in the community. Occupational sufficiency will permit partial or total self-support.

Trainable (IQ 20—49)

Learning takes place primarily in the areas of self-help skills. Very limited achievement is seen in areas considered academic. Social adjustment is usually limited to home and closely surrounding area. Occupational performance is primarily in sheltered workshop or an institutional setting.

Custodial (IQ Below 20)

Usually unable to achieve even sufficient skills to care for basic needs. They, usually, require nearly total care and supervision throughout their life time.

COMMON CLINICAL TYPES OF MENTALLY HANDICAPPED

The knowledge of well-known categories of mental deficiency or handicapped based on a number of clinical symptoms and syndromes is useful in the identification, treatment and care of the handicapped.

Mongolism

The mental deficient whose facial characteristics bear a superficial resemblance to members of the Mongolian race are classified as Mongols. The handicappedness in them ranges from moderate to severe (IQ approximately 20—50).

The Mongoloids tend to be short in stature with small round heads, abnormally short neck, thumbs and fingers, slanting almond-shaped eyes, and short flat noses. They usually have a

small mouth, fissured and dry lips and tongue. Their hands and feet are broad and clumsy, and they have a deep voice. Motor co-ordination is awkward. They are handicapped in any learning or training, but most of them can learn self help skills, acceptable social behaviour and routine manual skills.

The causes of mongolism are faulty heredity, possible chromosomal anomalies, and metabolic factors (glandular imbalance often involving pituitary glands). But, once it occurs, it is irreversible. There is no effective treatment or workable preventive measure.

Cretinism

This mental deficiency ranging from moderate to severe handicapped results from thyroid deficiency. The severity of the disorder depends on the age at which the deficiency as well as on the degree and duration of the deficiency.

The physical symptoms in the case of persons suffering from cretinism consist of a dwarf-like thick-set body, coarse and thick skin, short and stubby extremities, abundant hair of wiry consistency and thick eyelids that give a sleepy appearance. Other pronounced symptoms include a broad flat nose, large and flabby ears, a protruding abdomen and failure to mature sexually. Early timely treatment in the form of injection of thyroid gland extract produces favourable results in all cases except those of long standing where the damage to the nervous system and to general physical development is beyond repair.

Microcephaly

It refers to mental deficiency associated with failure of cranium to attain normal size on account of the impaired development of the brain. The microcephalic has an unusually small head which rarely exceeds a circumference of seventeen inches, as compared with the normal of approximately twenty-

two inches. In addition, he is short statured with the usual cone-shaped skull and receding chin and forehead. Depending upon the degree of severity of mental handicap, microcephalic fall into the profound, severe and moderate categories of mentally handicapped.

Both genetic as well as non-genetic factors impair development of the brain and thus cause microcephaly. There is no proper medical treatment available for microcephaly if there has been impaired brain development.

Hydrocephaly

This mental deficiency results from the accumulation of an unusually large amount of cerebro-spinal fluid within the cranium, causing damage to the brain and enlargement of the skull.

The main symptom is hydrocephaly consists of the gradual increase in the size of the skull. The causes seem to be genetic as well as non-genetic. In some cases, the disorder is present at birth or the head begins to enlarge soon after birth on account of prenatal disturbances. More often, the disorder develops during infancy or early childhood on account of intracranial neoplasm or acute inflammatory brain disease.

An early diagnosis and proper surgical treatment show favourable results in checking further damage of the brain tissue. However, the advanced acute stage does not respond to any treatment and eventually results in death.

Phenyleketonuria (PKU)

This disorder has a genetic base and is assumed to be transmitted through a recessive gene carrying metabolic disturbance. As a result the child at birth lacks an enzyme needed to breakdown phenylalanine, an amino acid found in protein foods. Consequently, there will be an abnormal

accumulation of phenylalanine in the blood causing damage to the brain tissue.

The symptoms such as vomiting, a peculiar musty odour, infantile eczema and seizures, motor in co-ordination, signs of mental retardation and neurological manifestations relating to severe brain damage are found to be common with this disorder. However, diagnosis of this disorder can be primarily made on the basis of the presence of phenylpyruvic acid in the urine.

The treatment of PKU depends on early detection. Special diet, low in phenylalanine, is recommended to the affected infants. Timely treatment helps in restraining or preventing brain damage.

Amaurotic Idiocy

It is a rare hereditary disorder of fat metabolism transmitted as a simple recessive characteristic. It is never transmitted directly from parent to offspring, because death generally occurs before puberty. The only mode of transmission is through the mating of persons who although free of overt symptoms, are carriers of the defective genes. This disorder has been described to occur in two different forms—infantile and juvenile—depending on the ages at which it occurs.

The major symptoms of this disorder include muscular weakness, inability to maintain normal posture, loss in the ability to grasp objects, visual difficulties leading to progressive blindness, seizures and neurologic manifestations.

Infantile Amaurotic Idiocy

Also known as Tay-Sachs disease, it is common among infants. The disorder appears at about six months of age and death occurs between the ages of two and three years. Juvenile Amaurotic Idiocy occurs at five or six years of age and the patient my live up to thirteen years.

OTHER DISORDERS ASSOCIATED WITH MENTAL HANDICAP

Trisomy Syndrome

Peculiar pattern of multiple congenial anomalies such as lowered malformed ears, flexion of fingers, small mandible, and heart defects are seen. The cause for these problems is autosomal anomaly of chromosome 18.

Tay-Sachs Disease

The common features of this disease are hypertonicity, restlessness, blindness, progressive spastic paralysis and convulsions (death by the third year).

The reason for this problem is disorder of lipid metabolism, carried by the single recessive gene.

Turners Syndrome

The clinical features present are webbing of the neck, increased carrying angle of forearm, and sexual infantilism. Sex chromosome anomaly is the main cause.

Klinefelters Syndrome

The clinical features vary from case to case, the only constant finding being the presence of small testes after puberty. Sex chromosome anomaly is the main cause.

Niemann-picks Disease

The onset of the problem is usually in the infancy, with loss of weight, dehydration and progressive paralysis. Disorder of lipoid metabolism is the main cause.

Bilirubin Encephalopathy

Abnormal level of Bilirubin (a toxic substance released by red cell destruction) is found in the blood. Often Rh, ABO blood

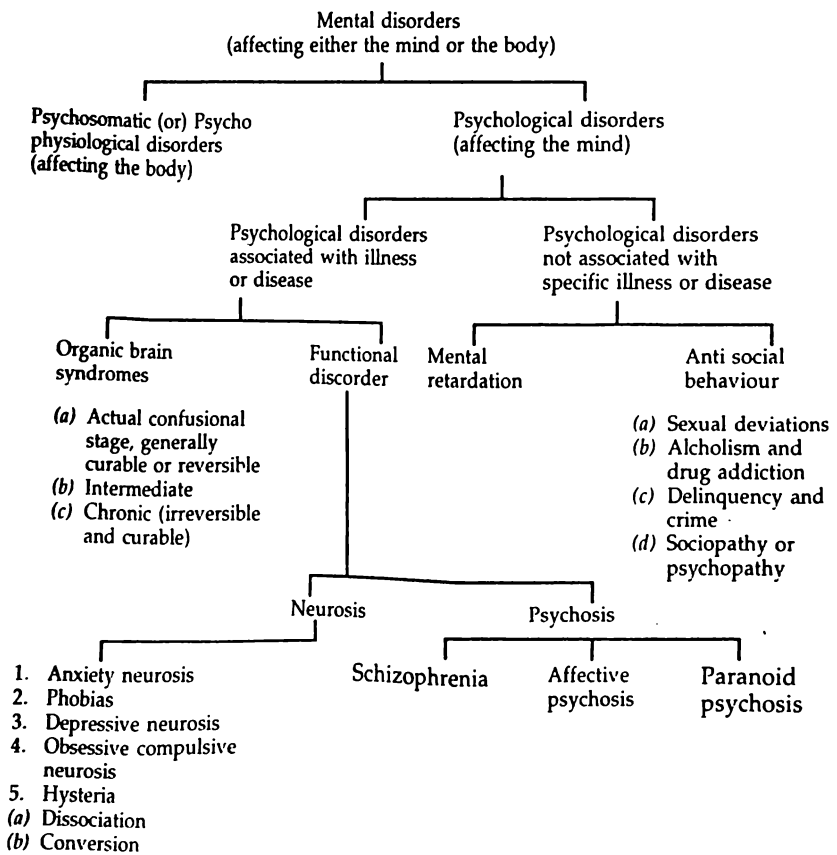
group incompatibility between mother and fetus is the main cause of bilirubin encephalopathy.

Rubella Congenital

The main problems seen are visual difficulties with cataracts and retinal problems often occurring together with deafness and anomalies in the values and septa of the heart.

CLASSIFICATION OF MENTAL DISORDERS

As per S.K. Mangal, the following is the classification of mental disorders.



CAUSES FOR MENTAL HANDICAP

Heredity

Heredity is the most important and major cause of mental handicap. About 50% to 75% of mentally handicapped children come from families in which the members are intellectually weak or possess less than average intelligence. Hopwood, Penrose, Kirk and Keiser made studies which revealed that feeble-mindedness of the parents is one major cause of mental handicap. In twins, very rarely, one child may be normally intelligent and other mentally handicapped. The studies conducted by Rosanof and his associates indicated that, as a general rule, 91% of the identical twins and 53% of the fraternal twins exhibit signs of mental retardation. This view has been confirmed by other psychologists also on the basis of statistics collected by them.

If the development of brain of parents is not proper it can be inherited by their sons or daughters. The study of Goddard revealed that only 6 children were normal out of 100 children of 40 feeble-minded parents. If the parents has the diseases of nerves, *i.e.* epilepsy, syphills, etc., children can also show the same.

Consanguinity

It is universally accepted belief that sexual relationship with blood relatives will result in the birth of mentally handicapped children. It is certainly true that the case of sexual intercourse with relatives of blood can increase the danger of defective genes becoming concentrated and manifesting themselves in the form of defects in any child that is born. But, even in a case of sexual intercourse with blood relatives, if no defects persists in either or the two parents, retarded child will not be born.

Preconceptional Factors

This includes factors before a woman conceives. Some of the preconceptional factors are history of mental handicap in the

family of either the husband or the wife, maternal age at conception and history of infertility or repeated abortions in the mother (heredity factors).

Prenatal Factors

Factors affecting during pregnancy are called prenatal factors. This includes in the mother such as jaundice, chicken pox and measles especially in the first three months of pregnancy, injury to the abdomen of the mother due to the accidents, X-ray exposure of the abdomen especially in the early months, drug intake without medical advice, attempted abortion, mother getting fits during pregnancy, Rh blood incompatibility and so on. Pregnant women consuming alcohol and tobacco is harmful to the growing child during pregnancy. Chromosomal aberrations also cause mental retardation. Some times, at conception, an extra chromosome may be formed resulting in Down's syndrome. Maternal malnutrition is reported to be one of the causes for the birth of a handicapped.

Natal Causes

Natal causes are those factors that affect the child during birth. This would include premature delivery, prolonged labour when the oxygen supply to the child's brain may be insufficient thus damaging the brain, abnormal presentation of the baby at delivery, too small-sized pelvis of the mother to allow easy birth of the baby, inappropriate use of forceps or improperly attended delivery by untrained persons, and delayed birth cry of the baby.

Post-Natal Causes

The post-natal causes or the factors affecting after the birth of the child leading to mental handicap include low birth weight, metabolic disorders, brain fever of meningitis, encephalitis, epileptic fits, measles, chicken pox, head injury, poor nutrition and jaundice in infancy and childhood.

GENERAL CHARACTERISTICS OF MENTALLY HANDICAPPED

The following are the main characteristic conditions of mentally handicapped and it is on the basis of these characteristics that the mentally handicapped individuals can be separated and distinguished from the normal individuals.

Slower Intellectual Growth

Mental handicappedness is characterized by low intelligence in comparison to normal individuals. It is lack of certain innate mental capacity. The intellectual growth of the mentally handicapped individuals is slower than that of the normal. The growth ceases earlier. Gradually the gap tends to increase with age and becomes permanent and largely irremediable. The following mental characteristics are observed in mentally handicapped.

— Incomplete development of mind.

— Retarded individuals lack in concentration and co-ordination.

— Their attention become diverted very easily.

— They cannot concentrate on or stick to anything or subject for long.

— The power of recollection is limited and the range of memory is narrow.

— Their power of imagination and thinking is low and limited and therefore they avoid thinking.

— The creative impulse is also very low.

— They possess a poor self-concept and are very impulsive.

— They have short interest and attention span.

— They are unable to think abstractly or to handle symbolic materials.

Inability to Learn

Some experts have termed mental handicap as educationally subnormal. From that angle, one of the predominant characteristics of mentally handicapped is their inability to learn. They have difficulty in understanding common learning materials. Though a number of characteristic conditions are observed in them, inability to learn is considered as most important one in educational point of view. Their sub-average general intellectual functioning results in reduced learning capacity.

Social Immunity

Socially they demonstrate immunity and to some degree, depending on the severity of the case, they may remain dependent on adults and require some protection, guardianship or guidance in their life. The individuals become incapable of adjusting themselves to their social environment efficiently and harmoniously and become dependent on external control, care, assistance and supervision. The following are some of the important characteristics that are included under social immaturity.

— They lack self-control and self-sufficiency.

— They do not have the ability or means to earn their livelihood independently and are dependent upon others for material help and assistance.

— They cannot solve their own social and personal problems and difficulties.

— They tend to indulge in immoral, criminal and anti-social activities without knowing and understanding the nature and consequence of their acts.

— They develop inferiority complex in front of their age-mates.

— They are rejected and under-estimated by society.

Linguistic Characteristics

From the linguistic point of view, they show inability to construct compound sentences. They have limited vocabulary. Their sentences are limited within two or three words. It has been observed that they use less pronouns and prepositions in their language activities. They have communicative deficiencies such as lowered use and understanding of abstract words and ideas, generalizations and descriptive language.

Slower in Sensory—Motor Development

The sensory-motor development in mentally handicapped is slower as compared to the normal child. They take longer time to make progress in physical activities such as walking, habit training, self-fooding and language development. They take more reaction time for which they cannot perform any delicate activities. Besides, the speed of reaction they have is muscular co-ordination. The motor skills are also poor.

Defects of Drives and Emotions

Since the mentally handicapped lack mental power, they also suffer from defects of drives and emotions. These defects originate due to inborn deficiency. Mentally handicapped individuals suffering from defects of drives and emotions may, in extreme cases, show the lack of even vital drive of self-preservation. If that is so, they become incapable of showing their own hunger and thirst and find it difficult to escape

impending danger. The emotional life of every handicapped individual is sometimes worse than the animals. There is almost complete absence of complex emotions in them.

Defects of Personality

The personality traits of mentally handicapped individuals are different from that of normal. When there is lack of requisite mental power, the personality also undergoes disorganisation. Therefore, generally, the personalities of mentally handicapped individuals are not dynamic and lack courage and strength and other good qualities. Normally, they possess a personality that is unattractive, unstable and liable to be easily influenced.

DETECTION OR IDENTIFICATION OF MENTAL HANDICAP

Mental handicap is concerned with the retarded or arrested growth and development of one's intellectual functioning or with the inability to adapt one's behaviour to the environmental needs. The causes may range from a genetic basis of biochemical, neurological, accidental, infectious and socio-psychological determinants. Whatever the degree of severity of the retardation, its prevention and treatment involves detection and identification at an early stage.

Detection Before Birth

By means of certain tests in which a small amount of fluid surrounding the developing fetus is examined and it is possible to screen metabolic diseases or the incurable chromosomal abnormalities affecting the developing fetus.

Detection At the Time of Birth

Most of the metabolic diseases and developmental defects causing mental retardation may be detected soon after birth. For example, Phenyleketonuria (PKV) may be easily diagnosed

through detection of phenylpyruvic acid in a new born infant with the help of the urine test or a relatively simple blood test. Similarly, congenital cerebral defects causing biological disorders for the mental retardation like macrocephaly, microcephaly, hydrocephaly may be detected soon after birth.

Collecting History of the Causation or Development of Mental Retardation

Useful information about the history of the causation and development of mental retardation can help in the identification of disabilities among the retarded. This may be in the form of genetic information, the prenatal history of the child and the mother's condition and experiences during pregnancy, history of labour and delivery, blood group incompatibility, exposure to infections and chronic diseases, happenings in the form of accidents, seizure and impairment in motor and intellectual development, emotional episodes and psychological stresses.

Assessment of Intellectual Functioning

Intelligence test scores in terms of IQ are used not only for identifying or segregating individuals with subnormal intellectual capacities but also for classifying the severity of their mental retardation into various categories (like moron, imbecile and idiot) and degrees (like moderate, severe and profound).

However, the diagnosis of subnormal intellectual capacity cannot be made merely on the basis of a relatively low IQ. The following characteristics such as the following should be kept in mind. *(i)* Mentally subnormal children lack much in the power of observation, imagination, thinking and reasoning and ability to generalize. *(ii)* They are poor at abstraction and can only think in terms of concrete objects and situations. *(iii)* They are slow learners. It has been found that they take longer to learn a skill. *(iv)* They are poor at following general verbal instructions, unless these are repeated at frequent intervals. *(v)* Their rate of intellectual development is too slow in comparison with children

of their own age. *(vi)* The areas of their interest, aptitudes and choices are limited. *(vii)* The creativity aspect is almost absent in such children.

Assessment of Adaptive Behaviour

In addition to the criterion of subnormal intellectual capacities, an assessment of one's deficiency in terms of adaptive behaviour and personality problems may also prove helpful in the diagnosis of mental handicap. The mentally handicapped are socially as well as emotionally maladjusted personalities. They do not realize that right and obligations towards others and often have deficient moral judgement and suffer from character disorders.

Most of these handicapped are dependent and experience difficulty in managing their affairs. In some severe cases, the extent of personal independence is so limited that they are incapable of protecting themselves against common physical dangers. Personality problems and deficiency in terms of adaptive behaviour may be assessed through a keen observation, or with the help of tests like Adaptive Behaviour Scale and Minnesota Developmental Programming System.

Prevention

The primary step towards prevention of mental retardation is to have a regular check up during pregnancy, intake of healthy and nutritious food, being careful to avoid contact with people who have infections such as measles and chicken pox, and avoiding physical trauma or accidents such as carrying heavy weights or reaching for objects which are at a height. If the parents choose to have an abortion it should be conducted by medical persons. If the elder child is mentally handicapped, it is better to get medical advice before delivering another child. It is advisable to restrict the maternal age of conception between 20 and 30 years.

The delivery should be attended by trained persons and ideally conducted in the hospitals where facilities are available in case of emergency. The mother should make it a point to have the delivery in a hospital especially if her other baby is already mentally handicapped due to birth trauma.

After the birth of the child, he should be duly immunized against tuberculosis, poliomyelitis, diphtheria, whooping cough and tetanus. Care must be taken to see that he does not develop high fever leading to loss of consciousness. Prompt medical attention should be given to keep the temperature reduced. Epileptic fits should be attended by doctors immediately and the medicines prescribed should be given regularly. If there is a delay in the development of the child such as sitting, standing, walking or talking, immediate professional attention should be sought.

REMEDIAL MEASURES FOR MENTALLY HANDICAPPED

Whatever preventive measures one may adopt, it is neither possible nor feasible to eliminate completely the possibility of the occurrence of mental handicap. One thing which should be made clear while seeking treatment of mental handicap is the fact that there is no cure for mental deficiency.

Medical or Physical Measures

Mental handicap, to some extent, is said to be a medical problem. The following medical measures may prove helpful in some cases.

Cretinism: This mental handicap resulting from deficiency in thyroid secretion, if recognized at birth or in its early manifestations, may be corrected or controlled by the institution of thyroid therapy.

Congenital Syphilis: Children infected with congenital syphilis are usually found to be suffering from severe mental

subnormality. An early detection and prompt penicillin therapy is found to be helpful in the prevention as well as control of many effects of congenital syphilis.

Phenylketonuria: On early detection, with the help of a simple urine test, this metabolic disorder causing mental handicap may be checked or controlled, to a great extent, by placing the infant on a special diet relatively free of phenylanine found in most protein foods.

Hydrocephalus: Hydrocephalus, resulting from the accumulation of an abnormal amount of cerebrospinal fluid within the cranium results in mental retardation. Surgical treatment is found to be very effective in the treatment of this disorder. It is aimed at the reduction of the normal production of cerebrospinal fluid or to the channeling of the fluid by removing blockade or obstruction resulting from congenital malformations or post-natal infections.

Epileptic Seizures: In the case of patients subjected to epileptic seizures, the administration of anticonvulsant medication may prove helpful in controlling and minimizing intellectual deterioration.

Controlling Disturbed Behaviour: The administration of tranquilizers proves useful in controlling hyperactive and disturbed behaviour among mentally handicapped.

Psychological Treatment

Often, on account of the link between mental subnormality and psychological factors, psychological treatment in the form of individual or group psychotherapy is found to be useful in providing remedial measures for mental handicap. Children can be helped in solving problems of their emotional and social maladjustment and resolving their mental conflicts through psychological measures.

Educating the Parents

Parents can also help on the welfare and care as well as treatment of the mentally handicapped. For this purpose, there is a need for proper counselling service for them. First, parents should accept the truth about their child. Secondly, they should get education to behave normally with their mentally subnormal child without being over protective or rejecting the child. Thirdly, they should get education to provide essential training at home to their mentally handicapped child. Finally, the parents should be made to realize that, if needed, there is no harm in sending their children to special schools meant for the mentally handicapped.

PROVISION OF SPECIAL EDUCATION AND TRAINING

(i) There should be proper grouping and classification of the mentally handicapped children on the basis of the degree of the diversity of their retardation.

(ii) The "educable" should be educated and the "trainable" should be trained.

(iii) The schools should provide essential environment for maximum development of the abilities and capacities of all mentally handicapped.

(iv) There should be a provision for specially trained teachers who are able to utilize new materials and techniques for their education or training.

(v) The special schools should have the provision for vocational education and training.

The education or training should begin at home. Thereafter, special schools or institutions may be involved. The society and the state should take the responsibility for their rehabilitation and adjustment.

SOME RESEARCH STUDIES ON MENTAL HANDICAP

Reeta Peshwaria, S. Venkatesan and D.K. Menon (1989) analyzed the parental needs with regard to behaviour problems in their mentally handicapped children in twelve areas, *viz.*, physical harm towards others, damages property, misbehaves with others, temper tantrums, wanders, disobedience, repetitive behaviours, fears and sexual problems. The trends in parental needs of behaviour problems were analyzed in terms of severity, sex and age of the mentally handicapped persons, with reported behaviour problems registered at NIMH during the year 1987 and 88. The findings are:

In terms of overall needs, parents predominantly seek help for managing problems of disobedience in their mentally handicapped children, followed by physical harm towards others, odd behaviours, damages property, wanders, and misbehaves with others. The least perceived behaviour problem is in the sexual area, which could be more due to inhibitions in the parents of mentally handicapped children to openly report on such matters at first contact.

In terms of severity of mental handicap, the trends appear to be similar for the mild and moderate groups where disobedience and physical harm towards others are perceived as major behaviour problems in contrast for the severe and profound groups of mentally handicapped children. Odd behaviours are perceived as more common features.

In terms of age of mental handicap parents, they are expecting more obedience from their children as they advance in years. Probably, age does influence behaviour problems as indicated by the results of this study. However, misbehaviour with others and disobedience appear to increase with age.

As regards to sex variable, the characteristic trend appears to be that disobedience predominates in the males and is followed by physical harm towards others; the reverse is

reported for females. Physical harm towards others is perceived by parents as a greater problem than disobedience.

In terms of the family variable, it appears that both parents from nuclear as well as non-nuclear families perceive disobedience as the major behaviour problem in their mentally handicapped children.

Analysis in terms of area of residence reveals that parents of mentally handicapped children from urban set-up report more behaviour problems related to disobedience in contrast with parents from rural set-up who report a greater frequency of physical harm towards others followed by wandering.

E. Bromely and Jan Blacher (1991) found the parental reasons for out-of-home placement of children with severe handicap are child's behaviour problems, daily stress; and the child's low level of functioning has strong influence on the placement decision. Results of the study suggest that the behaviour problems and level of functioning were also strong contributors. This study was conducted over 66 parents who placed their children out-of-home.

Rutter, *et. al.* (1976) reported that behaviour disturbances are reported to be four to five times more in mentally handicapped persons as compared to intellectually normal persons. This results was concluded when a comparative study was done to find out the behaviour problems existing in school going children.

Peshwaria, *et. al.* (1988) found that one of the most sought area of service by parents of mentally handicapped children is the management of behaviour problems. This was analysed when a survey was conducted to find out the expectations of parents, whose children are undergoing rehabilitation services at National Institute for the Mentally Handicapped. (Government of India), Secunderabad.

Mortimore, *et. al.* (1983) found that the behaviour problems interfere in the educational process of mentally handicapped children. It was found that behaviour problems hinder the learning process of mentally handicapped children, especially of small children, with maximum deviation in attention and concentration areas. This study was carried out on a group of children who were attending special schools.

Blacher and Rousev (1988) reported that children exhibit low adaptive behaviour, when compared to a sample of children with severe retardation remaining at home. This study was carried out on severe mentally handicapped who were remaining in their home for the past five years.

German and Maist (1982) found that maladaptive behaviour or behaviour problems of the mentally handicapped children played a vital role in placement of children out of home. This study was carried out on 100 parents who placed their children out of home.

Terence L. Belcher (1994) found that increased frequency of maladaptive behaviour problems occur with individuals moving from large institutions. Results revealed that maladaptive behaviours exhibited in institutions decreased significantly after one year, when they were brought back to community.

Studies were conducted on mentally handicapped children taking their learning capacities, rural and urban, and children staying out of home. Few studies were carried out comparing retardation with variables like age and sex. This study on "problems of mentally handicapped children" was undertaken in order to study the problems of mentally handicapped studying in a special school, Dakshinya Institute for the Mentally Handicapped.

3. Research Methodology

Design is the heart of any research. The following aspects have been discussed which are concerned with the design of the present study entitled "A Study of the Problems of Mentally Handicapped Children".

Taking the objectives into consideration the following variables were selected for the present study: *(i)* Boys versus Girls, *(ii)* Handicapped aged above 12 years versus below 12 years. The population of the present study, namely, Mentally Handicapped Children, was selected from the Dakshinya Institute for the Mentally Handicapped, Guntur. After a detailed study of the different sampling techniques, the cluster sampling technique was used for selection of sample.

OPERATIONAL DEFINITIONS OF KEY TERMS

The different terms that have been used in this study are defined in order to understand them properly in the present context.

Mentally Handicapped Children

Mental retardation refers to a chronic condition present from birth or early childhood which is characterized by both impaired intellectual functioning as measured by standardized

tests and impaired adaptation to the demands of the individual's social environment. (*Rusen, Fox and Gregory*)

As per the British Mental Deficiency Act, mental retardation is a condition of arrested or incomplete development of mind existing before the age of 18 years whether arising from inherent causes or induced by disease on injury.

As per American Association of (AAMR, 1993), the mental retardation refers to substantial limitation in present functioning, characterized by significant and sub-average intellectual functioning, existing concurrently with related limitation in two or more of the adaptive skill areas like communication, home living, community use, help and safety, leisure, self care, social skills, self direction, functional academics and work, the manifestation of mental retardation before the age of 18 years.

Here, in the present study, mentally handicapped children are those who are with impaired intellectual functioning and maladaptive behaviour.

Behaviour Problems

In our lives, we perform so many activities. We sit, stand, chew, cry, appreciate, swallow, respect, fear, like, dislike, etc. All these are some of the examples of the activities we perform in our daily life. Some of our activities are directly observable while some are not directly observable. In other words, some activities can be directly seen while some activities can not be directly seen as they are abstract and can only be interpreted. For example, the activity "Happy" can not be seen directly. It can be only interpreted through behaviours, such as, smiles, laugh, etc. Such several behaviour aspects are considered and if they are not normal, they are considered behaviour problems.

Motor Problems

The problems concerned with the muscular activities or functions of the mentally handicapped children are considered

as motor problems. For example, speech, walking, running, sitting, standing, writing, etc.

Assets Problems

The problems concerned to the life and social activities to be used in daily life such as arithmetic, bathing, dressing, games, etc., are considered as assets problems.

VARIABLES OF THE STUDY

The variables considered for the present study were sex and age.

Sex

Both mentally handicapped boys and girls were included in the present study to find out whether there is any difference between boys and girls as many researchers and psychologists state that there will be differences between male and female human beings in physiological and phychological aspects.

Age

As human beings grow and develop physiologically and psychologically in accordance with the chronological age, the age was taken into consideration as a variable. The whole sample of mentally handicapped children were divided into two categories, namely, below 12 years and above 12 years.

SAMPLE OF THE STUDY

After finalising the variables of the present study, consideration was given to whether the entire population is to be made the subject for data collection or a particular group is to be selected as representative of the whole population. The "entire population" here refers to all the mentally handicapped children. Considering the resources that are available for the present study and the sample to be selected for the study, and taking the objectives into consideration the cluster sampling technique was chosen to select the sample for the study.

The advantages of the cluster sampling are: *(i)* When sampling frame of all elements is not available, we can resort only to cluster sampling. This often is the case in practice. *(ii)* In cluster sampling, the field work gets localised or concentrated on a "cluster", as information is simultaneously obtained on all the elements of the cluster, whereas sampling by elements there may be wider selection of elements in the field or operation. As such, field cost for collecting data with cluster is comparatively lesser, and further, the fieldwork period will also be lesser. *(iii)* Cluster sampling is also useful to collect qualitative data of an area or institution.

By following cluster sampling technique, 110 mentally handicapped children were selected as sample from the Dakshinya Institute for the Mentally Handicapped, Guntur; out of which, when classified variable-wise, 78 were boys and 32 were girls, and 78 were above 12 years of age and 32 were below 12 years of age.

SELECTION OF TOOL

A research tool plays a major role in any worthwhile research as it is the sole factor in determining the sound data and in arriving at perfect conclusions about the problem or study at hand, which ultimately helps in providing suitable remedial measures to the problem concerned.

The problems or allied aspects of the mentally handicapped children were categorized as family history, motor problems, behaviour problems, assets problems and programmes suggested to the mentally handicapped children. The teachers working in the Dakshinya Institute for the Mentally Handicapped, were asked to provide data of each mentally handicapped child studying in Dakshinya Institute for the Mentally Handicapped. Using the Behaviour Checklist developed by the National Institute of Mentally Handicapped (Government of India), Secunderabad. The information thus collected was used as raw data for analysis and drawing conclusions.

4. Analysis of Data

The next steps in the process of research, after the collection of data, are the organisation, analysis and interpretation of data and formulation of conclusions and generalizations to get a meaningful picture out of the raw information collected, the analysis and interpretation of the researcher and his subjective reactions and desires to be derived from the data.

The mass data collected through the use of tool, need to be systematized and organized, *i.e.* edited, classified and tabulated before it can serve the purpose. Here, editing implies the checking of gathered data for accuracy, utility and completeness; classifying refers to the dividing of the information into different categories, classes or heads for use; and tabulating denotes the recording of the classified material in accurate mathematical terms, *i.e.*, marking and counting frequency tallies for different items on which information is gathered.

Analysis of data means studying the tabulated material in order to determine inherent facts or meanings. It involves breaking down the existing complex factors into simpler parts and putting the parts together in new arrangements for the purpose of interpretation.

The raw information collected from the mentally handicapped children was arranged in rank order depending on

the frequency on occurrence of each problem or allied aspect. The frequency of each problem or allied aspect was converted into percentages. The conclusions were drawn based on the frequency of occurrence of each problem or allied aspect and also based on the presence or occurrence of each problem or allied aspect.

Family History

1. To identify the family history of the mentally handicapped children, data was collected about the mental handicap of the family members. The information is given below in Table—1.

Table—1. Family History of The Mentally Handicapped Children

S. No.	Family History	Frequency (N = 110)	%
1.	Father	2	1.81
2.	Mother	1	0.90
3.	Brother	6	5.45
4.	Sister	5	4.54
5.	Father's Sister	1	0.90

As per Table—1, the sample of mentally handicapped children is with little family history of mental handicap. Of the total sample, six brothers, five sisters, two fathers and one mother are with mental handicap.

Motor Problems

2. The motor problems of the mentally handicapped children were recorded and are given in Table—2.

Table—2. Motor Problems of The Mentally Handicapped Children

S. No.	Motor Problems	Frequency (N = 110)	%
1.	Speech	45	40.90
2.	Jumps	40	36.36
3.	Skips	37	33.63
4.	Writing	32	29.09
5.	Running	22	20.00
6.	Unscrews a bottle lid	13	11.81
7.	Walking	9	08.18
8.	Epilepsy	9	08.18
9.	Walks up	6	05.45
10.	Walks down stairs	6	05.45
11.	Standing	2	01.81
12.	Eyes/ears	2	01.81
13.	Right/left leg	2	01.81
14.	Right/left hand	2	01.81

As per the self-explanatory Table—2, there are 14 motor problems associated with mentally handicapped children. Speech, jumping, skipping, writing, and running are the most predominant motor problems, and the least occurring motor problems are standing, problems of eyes/ears, problems of right/left leg, problems of right/left hand.

3. Motor problems associated with either sex of the mentally handicapped children are given in Table—3.

Table—3. Motor Problems of The Mentally Handicapped Children: Sex–wise

S. No.	Motor Problems	Boys		Girls	
		N = 78	(%)	N = 32	(%)
1.	Speech	32	41.02	13	40.62
2.	Jumps	27	34.61	13	40.62
3.	Skips	24	30.76	13	40.62
4.	Writing	20	25.64	12	37.50
5.	Running	14	17.94	8	25.00
6.	Unscrews a bottle lid	8	10.25	5	15.62
7.	Epilepsy	6	07.69	3	09.37
8.	Walking	4	05.12	5	15.62
9.	Walks up stairs	3	03.84	3	09.37
10.	Walks down stairs	3	03.84	3	09.37
11.	Right/left hand	2	02.56	–	–
12.	Right/left leg	2	02.56	–	–
13.	Standing	1	01.28	1	03.12
14.	Eyes/ears	1	01.28	1	03.12

As per the self-explanatory Table—3, boys are having more motor problems when compared with girls. The frequency of occurrence of motor problems is also differing from boys to girls.

The predominant motor problems of the boys are speech, jumping, skipping, writing, etc., and the least are problems of eyes/ears, standing, problems of leg, problems of hand.

The predominant motor problems of the girls are speech, jumping, skipping, writing, etc., and the least are problems of eyes/ears, standing, etc.

4. Motor Problems of the mentally handicapped children were identified age-wise and are given in Table—4

Table—4. Motor Problems of The Mentally Handicapped Children: Age-wise

S. No.	Motor Problems	Aove 12 years		Below 12 years	
		N = 78	(%)	N = 32	(%)
1.	Speech	25	32.05	20	62.50
2.	Jumps	22	28.20	18	56.25
3.	Skips	19	24.35	18	56.25
4.	Writing	14	17.94	18	56.25
5.	Running	9	11.53	13	40.62
6.	Walking	5	06.41	4	12.50
7.	Epiiepsy	3	03.84	6	18.75
8.	Unscrews a bottle lid	3	03.84	10	31.25
9.	Right/left hand	2	02.56	–	–
10.	Right/left leg	2	02.56	–	–
11.	Standing	1	01.28	1	03.12
12.	Walks up stairs	1	01.28	5	15.62
13.	Walks down stairs	1	01.28	5	15.62
14.	Eyes/ears	1	01.28	1	03.12

As per the self-explanatory Table—4, the mentally handicapped children with above 12 years of age are having more motor problems than the mentally handicapped children with below 12 years of age.

The predominant motor problems associated with mentally handicapped children with above 12 years of age are speech, jumping, skipping, writing, etc., and the least are standing, walking up, going down stairs, problems of eyes/ears, etc.

The predominant motor problems associated with the mentally handicapped children with below 12 years of age are speech, jumping, skipping, writing, etc., and the least are standing, problems of eyes/ears, etc.

BEHAVIOUR PROBLEMS

Data was collected to know about the behaviour problems of the mentally children. The data is presented in Table—5.

Table—5. Behaviour Problems of The Mentally Handicapped Children

S. No.	Behaviour Problems	Frequency	Percentage
1	2	3	4
1.	Refuses to obey commands	18	16.36
2.	Does not pay attention to the task at hand	17	15.45
3.	Self laughing	15	13.63
4.	Does not continue with the task at hand for required time	15	13.63
5.	Does not sit at one place for required time	15	13.63
6.	Pushes others/hits others/slaps others	15	13.63

(Contd...)

1	2	3	4
7.	Talks to self/talks irrelevantly	13	11.81
8.	Laughs irrelevantly	11	10.00
9.	Nail biting/teeth grinding/nose picking	11	10.00
10.	Thumb sucking/putting fingers into mouth	9	8.18
11.	Body rocking	9	8.18
12.	Fear animals/objects/persons	9	8.18
13.	Biting self/bites others/kicks others	7	6.36
14.	Head nodding/head banging	7	6.36
15.	Uses vulgar language	7	6.36
16.	Kisses/hugs/shakes/hands/licks people/laughs/talks unnecessarily	6	5.45
17.	Pulls objects from others	5	4.45
18.	Pinches others	5	4.45
19.	Smells objects	4	3.63
20.	Cries excessively	4	3.63
21.	Eats indelible objects	4	3.63
22.	Tears/pulls threads from clothing of others	4	3.63
23.	Does the same activity over and over again	3	2.72
24.	Refuses to perform regular routine on time (eating, walking, etc.)	3	2.72
25.	Lies	2	1.81
26.	Rotates objects of others/spits on others	2	1.81

(Contd...)

(Table—5 Contd...)

1	2	3	4
27.	Steals	2	1.81
28.	Throws objects at others	2	1.81
29.	Breaks objects/others	2	1.81
30.	Pulls hair/ear/body parts of others	2	1.81
31.	Tells others what to do	2	1.81
32.	Makes peculiar/unpleasant sounds	2	1.81
33.	Waves hands/body parts continuously	2	1.81
34.	Makes loud noise when others are working/reading/talking etc.	1	0.90
35.	Beats self	1	0.90
36.	Screaming/yelling	1	0.90
37.	Exposes body parts inappropriately	1	0.90
38.	Undresses in front of others	1	0.90
39.	Touches other or own private parts in public/other places	1	0.90
40.	Tears/pulls threads from clothing	1	0.90
41.	Stamping feet	1	0.90
42.	Refuses to participate in regular activities	1	0.90
43.	Threatens physical violence	1	0.90
44.	Damages furniture	1	0.90
45.	Picks at wounds on own body	1	0.90
46.	Scratching/rubbing self	1	0.90
47.	Jumps up and down	1	0.90

As per Table—5, the most predominant behaviour problems are refusing to obey the commands, not paying any attention to the task at hand, self laughing, not continuing the task at hand for a prescribed period of time, not sitting at one place for required time, pushing hitting and slapping others, talking to self and talking irrelevantly, to self, laughing irrelevantly, biting nails, grinding teeth, picking nose, putting fingers into mouth, rocking the body, fearing on seeing objects animals and persons, etc.

6. Behaviour problems of the mentally handicapped children were compared sex-wise. The problems are given in Table—6 in detail.

Table—6. Behaviour Problems of Mentally Handicapped Children: Sex–wise

S. No.	Behaviour Problems	Boys		Girls	
		N = 78	(%)	N = 32	(%)
1	2	3	4	5	6
1.	Does not pay attention to the task at hand	12	15.83	5	15.62
2.	Self laughing	12	15.83	3	9.37
3.	Does not sit at one place for required time	12	15.83	3	9.37
4.	Refuses to obey commands	11	14.1	7	21.87
5.	Does not continue with the task at hand for required time	10	12.82	5	15.62
6.	Pushes others/hits others/slaps others	10	12.82	5	15.62
7.	Talks to self/talks irrelevantly	8	10.25	5	15.62
8.	Nail biting/teeth grinding/nose picking	8	10.25	3	9.37
9.	Body rocking	8	10.25	1	3.12
10.	Thumb sucking/putting fingers into mouth	6	6.41	3	9.37

(Contd...)

(Table—6 Contd...)

1	2	3	4	5	6
11.	Laughs irrelevantly	5	6.41	6	18.75
12.	Head nodding/head banging	5	6.41	2	6.25
13.	Fears animals/objects/persons	4	5.12	5	15.62
14.	Bites self/bites others/kicks others	4	5.12	3	9.37
15.	Uses vulgar language	4	5.12	3	9.37
16.	Cries excessively	4	5.12	—	—
17.	Kisses/hugs/shakes hands/licks people/laughs unnecessarily	3	3.84	3	9.37
18.	Pinches others	3	3.84	2	6.25
19.	Smells objects	3	3.84	1	3.12
20.	Eat inedible objects	3	3.84	1	3.12
21.	Pulls objects from others	2	2.56	3	9.37
22.	Tears/pulls threads from clothing of others	2	2.56	2	6.25
23.	Does the same activity over and over again	2	2.56	1	3.12
24.	Pulls hair/ear/body parts	2	2.56	—	—
25.	Waves hands/body parts continuously	2	2.56	—	—
26.	Refuses to perform regular routine on time (eating, walking, etc.)	1	1.28	1	3.12
27.	Lies	1	1.28	1	3.12
28.	Rotates objects of others/spits on others	1	1.28	1	3.12
29.	Throws objects at others	1	1.28	1	3.12
30.	Breaks objects/glass	1	1.28	1	3.12

(Contd...)

(Table--6 Contd...)

1	2	3	4	5	6
31.	Makes peculiar/unpleasant sounds	1	1.28	1	3.12
32.	Screaming/yelling	1	1.28	—	—
33.	Threatens physical violence	1	1.28	—	—
34.	Damages furniture	1	1.28	—	—
35.	Jumps up and down	1	1.28	—	—
36.	Steals	1	1.28	—	—
37.	Tells others what to do	—	—	2	6.25
38.	Makes loud noise when others are working/ reading/talking/etc.	—	—	2	6.25
39.	Beats self	—	—	1	3.12
40.	Tears/pulls threads from clothing	—	—	1	3.12
41.	Undresses in front of others	—	—	1	3.12
42.	Touches other or own private parts in public/ other places	—	—	1	3.12
43.	Tears up books/papers/magazines	—	—	1	3.12
44.	Stamping feet	—	—	1	3.12
45.	Refuses to participate in regular activities	—	—	1	3.12
46.	Picking at wounds on own body	—	—	1	3.12
47.	Scratching/rubbing self	—	—	1	3.12

As per the self-explanatory Table—6, the behaviour problems associated with girls are more when compared with boys, and the frequency of occurrence is also different.

The major behavioural problems of boys, out of 36 identified, are not paying any attention to the task at hand, self

laughing, not sitting at one place for required period of time, refusing to obey commands, not continuing the task at hand for a required period of time, pushing hitting and slapping others, talking to self, talking irrelevantly, biting nails, grinding teeth, picking nose, rocking the body, etc.

The major behavioural problems of girls, out of 39 identified, are refusing to obey commands, laughing to self and laughing irrelevantly, not paying attention to the task at hand, not continuing the work at hand for required period of time, pushing hitting and slapping others, talking to self and talking irrelevantly, fearing on seeing the animals objects and persons etc.

The girls are having different behaviour problems other than boys to a tune of 11, and the boys are having different problems other than girls to a tune of 7. Whatever the different behaviour problems they may be having in independent capacity, they are having 29 common behaviour problems.

7. The behaviour problems of the mentally handicapped children were studied age-wise to identify the differences that appear at different ages. The data is given in Table—7.

Table—7. Behaviour Problems of Mentally Handicapped Children: Age-wise

S. No.	Behaviour Problems	Above 12 years		Below 12 years	
		N = 78	(%)	N = 32	(%)
1	2	3	4	5	6
1.	Refuses to obey commands	14	17.94	4	12.50
2.	Self Laughing	9	11.53	6	18.75
3.	Talks to self/talks irrelevantly	9	11.53	4	12.50
4.	Laughs irrelevantly	9	11.53	2	6.25

(Contd...)

1	2	3	4	5	6
5.	Nail biting/teeth grinding/nose picking	8	10.25	3	9.37
6.	Pushes others/hits others/slaps others	7	8.97	8	25.00
7.	Does not pay attention to the task at hand	6	7.69	11	34.37
8.	Body rocking	6	7.69	3	9.37
9.	Does not continue with the task at hand for required time	5	6.41	10	31.25
10.	Does not sit at one place for required time	5	6.41	10	31.25
11.	Bites self/bites others/kicks others	3	3.84	4	12.50
12.	Smells objects	3	3.84	1	3.12
13.	Does the same activity over and over again	3	3.84	—	—
14.	Fears animals/objects/persons	2	2.56	7	21.87
15.	Head nidding/head banging	2	2.56	5	15.62
16.	Uses vulgar language	2	2.56	5	15.62
17.	Puts objects from others	2	2.56	3	9.37
18.	Refuses to perform regular routine on time (eating, walking, etc.)	2	2.56	1	3.12
19.	Tells others what to do	2	2.56	—	—
20.	Makes peculiar/unpleasant sounds	2	2.56	—	—
21.	Waves hands/body parts continuously	2	2.56	—	—
22.	Kisses/hugs/shakes hands/licks people/ laughs/talks unnecessarily	2	2.56	4	12.50
23.	Eats inedible objects	2	2.56	2	6.25
24.	Thumb sucking/putting fingers into mouth	1	1.28	8	25.00

(Contd...)

(Table—7 Contd...)

1	2	3	4	5	6
25.	Pinches others	1	1.28	4	12.50
26.	Cries excessively	1	1.28	3	9.37
27.	Tears/pulls threads from clothing of others	1	1.28	3	9.37
28.	Lies	1	1.28	1	3.12
29.	Steals	1	1.28	1	3.12
30.	Throws objects at others	1	1.28	1	3.12
31.	Breaks objects/glass	1	1.28	1	3.12
32.	Makes loud noise when others are working/reading/talking/etc.	1	1.28	—	—
33.	Beating self	1	1.28	—	—
34.	Screaming/yelling	1	1.28	—	—
35.	Exposes body parts inappropriately	1	1.28	—	—
36.	Undresses in front of others	1	1.28	—	—
37.	Touches other or own private parts in public/other places	1	1.28	—	—
38.	Tears up books/papers/magazines	1	1.28	—	—
39.	Stamping feet	1	1.28	1	3.12
40.	Rotates objects of others/spits on others	—	—	2	6.25
41.	Refuses to participate in regular activities	—	—	1	3.12
42.	Threatens physical violence	—	—	1	3.12
43.	Damages furniture	—	—	1	3.12
44.	Picking at wounds on own body	—	—	1	3.12
45.	Screaming/rubbing self	—	—	1	3.12
46.	Jumping up and down	—	—	1	3.12
47.	Pulls hair/ear/body parts of others	—	—	2	6.25

As per the self-explanatory Table—7, the behaviour problems associated with the mentally handicapped children with more than 12 years of age are more when compared with the mentally handicapped children with below 12 years of age.

The major problems associated with above 12 years aged mentally handicapped children are refusing to obey commands, self laughing, talking to self, laughing irrelevantly, biting nails, grinding teeth, picking nose, etc.

The major behaviour problems associated with the below 12 years aged mentally handicapped children are not paying attention to the task at hand, not continuing the task at hand for a required period of time, fearing on seeing animals objects and persons, laughing to self, nodding head and banging head, using vulgar language, refusing to obey commands, pinching others, etc.

When compared, 39 behaviour problems are associated with above 12 years aged mentally handicapped children and 37 behaviour problems are associated with below 12 years aged mentally handicapped children.

Assets Problems

8. Assets problems of the mentally handicapped children were identified and are given in Table—8 in detail.

Table—8. **Assets Problems of Mentally Handicapped Children**

S. No.	Asset problem	Frequency (No = 110)	Percentage %
1	2	3	4
1.	Measurements	89	80.90
2.	Reading	87	79.09
3.	Arithmetic	72	65.45

(Contd...)

(Table—8 Contd...)

1	2	3	4
4.	Time	67	60.90
5.	Money	59	53.63
6.	Grooming	46	41.81
7.	Writing	45	40.90
8.	Out door games	44	40.00
9.	Bathing	43	39.09
10.	Dressing	42	38.35
11.	Indoor games	39	35.45
12.	Peer group interaction	38	34.54
13.	Numbers	38	34.54
14.	Yoga	36	32.72
15.	Group play	30	27.27
16.	Dance	28	25.45
17.	Greeting	27	24.54
18.	Craft work	22	20.00
19.	Brushing	22	20.00
20.	Drawing	21	19.09
21.	Toileting	20	18.18
22.	Eating	16	14.54

As per the self-explanatory Table—8, the mentally handicapped children are having 22 assets problems. Among them, the predominant assets problems are measurement, reading, arithmetic, time, money, etc.

In the hierarchy of assets problems of the mentally handicapped children from the bottom are eating, toileting, drawing, craft work, etc.

9. Assets problems of the boys and girls were identified and are given in Table—9.

Table—9. Assets Problems of Mentally Handicapped Children: Sex-wise

S. No.	Assets Problems	Boys		Girls	
		N = 78	(%)	N = 32	(%)
1	2	3	4	5	6
1.	Reading	59	75.64	28	87.05
2.	Measurements	58	74.35	31	96.87
3.	Arithmetic	49	62.82	23	71.87
4.	Time	44	56.41	23	71.87
5.	Money	39	50	20	62.05
6.	Outdoor games	29	37.17	15	46.87
7.	Writing	28	35.89	17	53.12
8.	Bathing	26	33.33	17	53.12
9.	Dressing	26	33.33	16	50.00
10.	Grooming	26	33.33	20	62.05
11.	Peer group interaction	26	33.33	12	37.05
12.	Indoor games	25	32.05	14	43.75
13.	Numbers	24	30.76	14	43.75
14.	Yoga	21	26.92	15	46.87

(Contd...)

(Table---9 Contd...)

1	2	3	4	5	6
15.	Group pay	20	25.64	10	31.25
16.	Greetings	18	23.07	9	28.12
17.	Dance	15	19.23	13	40.62
18.	Drawing	13	16.66	8	25.00
19.	Craft work	13	16.66	9	28.12
20.	Brushing	12	15.38	10	31.25
21.	Toileting	12	15.38	8	25.00
22.	Eating	10	12.82	6	18.75

As per the self-explanatory Table—9, both boys and girls are having 22 assets problems. The girls are having assets problems in additional frequency when compared with their counterparts.

The most predominant assets problems of the boys are reading, measurement, arithmetic, time, money, etc., and the least assets problems are eating, toileting, brushing, craft work, drawing, etc.

The most predominant assets problems of girls are measurement, reading, arithmetic, time, money, grooming, writing, bathing, dressing, etc., and the least assets problems are eating, toileting, drawing, greeting, craft work, etc.

10. Assets problems of the mentally handicapped children were identified age-wise are given in Table—10.

Table—10. Assets Problems of Mentally Handicapped Children: Age–wise

S. No.	Assets Problems	Above 12 years		Below 12 years	
		N = 78	(%)	N = 32	(%)
1	2	3	4	5	6
1.	Measurements	60	76.92	29	90.62
2.	Reading	58	74.35	29	90.62
3.	Arithmetic	43	55.12	29	90.62
4.	Time	38	48.71	29	90.62
5.	Money	32	41.02	27	84.37
6.	Grooming	21	26.92	25	78.12
7.	Writing	21	26.92	24	75.00
8.	Outdoor games	21	26.92	23	71.87
9.	Yoga	18	23.07	18	56.25
10.	Bathing	17	21.79	26	81.25
11.	Brushing	17	21.79	25	78.12
12.	Indoor games	17	21.79	22	68.75
13.	Peer group interaction	16	20.51	22	68.75
14.	Numbers	16	20.51	22	68.75
15.	Dance	13	16.66	15	46.87
16.	Group play	12	15.38	18	56.25
17.	Greetings	10	12.82	17	53.12
18.	Craft work	8	10.25	14	43.75

(Contd...)

(Table—10 Contd...)

1	2	3	4	5	6
19.	Brushing	8	10.25	14	43.75
20.	Drawing	7	8.97	14	43.75
21.	Toileting	6	7.69	14	43.75
22.	Eating	5	6.41	11	34.37

As per the self-explanatory Table—10, the mentally handicapped children with below 12 years of age are having additional frequency of assets problems when compared to the mentally handicapped children with above 12 years of age though both of the sub-samples are having 22 assets problems.

The most predominant assets problems of mentally handicapped children with above 12 years of age are measurement, reading, arithmetic, etc., are the least assets problems are eating, toileting, drawing, craft work, etc.

The most predominant assets problems of mentally handicapped children with below 12 years of age are measurement, reading, arithmetic, time, money, yoga, etc., and the least assets problems are eating, toileting, drawing, brushing, craft work, etc.

Programmes

11. The programmes suggested by the teachers to the mentally handicapped children are given in Table—11.

As per the self-explanatory Table—11, the programmes suggested by the teachers for the mentally handicapped children are special education, behaviour modification, speech therapy, physiotherapy, vocational training, yoga therapy and medical care.

Table—11. Programmes Suggested by the Teachers for Mentally Handicapped Children

S. No.	Programmes Suggested by Teachers	For Number of Children (N = 110)	(%)
1.	Special education	110	100
2.	Behaviour modification	90	81.81
3.	Speech therapy	45	40.90
4.	Physiotherapy	40	36.36
5.	Yoga therapy	36	32.72
6.	Dance therapy	28	25.45
7.	Vocational training	24	21.81
8.	Medical care	9	8.18

5. Summary, Conclusions and Discussion

Mental handicap is a negative concept, yet it is a challenge to human race as a whole. This is an interesting matter for guardians, educationists, psychologists and doctors, and especially for psycriatrists to concern themselves with the child as he remains backward due to handicap and experiences difficulty in communication skills and is consequently socially maladjusted. Hence, educationists, psychologists, sociologists, and doctors have been doing researchers for the last fifty years or so to develop their normal abilities.

Mentally handicapped children have problems concerned to behaviour, motor, assets, etc., and need additional care and comfort in home and institution. So, it is important for the service providers to know what are the various problems posed by mentally handicapped children to their parents or teachers for which they seek professional help. The present study attempts to analyse such problems and also try to find how these are related to age and sex of mentally handicapped children.

The following were the objectives of the present study: *(i)* To find out the family history of mentally handicapped children, *(ii)* To find out the motor problems, behavioural problems, assets

problems of mentally handicapped children, *(iii)* To find out the difference between boys and girls with regard to motor problems, behaviour problems, and assets problems, *(iv)* To find out the difference between below 12 years and above 12 years old mentally handicapped children with regard to motor problems, behaviour problems and assets problems, *(v)* To find out the programmes suggested by teachers to the mentally handicapped children.

The present study was confined to the mentally handicapped children attending the programmes organised by Dakshinya Institute for Mentally Handicapped in Guntur city. Sex and age were taken as variables to identify their role. Only motor problems, behaviour problems, assets problems, family history, suggested programmes were considered for this study.

Cluster sampling technique was chosen to select sample for the study. One hundred and ten (110) mentally handicapped children were selected as a sample for the present study. Among the sample 78 were boys and 32 were girls. As for the age, 78 were above 12 years of age and 32 were below 12 years of age.

The tools occupy a major role any research study because they are useful in the collection and analysis of data to draw meaningful conclusions. For the present study the problems or allied aspects of the mentally handicapped children were categorized as family history, motor problems, behavioural problems, assets problems and programmes suggested to the mentally handicapped. Teachers were asked to provide data of handicapped children studying in Dakshinya Institute for the Mentally Handicapped using the Behaviour Checklist developed by N.I.M.H. The information thus collected was used as raw data for drawing conclusions.

The problems of the mentally handicapped children were arranged in rank order depending on the frequency of occurrence of each problem or allied aspect and were converted into percentages. The conclusions were drawn based on the

frequency of occurrence of each problem or allied aspects and also based on the presence or occurrence of each problem or allied aspects.

CONCLUSIONS AND DISCUSSIONS

The following are the conclusions drawn from the analysis of data with regard to the problems of mentally handicapped children.

1. *Out of 110 mentally handicapped children, 15 are having family history of mental handicap.*

The families that are having mental handicap should not engage in reproductive activities in order to arrest the production of mentally handicapped children. If they want children, they should take the advice of doctors.

2. *The mentally handicapped children are having 14 motor problems. The boys are having 14 and the girls are having 12 motor problems. The mentally handicapped children with more than 12 years of age are having 14 and the mentally handicapped children with below 12 years of age are having 12 motor problems.*

The teachers, physiotherapists and other personnel involved in the development of mentally handicapped children should take care in the physical development of these children by providing different types of muscular exercises and activities. Repeated muscular activities may help these children in solving many motor problems.

3. *The mentally handicapped children are having 47 behaviour problems. When compared, girls and mentally handicapped children with above 12 years of age are having more behaviour problems than their counterparts.*

The personnel involved in the programmes of mentally handicapped children should attend the behaviour problems individually taking into consideration the age, sex, etc.

4. *The mentally handicapped children are having 22 assets problems. When compared, girls and mentally handicapped children with below 12 years of age are having more percentage of assets problems than their opponents.*

The mentally handicapped children must be adequately trained in overcoming the assets problems by education, physiotherapy, training, etc.

5. *The teachers associated with the sample of mentally handicapped children have suggested 8 programmes to help the children in leading a comfortable living.*

As the teachers have suggested special education, behaviour modification, speech therapy, physiotherapy, yoga therapy, dance therapy, vocational training and medical care as the suitable programmes to the mentally handicapped children in leading a comfortable life, the elders, the parents, the brothers and sisters, the neighbours, the special education teachers, the medical people, etc., should help the mentally handicapped children in leading their life without much difficulty.

SUGGESTIONS FOR THE FURTHER RESEARCH

The present study on the problems of mentally handicapped children has brought into light some new areas to be investigated thoroughly.

1. Studies may be taken up to identify the role of heredity in mental handicappedness.

2. Studies may be taken up to identify the role of physical and psychological aspects in the development of mental handicap.

3. Studies may be taken up to identify the role of different specialized training programmes and educational programmes in solving the motor, behaviour and assets problems of mentally handicapped children.

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Appendix

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Behaviour Check List

1. Threatens physical violence
2. Pushes others
3. Pinches others
4. Pulls hair/ear/body parts of others
5. Bites others
6. Kicks others
7. Hits/slaps others
8. Attacks or pokes others with weapons
9. Throws object at others
10. Tears/pulls threads from clothing
11. Tears up books/papers/magazines

12. Breaks objects/glass
13. Damages possessions/toys
14. Damages furniture
15. Pulls objects from others
16. Does not allow others to carry on their own activities
17. Makes loud noices when others are working/reading/talking etc.
18. Takes others possessions without their permission openly
19. Knocks things down
20. Tells others what to do
21. Uses abusive language
22. Cries excessively
23. Screaming/yelling
24. Slamming doors
25. Banging objects
26. Stamping feet
27. Kicks legs while on floor/rolling on floor
28. Spits on others
29. Head banging
30. Biting self
31. Cutting self
32. Pulling at wounds on own body

33. Picking at wounds on own body
34. Scratching/Rubbing self
35. Beating self
36. Putting objects into eyes/nose/ears
37. Eating inedible objects
38. Thumb sucking/putting fingers into mouth
39. Nail biting
40. Nose picking
41. Teeth grinding
42. Head nodding
43. Body rocking
44. Tapping feet continuously
45. Waving hands/body parts continuously
46. Swinging round and round
47. Does the same activity over and over again
48. Rotating objects
49. Laughs to self/laughs inappropriately
50. Talks to self
51. Makes peculiar/unpleasant sounds
52. Smears dirt/feaces on self
53. Plays with unwanted objects excessively (clothes, chappals, strings, feaces, water, dirt, etc.)

54. Hoards unwanted objects
55. Stands close to people
56. Talks irrelevantly
57. Kisses/hugs/shakes hands/licks people unnecessarily
58. Smells objects
59. Sits with body up, body curled up
60. Hides face in group situations
61. Stares blankly
62. Sits, stands, lies down for long periods of time without doing anything
63. Lies
64. Steals
65. Makes obscene gestures
66. Exposes body parts inappropriately
67. Undresses in front of others
68. Makes sexual overtures to members of the opposite sex
69. Gambles
70. Uses vulgar language
71. Touches others or own private parts in public
72. Refuses to obey commands
73. Refuses to participate in regular activities
74. Refuses to perform regular routine on time (eating, walking, dressing, sleeping, etc.)

75. Refuses to attend to personal hygiene and self-care
76. Does opposite of what is requested
77. Takes very long intentionally to complete tasks
78. Talks rudely/becomes argumentative
79. Wanders outside home/school
80. Runs away from home/school
81. Does not pay attention to the task at hand
82. Does not continue with the task at hand for required time
83. Does not sit at one place for required time
84. Fear of animals
    (Specify————)
85. Fear of objects
    (Specify————)
86. Fear of places
    (Specify————)
87. Fear of persons
    (Specify————)

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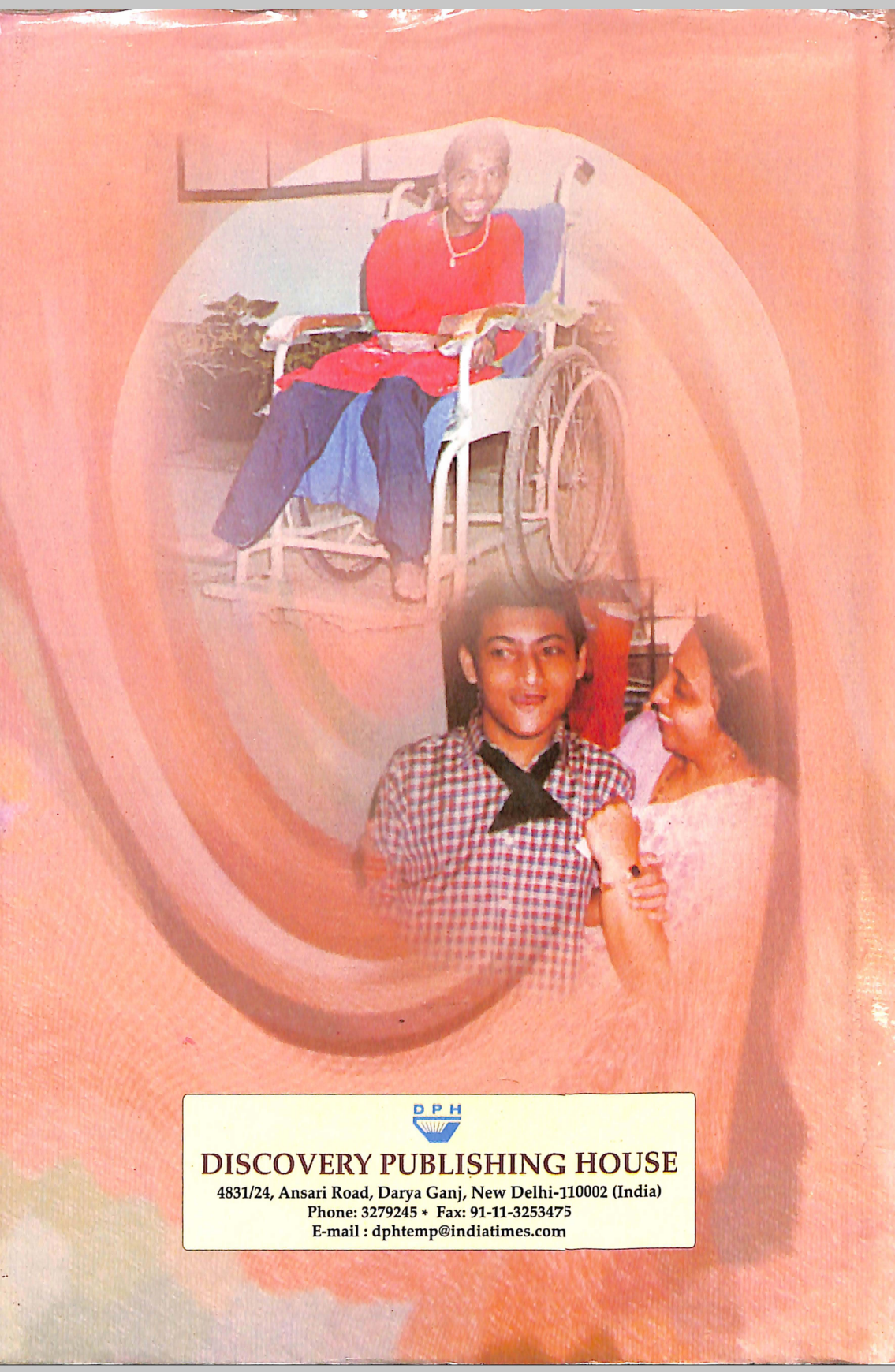

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