

CHAPTER - 5
SUMMARY AND
CONCLUSION

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5.0 INTRODUCTION :

A democratic welfare society which we talk about is where people live without any prejudices, with equal freedom and equal rights. Here the democratic values are settled as leading ideologies in particular, where humanism and rationalism are inter-woven in the fabric of our lives. When such ideologies are inter woven in our lives then why such injustice to the so-called differently abled persons. Further we talk of a society which is hopeful of having mentally disabled people living in harmony with their abled colleagues-fully understood and fully supported. Taking into consideration all these aspects and for the upliftment of these people in the society a remarkable progress in the fields of social, economic and medical advances has gained impetus. However, there are many more problems which still remains to be dealt with.

In this fast growing world it is generally believed that around 4% of the population constitutes one or the other kind of disability. Out of these 3% constitute persons with mental retardation. However, there is no systematic survey conducted in India to determine the exact number. In 2000 the survey conducted by Indian National Institute for the mentally handicapped (NIMH), Secunderabad reveals an estimation of about 20 million persons who are mildly retarded and about 4 million persons falling under the moderate and the severe categories of mental retardation. If we talk about the world scenario then there are more than 500 million people in the world today having some form of disability. At least 150 million of them are children out of which 120 million live in the developing countries. Still further, it can be estimated that one child in every ten children is born with some form of impairment which leads to permanent disability. (WHO-2007).

5.1 HISTORICAL PERSPECTIVE ABOUT MENTAL RETARDATION:

Before the advent of 20th century, the interest in children with mental retardation had waxed for more than 100 years. In around 1800, there was no provision for the persons with mental retardation in the society - they were either killed by throwing them over a cliff or drowned, and if they were made to survive then they were left on their own without care and attention from the people of the family or of the society. People then thought it to be a bad omen having a child with mental retardation and it was a punishment given to them from the mighty lord. Thus nothing was done for such people in the 18th century. In the 19th century some progress in the area of mental retardation was seen and mainly it was put forward by the works of Jean Itard who understood the task of educating up to civilized state a young boy who had been living in a wild and savage like condition. Since then the educational model which is even prevalent today came to be known as Itard's model. And through his efforts for the first time people started developing hope for those who then were considered as hopeless. Further his training programme or his educational module is considered as the first scientifically documented report for the training and treatment of persons with retardation by means of planned education. In spite of his efforts many misconceptions still prevailed in the society among the general public as well as professional workers. Among many of such misconceptions few being (a) mental deficiency was a disease and delinquency and criminal behaviours were seen because of this, (b) Persons with mental retardation were considered to be insane and were labeled the same, (c) The women who gave birth to such children were considered as having affected by some omen and she along with her child was abandoned from the society.

After the work of Itard many people got interested in the area and came forward with their works. Globally special education has been viewed under four major headings –

- (a) Stage of neglect where disability was viewed as punishment for the parents for their past sins and nobody wanted to interfere in the justice of lord.
- (b) Pity and compassion for the disabled. This was mostly on religious background so as to free the person from pain or to reduce his misery and pain.
- (c) Emergence of the special schools. The main focus of these schools was to segregate the so called disabled from their counterparts.
- (d) Main streaming and Integration. After segregating them in special schools and making them self efficient the focus was on admitting them into general schools along with their normal counterparts. It was a step taken as a part of attaining normalization on the part of these children.

During the 50's and 60's a growing concern for the children with mental retardation developed where in experts from different walks of life like medical practitioners, sociologists, psychologists, teratogenologists, social workers etc came forward to help these children and efforts were made on their parts. The Parents were group started to organize. All of them realized the ultimate need for integration of children with special needs into the social fabric of society. They need to be accepted as the functional beings as per the universal declaration of human rights reflected in the national aspirations embodied in the constitutional documents in developmental plans.

The work in mental retardation in the western countries goes back in 1960's where people came to know about the capabilities and potentials of these people. In India it started in 1970's with the advent of National Institute for the Mentally Handicapped (NIMH) at Secunderabad. Since then there is no looking back, today in 2008 every day new strategies are being developed and applied for the overall development of persons with mental retardation. Special as well as integrated schools have been set up for their educational, social and physical well being. A multi disciplinary approach involving professionals in different discipline should come together and work for the overall development of the child. It is not only the person affected is being taken care of, but also all the rest of the people who are directly associated with him are sensitized and made aware about the problem. Thus force is applied from all directions for the

overall development of the person. Parents as well as society have become much aware about such people due to which the label and the stigma attached to them have reduced and their acceptance in the society has increased.

5.2 EDUCATIONAL AND LEGISLATIVE PERSPECTIVE IN MENTAL RETARDATION

For a long time people with disabilities have been deprived of basic human rights like an honorable place in the family, education, training and employment. This is not because they can not receive education or training but it is largely because of the negative attitude prevalent in the community. These negative attitudes are basically the product of perceiving disability as threat and we forget that individual differences are an integral part of life. We need to emphasize the fact that people with disability can become as productive as the rest of us. Irrespective of whether the disability is visible, invisible, mild, moderate or severe, the individual does possess quiet a bit of potential for developing his remaining abilities for his own advantage and for the advantage of the community.

Since 1947, many social interventions in the area of disability have been made. In 1977, the ministry of social welfare reserved 3% vacancies in government departments and public undertakings for the visual, hearing and loco motor impairment. The year 1981 was declared as the International year of disabled person. As a result, in 1981 many NGO's launched new programmes for the education and rehabilitation for the disabled. The period between 1983 to 1992 was declared as an Asia - Pacific decade for the disabled. The United Nations General Assembly developed a world programme of action concerning disability and laid down standard rules to equalize opportunities for persons with disabilities.

5.2.1 National Policy on Education (NPE) (1986)

Taking into consideration all these aspects a national policy on education was put forth in 1986 which for the first time emphasized for

(a) the education of children with mild disabilities in regular school.

- (b) children with severe disabilities to be placed in special school with hostel facilities.
- (c) initiating Vocationalisation of education .
- (d) teachers training programmes to be re-oriented to include education of the disabled children.
- (e) all voluntary efforts to be encouraged.

5.2.2. Programme of Action (POA) (1990)

The programme of Action of India (POA) called for the establishment of special schools at district and sub district levels, curricular development a part from provision of infrastructure facilities and specific target setting for universal primary education for the children with disabilities. It was for the first time that the education of the disabled had been recognized as a human resource development activity, rather than a more welfare activity.

5.2.3. Rehabilitation Council of India Act 1992

This act passed in 1992 for the purpose of constructing the rehabilitation Council of India, for regulating the training of rehabilitation professionals and for maintenance of a central rehabilitation register. It was amended by rehabilitation council of India Act, 2000, to provide for monitoring the training of rehabilitation professionals and personnel, promoting research in rehabilitation and special education as additional objectives of the council.

5.2.4. Persons with disabilities (Equal opportunities protection and right and full participation) ACT 1995

This was passed by the parliament on December 12, 1995 and notified on February 7, 1996. The act elaborated the responsibility of the central and state government, local bodies to provide service, facilities and equal opportunities to people with disabilities for participating as productive citizens of the country. The act enlists the rights and facilities persons with disabilities would be entitled to and which are enforceable. Thus it provides both preventive and promotional aspects of rehabilitation. The disabilities covered in the act are

blindness, low vision, leprosy cured, hearing impairment, loco motor disability, mental retardation and mental illness.

The act further envisages that every child with disability should have access to free and adequate education till the age of 18. Students with disabilities should be integrated into general schools. Special schools should be established in government and private sectors and equipped with vocational training facilities.

5.2.5. National Trust Act (For the Welfare of Persons with Autism, cerebral palsy, mental retardation and multiple disabilities) 1999

The national Trust Act is a statutory body under the Ministry of Social Justice and Empowerment. Government of India set it up for the welfare of persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities Act (Act 44 of 1999). The main objectives of the act are (a) to enable and empower persons with disability to live as independently and as fully as possible within and as close to the community to which they live. (b) to strengthen facilities to provide support to persons with disability (c) To facilitate the realization of equal opportunities, protection of rights and full participation of persons with disability. The thrust areas of the act being - campaign for positive attitudinal change creating barrier free environment, developing skills, promoting self help groups, research in the four areas of disabilities. Advocacy for the rights of persons with four disabilities, programme for persons with severe disabilities and women with disabilities.

5.2.6 National Handicapped Finance and Development Corporation (NHFDC)

This is a scheme introduced by government of India for enhancing employment of persons with disabilities. According to this any Indian with disability in the age range of 18-55 yrs with 40% or more disabilities is eligible for the scheme. Specific jobs have been identified for persons with intellectual impairment for availing the facility of loan through the scheme.

5.2.7 Scheme of Assistance to Disabled person for purchase of fitting of Aids and Appliances (ADIP)

Provision of aids, appliances and assistive devices at low cost has been a major objective of the government of India. Under this scheme persons with mental retardation may receive free of cost assistive devices, educational kits and supplies for daily living skills depending upon the income of the parents.

5.2.8 Integrated Education for the Disabled Children

It is a scheme implemented by the ministry of human resources development. In this, the trained resource teachers support the regular class teacher so as to provide appropriate education to children with disabilities.

5.2.9 National Institute of Open School (NIOS)

It is a programme of open education in which children with intellectual impairment are included. Those with borderline intelligence can study at their own pace with a reduced curricular content as per this school system.

5.2.10 The District Primary Education Programme (DPEP) or the Sarva Siksha Abhiyan

Throughout the world inclusive education has been emphasized, the DPEP too aims at including the children at primary level i.e. up to class 5 with suitable teacher participation, infrastructural facilities and Aids and appliances.

5.2.11 Community Based Rehabilitation Programme (CBR)

CBR programme has been implemented in India as children are always with families and their neighbours always extend helping hand whenever and wherever needed. A CBR programme is a systematic approach to help the disabled persons within their own community making the best of social resources and helping the community to become aware of their responsibility in this regard. The main focus of this is to provide services from within and with the active involvement of the community, family and the local administration.

5.2.12 UN Declaration on the rights of Disabled Persons

The UN General assembly proclaims the declaration on the rights of the disabled persons and called for National and International action to ensure that it will be used as a common basis and frame of reference for the protection of these rights.

- (1) The term disabled person means any person unable to ensure by himself or herself, wholly or partly, the necessities of a normal individual and / or social life as a result of deficiency either congenital or not or his physical or mental capabilities.
- (2) Disabled persons shall enjoy all the rights set forth by this declaration. These rights shall be granted to all disabled persons without any exception what so ever and without distinction or discrimination on the basis of race, colour, sex, language, religion, political or other option, national or social origin, state of wealth, birth or any other situation applying either to the disable person himself / herself or his or her family.
- (3) Disabled persons have the equal right to respect for their human dignity. Disabled persons, whatsoever the origin, nature and seriousness of their handicaps and disabilities have the same fundamental rights as their right to enjoy a decent life as normal as possible.
- (4) Disabled person have the same civil and political rights as other human beings. Paragraph - 7 of the declaration on the right of persons with mental retardation applies to any possible limitation or suppression of those rights for mentally disabled person.
- (5) Disabled persons entitled to the measures designed to enable them to become as self reliant as possible.
- (6) Disabled persons have the right to medical, psychological and functional treatment including all appliances, medical and social rehabilitation, education, vocational training, counseling, placement services and other services which will enable them to develop their capabilities and skills to the maximum and will hasten the process of their social integration and reintegration.

- (7) They have the right to economic and social security and to a decent level of living. They have the right according to their capabilities to secure and retain employment or to engage in a useful, productive and remunerative occupation and to join trade unions.
- (8) They are entitled to have their special needs taken into consideration at all stages of economic and social planning.
- (9) They have the right to stay with their families or foster parents and to participate in all social, creative and recreational activities.

5.3 NATURE AND MEANING OF MENTAL RETARDATION

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

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

Another personnel in this area views mental retardation as a deficit in intellectual functioning. According to Benoit, mental retardation is a deficit of intellectual functions resulting from varied intrapersonal and / or extra determinants, but having as a common proximate cause a diminished efficiency of the nervous system. Thus entailing a lessened general capacity for growth in perceptual and conceptual interpretation and consequently in environmental adjustment (Kirska and Johnson, 1957).

As stated earlier prior to September, 1959 mental retardation had many different definitions given by individual in various fields. But for legal purpose each state had its own definition and according to American Medical Association – Mental Retardation refers to sub average general intellectual functioning which originates during the developmental period and is associated with impairment in one or more of the following (1) maturation (2) learning and (3) Social adjustment.

World Health Organization (WHO) (1981) has given a definition of mental retardation according to which those children whose intellectual deficit is sufficiently severe so as to result in academic disabilities, are regarded as mentally retarded children. In this definition the WHO has emphasized the level of intellectual functioning to be responsible for mental retardation.

There are many more definition on mental retardation but the most comprehensive and most widely used till date is the one given by the American Association on Mental Retardation (AAMR) according to which – “Mental Retardation refers to significantly sub-average general intellectual functioning, resulting in or associated with concurrent impairments in adaptive behaviour manifested during the developmental personal.” (AAMR - 1983).

While analyzing the most comprehensive definition on mental retardation, the general intellectual functioning here is defined by the intelligence quotient (IQ) which can be obtained by the assessment with one or more of the standardized, individually administered intelligence tests which are developed for the purpose and adapted to the condition of the region or the country.

Significantly Sub-average intellectual functioning is defined as IQ of 70 or below on standardized measures of intelligence. The upper limit is intended as a guideline, it could be extended to 75 more, depending upon the reliability of the intelligence test used. Here it has been recorded that IQ varies from person to person with mental retardation.

Adaptive behaviour is defined as the degree with which the individual meets the standards of personal independence and social responsibility expected of his age and cultural group. Adaptive behaviour may be influenced by various factors including education, motivation, personality characteristic, social and vocational opportunities and the mental disorders and general medical conditions that may coexist with mental retardation. The problems in adaptation are more likely to improve with remedial efforts than is the cognitive IQ which teaches to remain a more stable attribute.

The deficits in the adaptive behaviour may be reflected in the following areas -

- During infancy and early childhood in -
 - (a) Sensory and motor skill development
 - (b) Communication skills including speech and language
 - (c) Self help skills
 - (d) Socialization
- During childhood and adolescence in -
 - (a) Application of basic academic skills in daily life activities.
 - (b) Application of appropriate reasoning and judgment of mastery in environment.
 - (C) Social Skills
- During late adolescence and adult life in -
 - (a) Vocational and social responsibilities and performances
- Developmental period - It is defined as the period of time between conception till 18 years of his life.

5.3.1. Classification

Classification of any condition is done so as to -

- (a) Help in using an acceptable, uniform system throughout the world.
- (b) Help in diagnostic and research purpose.
- (c) To facilitate efforts at prevention.

There are different methods of classification of mental retardation. They are medical, psychological and educational. The medical classification is based on the cause, the psychological classification on the level of intelligence and the

educational classification on the current level of functioning of the person with mental retardation.

Source Diagnostic and Statistical Manual of Mental Disorders - DSM-IV-1994.

5.3.2 Classification as per IQ and specific characteristic -

5.3.2.1 Mild mental retardation (IQ between 50-70)

Mild mental retardation is roughly equivalent to what is referred to educational category of 'educable'. This group constitutes largest segment i.e. about 85% of those with disorder. Individuals with this level of mental retardation develop social and communication skills during the pre school years i.e. ages 0-5 years, have minimal impairments in sensory motor areas and often are not distinguishable from children without mental retardation until a later age. By their late teens they can acquire academic skills up to approximately sixth grade level. During their adult years, they usually achieve social and vocational skills adequate for minimum self support, but may need supervision, guidance and assistance. When under unusual social or economic stress with appropriate support, individuals with mild mental retardation can usually live successfully in the community, either independently or in supervised settings.

5.3.2.2 Moderate mental retardation (IQ between 35 - 50) -

Moderate mental retardation is roughly, equivalent to what is referred to as the educational category or "Trainable". This group constitutes about 10% of the entire population of people with mental retardation. Most of the individuals with this level of mental retardation acquire communication skills during early childhood years. They profit from vocational training and with moderate supervision, can attend to their personal care. They can also benefit from training in social and occupational skills but are unlikely to progress beyond the second grade level in academic subjects. They may learn to travel to familiar places. During adolescence, their difficulties in recognizing social conventions may interfere with peer relationships. In their adult years, the majority are able to perform unskilled or semiskilled work under supervision in sheltered workshops or in the general work force. They adapt to life in the community usually in supervised settings.

5.3.2.3 Severe Mental Retardation (IQ between 20 - 35)-

The group with the severe mental retardation constitutes 3 % to 4 % of individuals with mental retardation. During the early childhood years, they acquire little or no communicative speech. During the school period they may learn to talk and can be trained in elementary self skills. They profit to only a limited extent from instructions on pre academic subjects. In their adult years, they may be able to perform simple tasks in closely supervised setting. Most adapt well to live in community, in group, homes or in their families, unless they have an associated handicap that requires specialized or other care.

5.3.2.4 Profound mental retardation (IQ less than 20) -

The group with profound mental retardation constitutes approximately 1% to 2% of people with mental retardation. Most individuals with this diagnosis have an identified neurological condition that accounts for their mental retardation. During the early childhood years, they display considerable impairments in sensorimotor functioning. Optimal development may occur in a highly structured environment with constant aid and supervision and individualized relationship with a care giver. Motor development and self care and communication skills may improve if appropriate training is provided. Some can perform simple tasks in closely supervised and sheltered settings.

5.4 CAUSES OF MENTAL RETARDATION

Mental retardation is caused by number of factors which can be broadly grouped into prenatal, natal and post natal factors.

5.4.1 Prenatal causes

These are the causes which occur during three trimesters of pregnancy i.e. from conception till birth. They are -

- (a) Chromosomal Abnormalities - There are 23 pairs of chromosomes in the human cell. Now if there is some error in the 21st pair of chromosome, it would result in mental retardation and the condition is known as Down's Syndrome. In this type of syndrome the person has striking physical

features such as slanting eyes, depressed nasal bridge, thick – short tongue, open mouth, short fingers with square palm.

There are many other syndromes like Apert's Syndrome, leish - Nyhan Syndrome, Rett's Syndrome etc which are caused due to some errors in the chromosomal structure.

(b) Genetic disorders -

Defect in which are transmitted from the parent to the child leads to mental retardation. In this sometimes it is found that the parent may or may not show any sign of such disorders but it occurs in the offspring. In this type of disorder there is a metabolic abnormality and a specific enzyme may be deficient or totally absent. This may result in accumulation of specific substance in the brain resulting in brain damage.

(c) Infections in expecting mothers -

Those infections which occur especially during the first trimester i.e. the first three months of pregnancy may damage the developing brain and cause mental retardation.

(d) Diseases in expecting mothers -

Some diseases like diabetes, high blood pressure, malnutrition of mother can damage the growing foetus. For e.g. if a mother is suffering from excess of thyroid i.e. hyper thyroidism then it affects the central nervous system which results in mental retardation in the child.

Also the foetus while inside requires all necessary ingredients for growth. Now in a malnourished mother the necessary ingredients are not obtained which would result in mental retardation in the child.

(e) Exposure to x-rays or other radiation and drugs -

This is one of the major causes in recent times due to which the infant born suffers from mental retardation. For e.g. - If the expecting mother is under the treatment for cancer then those rays would have an effect on the physical as well as mental development of the child.

Medicines taken for epilepsy, high blood pressure, for some common illness like malaria, typhoid etc, smoking, intake of alcohol during pregnancy may lead to mental retardation in the foetus.

(f) Traumatic experiences or accidents -

(g) Congenital defects -

These are the defects of the central nervous system where in the brain cells are not properly developed. For e.g. Hydrocephalus - here there is an excess of cerebrospinal fluid due to which there is no room left for the cells to grow and develop. Because of this fluid the head becomes large as compared to the normal head size as per the age.

The other condition is Microcephalus - here the brain cells are not properly developed due to which the head size remains smaller which would lead to mental retardation.

5.4.2 Natal causes -

These are the causes which occur at the time of delivery i.e. at the time of birth of an infant.

(a) Premature birth -

Due to some reason if a child is born before the due date then it would result into under development of the foetus which may then result into mental retardation.

(b) Low birth weight -

If the birth weight is less than the standard weight (2.5 kg) of an infant it may result into mental retardation.

(c) Birth Asphyxia -

If the infant does not cry immediately after birth then there is a lack of oxygen reaching to his brain resulting in mental retardation.

(d) Trauma or Injury to the head of the infant -

Here there may be some injury in the brain which may have occurred due to some faulty methods of delivery like forcep or vacuum, resulting in mental retardation.

- (e) Prolonged labor -
- (f) Coiling of umbilical cord around the neck or other part of the body of the foetus.
- (g) Abnormal position of the foetus in the uterus-
Due to this much time is taken for the delivery which would result in respiratory distress leading to mental retardation.
- (h) Severe Jaundice in the new born

5.4.3 Post natal Causes

- (a) Malnourished child -
The child is vulnerable to malnutrition during 12-18 weeks after birth during which period the multiplication of nerve cells is very active and it continuous from birth till the end of 2nd year. So this is a very important period for the child and most cases of mental retardation due to malnourishment occurs during this period.
- (b) Infections in the child -
Due to some or the other kind of infections in the brain the brain nerve gets affected resulting into mental retardation. The examples of infections are meningitis, encephalitis.
- (c) Epileptic seizures / convulsions -
In the words of a lay man it is called fits due to which the brain cells gets damaged leading to mental retardation.
- (d) Injury to the brain -
This may occur due to a fall or any accident or any traumatic condition which may result into brain damage leading to mental retardation.
- (e) Poisoning

5.4.4 Other causes -

- (a) Hereditary
- (b) Mothers age
- (c) Consanguineous marriages

(d) Teratogens / Environmental factors.

Particular causes are always unknown but due to condition & its symptom, no sure evidences.

5.5 CLASSIFICATION OF BEHAVIOUR

All behaviour in children with mental retardation can be divided into two categories

- (a) Skill behaviour
- (b) Problem behaviours

5.5.1 Skill Behaviour

Skill behaviours are those behaviours which would help the child become independent in his or her potentials.

All the children with mental retardation show deficit in some skill behaviours. This means that they perform poorly certain tasks which normal children of their age can do easily. Now what a given child with mental retardation can do or cannot do depends on various factors such as severity of mental retardation, opportunity provided for training, associated conditions etc. For the convenience of easy understanding, the various skill behaviours can be classified into the following categories or domains –

(a) Motor

This involves running, skipping, jumping, walking up and down the stairs, riding a bicycle, unscrewing, pouring liquid from one container to another etc. Meaning that all the activities which require hands and legs functioning can be put under this category.

(b) Activities of daily living (ADL)

A child requires to be independent in all those activities which he needs to perform daily. These activities include -

- (i) Eating - Drinking from cup or a glass, eating with own hands etc.
- (ii) Toileting - Indicates toilet needs, washes self, going on his own.
- (iii) Brushing - Brushing teeth, spitting, rinsing.
- (iv) Bathing - Pouring water, applying soap, drying with a towel.

- (v) Dressing - Wearing pant, shirt on his own, undressing, buttoning and unbuttoning, wearing shoes, socks, taking them off.
- (vi) Grooming - Applying powder, combing, clipping nails, etc.
- (c) Language - Language can further be categorized into,
 - (i) Receptive Language
This means understanding and then putting into action. It includes pointing to pictures in a book, arranging pictures after listening to a story etc.
 - (ii) Expressive Language
As the name suggests, expressing means verbally speaking out. It may also include gestures and written. Thus expression mean to bring out our feelings, thoughts and ideas through either verbal communication, through gestures or written. It may include using two word phrases, naming common objects in use etc.
- (d) Reading and writing -
As the child grows, he needs to develop reading and writing skills as it is helpful to him in his present life as well as for his future. Development of this skill includes reading words, reading own name, scribbling with pencil or chalk, writing own name, address, etc.
- (e) Number and time -
Along with reading and writing skills the child also develops number and time concept which includes rote counting till five, meaningful counting, addition of single digit numbers, telling the time by hours and minutes, names and identifies days of the week and months of the year.
- (f) Domestic and social -
This skill involves doing house hold chores like washing utensils, clothes, greeting people, learning to use etiquettes like please, thank you, etc.
- (g) Prevocational and money -
Developing this skill helps the child to become ready for the future endowments. It involves recognizing the values of coins, performing money transactions.

5.5.2 Problem Behaviours -

Many times, children with mental retardation show behaviours that are considered as problematic because of the harm or inconvenience they cause others, or to the child himself. The presence of problem behaviours in children puts great strain on teachers. Besides, they may interfere with learning in school or other settings. These problem behaviours could be due to number of reasons.

There are in all 130 problem behaviours listed but for the convenience of easy understanding, the various problem behaviours can be broadly classified into ten major domains as identified by R. Peshawaria (1992). Basic mental retardation, NIMH. They being -

(a) Violent and Destructive behaviours -

Violent types of behaviours are categorized by physical violence, pushing, pinching, spitting, pulling hair or ear or body parts of others, picking with sharp objects or kicking. Similarly destructive behaviours are those wherein the child tears books, clothes, break things, objects, damages toys and other possessions, damages furniture, personal belongings.

(b) Temper Tantrums -

In order to get something the child performs different activities which are quiet odd and they are known as temper tantrums. These being rolling on the floor screaming, crying excessively, etc.

(c) Misbehaviour with others / disruptive behaviour -

Here the child snatches objects from others, does not allow any one to carry on with their activities makes loud noise when others are working, takes others possessions without permission, screams unnecessarily, spits on others, etc.

(d) Self Injurious behaviours -

These types of problem behaviours are very dangerous as here the child is engaged in injuring his own self to such an extent that it hurts and harms the child to little or great extent. Self injurious behaviours includes banging head, biting self, cutting to the extent that he / she bleeds, pulling own hair, beating self, putting objects into eyes, nose, scratching self, pulling skin, etc.

(e) Repetitive or stereotyped behaviours -

As the name suggest in this type of behaviour the child is engaged in performing same kind of activity over and over again for a long period of time example, head nodding, teeth grinding, swinging round and round, jumping, rocking body, shaking part of the body, etc.

(f) Odd behaviours -

These are the behaviours which stand out from rest of others. In these kinds of behaviours the child laughs unnecessarily, talks to self loudly, makes peculiar and unpleasant sounds, mimics words (echolalia), mimics gestures (echopraxia), plays with unacceptable objects, touches others unnecessarily, collects rubbish, etc.

(g) Hyperactivity -

These kinds of behaviours are characterized by lack of concentration, less span of attention as per his age, talking excessively and many a times unnecessarily going or running away from school or home, messing the place, running about the place, inability to sit at one place for required time, not completing the task at hand, etc.

(h) Rebellious behaviour -

It is characterized by disobedience in which the child refuses to obey or follow instructions, breaks rules, refuses to participate in regular activities, refuses to perform regular activities on time, and does opposite of what is regulated.

(i) Anti social behaviour -

Anti social behaviours are those behaviours which are against the norms put forth by the society. It involves stealing, cheating in games, lying, twisting the truth, blaming others, making obscene gesture, undressing in front of others, using abusive language.

(j) Fears -

It involves being scared of some person, objects, places, animals, etc. There is one more category of problem behaviour not included in the list of above mentioned domains. It is -

(k) Withdrawal behaviours -

In this type of behaviours the child withdraws himself and goes into a shell of his own and it would become difficult for others to bring the child out of his

shell. Here he shows behavioural characteristics like sitting or standing without doing any activity for a long period of time, has no eye contact, does not talk spontaneously to others, stares blankly, does not reply to the questions.

5.5.3 Behavioural Techniques in Problem Behaviour Management -

Various behaviour techniques have been used successfully by teachers to manage behaviour problems of children individually on one to one basis and in classroom setting. There are number of techniques which are used but before using these techniques certain considerations are to be taken care of –

The most widely used techniques for modifying problem behaviours are -

1. Changing the Antecedents (Before Factors)

There are a number of antecedent factors, in the presence of which, behaviour problems may tend to occur. These factors may include particular settings, situations, places, persons, times, specific demands placed on the child, difficulty levels, methods of instructions used by the teacher, sudden change in routine etc. If the links between any of these factors and the occurrence of problem behaviours is found then a simple avoidance, alternation or change of such factors which may be sufficient to manage problem behaviours. Through this technique problem behaviours can be managed by controlling or changing the antecedents i.e. the factors which leads to problem behaviours.

Sometimes it may not be possible to have continuous control over the antecedent (before) factors in the natural environment. Hence, other techniques of controlling the after factors (consequences) needs to be applied in order to achieve long lasting results in the management of problem behaviours.

2. Extinction or Ignoring -

Extinction means removal of rewards permanently following problem behaviour. This includes action like not looking at the child, not talking to the child, not having any physical contact with the child following the problem behaviour. Many a times, child indulges into problem behaviours in order to seek attention of teachers or others. At this instance one need to identify

these attention seeking problem behaviours which may or may not be harmful to the child or others and ignore them for their effective management.

Extinction is a useful technique even for the management of such problem behaviours which are mediated by escape factors. For example - if a child cries in order to escape from any activity, then this behaviour needs to be ignored.

3. Time out -

Some problem behaviours in children are so serious or harmful to themselves or others that they cannot be simply ignored. For such kinds of behaviours time out can be the most effective technique. It may be helpful in dealing with aggressive and destructive behaviours.

Time out method includes removing the child from the reward or the reward from the child for a particular period of time following problem behaviour. There are different types of time out. There are many ways for using the techniques of time out in the school settings.

These different techniques are -

- a) Place the child outside the sphere of learning activity for a specified period of time in the class. The child should be placed in a position, where he can see or hear the activity, but cannot participate in it.
- b) Insist the child to place his head on the desk in a head down position for a specified period of time.
- c) Remove the rewarding activity materials from the child for a specified period of time.
- d) Remove the child to an area in the class where in he can neither see nor participate in the activities of other children for a specified period of time. For example - in the corner of the classroom facing the wall.
- e) Seclude the child to an isolated room also known as the 'Time out room' wherein he can neither see, hear nor participate in the activities of other children for a specified period of time.

Steps in the use of seclusion or Time Out -

1. When a child indulges in problem behaviour give a short statement describing what he did and just tell him that he must take a time out.
2. Be brief in all communications with the child. No communication with the child while he is in the time out area.
3. Place the child in the time out only for short period of not more than 2 - 5 minutes, after each occurrence of problem behaviour. Never remove the child from a time out while he is continuing to misbehaviours.
4. Use isolation in a time out room only when the child refuses to obey to minor forms of time out.
5. Use time out immediately if the child indulges into problem behaviour after coming out of the time out room.
6. Once the child is taken out of time out room he should not be given any special treatment.
7. If the child indulges in desirable behaviour after coming out from the time out, he should be rewarded.

4. Physical Restraint -

Physical Restraint involves restricting the physical movements of the child for some time following problem behaviour.

While indulging in some types of problem behaviours, a few children may completely lose control of themselves. They may even harm themselves by banging head, biting self etc. they may also harm others. At such times, it becomes necessary to physically stop the child from indulging in such behaviours. For this, we may hold his arms tightly, hold him in between the knees etc. For example - if the child continuously shakes his head then through physical restraint we can hold his head firmly in between the palms and help him stop his head movements.

Another form of physical restraint can be restricting the vision of the child for few seconds following the problem behaviour. Combine the use of physical restraint by repeatedly pairing it along with a loud verbal "No." Over a number

of trails, this enables the child to stop the problem behaviour even to an empathetic 'No.'

5. Response Cost -

Another way of decreasing problem behaviours in children is to take away the reward that the child has earned by performing specific good behaviours. In other words, this technique involves the child to pay a fine or the cost for indulging in problem behaviour by giving away something which he has earned from showing desirable behaviour.

Wherein the system of token economy is used in a school, teachers can arrange for the child to receive tokens on performing specific desirable behaviours and loose tokens for indulging in specific undesirable behaviours.

6. Restitution or over correction -

The use of this technique will not only decrease problem behaviours in children, but also teach appropriate ways of behaving. When this technique is implemented, after the occurrence of problem behaviour, the child is required to restore the disturbed situation to a state that is much better than what it was before the occurrence of the problem behaviour. The child also required to practice right ways of behaving.

For example - if the child throws his toys here and there in the class room then he is required to pick up any or all other toys or things lying in the class room and put them in appropriate places.

7. Conveying Displeasure -

In the use of this technique, one is required to give clear verbal commands expressing displeasure to a child following the occurrence of specific problem behaviour. This is also called as 'reprimands'.

8. Graduated Exposure for fears -

Graduated exposure techniques are especially used to decrease fears in children and adults. It involves a step by step gradual exposing the child to a feared

person, place, object or situation. For example - if a child has fear of dog, initially, let him pass by the dog from a long distance while his hand is being held and he feels secure. Then bring him closer to the dog while he gets an opportunity to observe a model with the dog. Eventually take him closer to the dog and if the dog is friendly, get him to touch it with his hands.

9. Differential Reward Technique -

This technique requires rewarding appropriate or non occurrence of problem behaviours in a planned way so as to decrease problem behaviours. It is also known as reinforcement or reward.

The event that happens after a behaviour which makes that behaviour to occur again in future is called 'reward'. All our behaviours which we tend to repeat are followed by rewards. If a particular behaviour is not followed by rewards that behaviour would not be performed again. Thus rewards are important means of changing behaviours in children. There are many kinds of rewards which can be categorized as primary and secondary rewards.

Primary rewards are mostly the eatables liked by the children.

Secondary rewards can further be classified into -

- (i) **Material Rewards** - These are the things or articles liked by the children.
- (ii) **Social Rewards** - They are verbal praises or signs of appreciation like by children. They can be grouped as verbal - Good, excellent, well done and nonverbal - A smile, pat, hug, nod.
- (iii) **Activity Rewards** - They are actions or behaviours liked to be performed by children.
- (iv) **Token Rewards** - Token rewards are items though valueless in their own right, gain value through association with other things. They are given to children following the performance of desired target behaviour.
- (v) **Privileges** - They are special status or positions, which every child likes to occupy. The procedure of giving these rewards involves placing the child in any status or position which makes him feel important.

After selecting the right reward, the best way to give it is -

1. Reward only the desirable behaviour. This has to be fixed before hand as to which behaviour is desirable and / or undesirable.
2. Reward clearly - Be clear and specific while rewarding.
3. Reward immediately - Always reward immediately after the occurrence of desirable behaviours.
4. Reward the desirable behaviour, each and every time it occurs.
5. Reward in appropriate amounts.
6. Combine the use of social rewards along with other kinds of reward.
7. Change the rewards.
8. Fading of rewards.

The differential rewards can be applied in various ways. They being -

1. Differential reward of opposite behaviours -
In this method, the behaviours which are opposite to the problem behaviour and which needs to be modified are to be rewarded. For example, if a child shows 'out of seat' behaviour, his 'on seat' behaviour needs to be rewarded.
2. Differential rewards of the other behaviour -
The method involves rewarding the child at the end of every pre-decided time interval during which targeted behaviour did not occur. For example - to bring down the 'out of seat' behaviour, it has to be planned that reward is immediately given at the end of each five minutes if the child did not get up from his seat. Thus according to this techniques the reward is given to the child for not showing the problem behaviour during a specific period of time.
3. Differential Reward period of time.
When the intension is just to reduce the intensity of misbehaviour and not to eliminate that behaviour completely, this technique is useful. For example - to reduce the intensity of screaming. If the child speaks too loudly, he is rewarded only when he speaks softly.

4. Differential reward of alternate behaviour -

In this method, other desirable behaviours are identified and rewards are being provided to these behaviours immediately. This technique is used along with other techniques for decreasing undesirable behaviours.

10. Self Management Techniques -

In case of children with mild mental retardation and at the upper age levels, these techniques are used which would make them more responsible to manage their own skill behaviours or problem behaviours. The use of these techniques will help in increase of self control in children whereby they would start taking the responsibility for their behaviours. There are many kinds of self management techniques that can be tried for better functioning in children.

They are –

(i) Self observation -

Here the child needs to observe his own behaviours in the given situations in which they occur.

(ii) Self recording -

Children can be taught to keep records of their own skill behaviours and/or problem behaviours by maintaining a daily diary.

(iii) Self cueing -

The child must be trained not only in the techniques of self recording but also in giving cues or hints to ones own self whenever and wherever the behaviour needs to be increased or decreased.

(iv) Self reward technique -

Most children with mental retardation mainly depend on external rewards for learning or modifying their behaviours. Through this technique the children are directed to seek internal rewards for their behaviour in the form of self satisfaction, feeling of achievement or success on completion of specific tasks or even giving themselves reward for their better behaviours and better performances.

(v) Correspondence Training -

As a part of self management techniques, children with mild mental retardation can be trained to make positive self statements about how they would behave in specific situations.

(vi) Anger control technique -

Some children lying in borderline category can be trained to observe, identify, record and manage their own anger behaviours by using self management techniques.

They can be trained in following ways -

1. To help him to recognize that he is angry in a given situation.
2. Train him to properly verbalize his anger saying 'I am angry'.
3. Help him to discover the immediate reason for his anger.
4. Help him to find out the accompanying thoughts and feelings when he is angry.
5. Help the child to replace his angry thoughts or feelings with more adaptive one.
6. The child can be instructed to relax by performing deep breathing exercises or lying down on a bed for some time.

5.6 RATIONALE OF THE STUDY:

Generally, it has been found that nearly 50 - 60 % of the children with mental retardation have behaviour problems. These problems arise because of poor skill development as a result of which they have difficulty in expressing themselves. So in order to express them and to reach out to other people, they develop certain kind of behaviours which cause hindrance in their daily living activities. As these behaviours affects their activities of daily living, these techniques of behaviour modification would help the child in better functioning thereby adjusting well and coping properly with all the situations and people in a better manner.

Further, 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 tolerate undesirable behaviours and to fulfill all demands of children with mental retardation in order to keep them, makes matters worse. Due to the presence of behaviour problems children with mental retardation may find it difficult to get admission in special schools, cause embarrassment to the parents and family members due to the presence of socially unacceptable behaviour. They may also find difficult to adjust in different settings. So controlling these behaviour problems becomes the priority for each and every person concerned with the child as well as for the child himself.

Also it is a known fact that mental retardation is a condition and cannot be cured but as a remedy to it, some training can be imparted to the child so as to become more functioned and independent. The behaviour modification techniques would help the child in attaining more independence. It is also found that when problem behaviours are identified and treatment is done earlier, it may produce long lasting and significant gain in children (Eachin, 1993).

It has been found that children with mental retardation have four to five times more behaviour problems than their normal counterparts. Many a times it so happens that parents are unaware about these problems so they either encourage some particular behaviours or discourage them due to which there are chances that more problems may arise. With this study parents can be made aware about the problems persisting in their children and thereby would be helped to help their children.

Many a times it so happens that parents as well as many teachers are unaware about the techniques of managing the child with behaviour problems. So they tend to use some punishments which in turn would further increase the problems in the behaviours of the child. So with the help of this study, the parents, teachers and other family members would be made aware about the different kinds of problem behaviours observed in the child and thereby help them in management and remedy of the problems with the help of behaviour management techniques which would help in the overall development and better

functioning of the child. Thus helping the child as well as the persons involved with him.

Sometimes it so happen that one problem may lead to another problem which would be harmful to the child or to others. So with the help of behaviour modification techniques such secondary conditions may be reduced or eradicated completely. With the help of this study the secondary problems arising in the child would be known and steps would be taken to resolve these problems as early as possible.

From the review of related literature it becomes clear that many studies related to behaviour problems in children with mental retardation and their associated problems have been done abroad but the Indian scenario states that not many studies have been conducted on behaviour problems in children with mental retardation. Further, it is also found that studies conducted in this area are mostly done on behaviour problems in children with mental retardation and very few quoted so far have studied the effectiveness of behaviour modification techniques on children with mental retardation. So this study would add up to the existing studies, different techniques useful in modification of problem behaviours.

Further more, research studies of name and year of researcher have established the efficacy of behaviour modification techniques for maintaining a stable general mental health. It is used as a supporting therapeutic in the treatment of much mental illness along with mental retardation. With children having mental retardation behaviour modification plays a major role in meeting the challenges of all skill training behaviour and in controlling the problematic or undesirable behaviour. The role of behaviour modification is also important in the training and rehabilitation of any mode of disabled condition.

After parents and the relatives of the children with problem behaviours, the most concerned are the teachers. This study would also help the teachers concerned, to know problem behaviours present in the child and the ways or the techniques which can be applied to modify these kinds of problem behaviours.

So as to help the child develop to his fullest and help other children in the class room who are being affected because of the problem behaviours in particular child.

Our main motive is to see the child as a whole so as a part of his training the main priority is to control the problem behaviours, so as to ensure his progress at the fullest. So this study would help to judge the priorities of the child and there by help in better functioning.

This study would also give an insight about the effectiveness of behaviour modification techniques, in children with mental retardation having behaviour problems. It would also suggest about the most effective techniques for the children with mental retardation.

At the end, the researcher would like to point that as per the definition given by AAMR on mental retardation, the children having mental retardation has limitation in present functioning and adaptive skills. It is established that 50 - 60 % of children has one or the other behavioural problems. This condition necessitates the need for behaviour modification and so this study has to be undertaken.

This intervention study developed to study the common behaviour problems of children with mental retardation and the general modification techniques could be practiced as an intervention to reduce or modify the frequency and intensity of occurrence of problem behaviours.

5.7 RESEARCH QUESTIONS:

Through this study the researcher has tried study the following questions:

1. Why is a need to modify problem behaviours?
2. Would the use of behaviour modification techniques be effective with children having mental retardation?
3. How far would the techniques be effective in minimizing the problem behaviours in children?
4. To what extent would the problem behaviours in children be reduced?

5. For how long would the effect of behaviours modification techniques last among the children having mental retardation?
6. Would there be any changes observed in the children in terms of frequency of occurrence of problem behaviours?

5.8 STATEMENT OF THE PROBLEM:

A study on effectiveness of behaviour modification techniques in children with mental retardation.

5.9 EXPLANATION OF TERMS:

The main terms used in this study are mental retardation, problem behaviours, effectiveness and behaviour modification techniques.

(i) Mental Retardation

Here mental retardation is the condition in the child which refers to significantly sub average general intellectual functioning resulting in or associated with concurrent impairment in adaptive behaviour and manifested during the developmental period.

For this study children having mild to moderate level of mental retardation are selected. mild level indicates IQ ranging between 50 - 70 and moderate level indicates IQ ranging between 35-50 as given by AAMR, 1983.

(ii) Problem Behaviours or Behaviour problems -

They are those behaviours observed in the child which causes harm or inconvenience to the child and to others and are not as per the norms of the society. (R. Peshawaria 1989)

(iii) Effectiveness -

In this study, effectiveness was studied in terms of change in / reduction in / improvement / intensity and frequency of occurrence of problem behaviours. Here intensity means the force with which the behaviour is manifested, the degree of which is higher than the normal manifested in a given period of time.

(iv) **Behaviour Modification Techniques -**

Behaviour modification techniques are those which when applied, reduces the problem behaviour or resolves it completely (R. Preshawaria, 1989).

5.10 OBJECTIVES:

1. To develop profile of each child with mental retardation.
2. To identify the problem behaviours amongst the children with mental retardation.
3. To make parents, family members aware about the behaviour modification techniques used to overcome problem behaviours in the children with mental retardation.
4. To study the effectiveness of behaviour modification techniques in terms of intensity and frequency of occurrence of problem behaviours.

5.11 DELIMITATIONS OF THE STUDY:

1. Only one institution working in the field of mental retardation has been taken for the study.
2. Only those children having mild to moderate level of mental retardation were taken for the study.
3. In this, behaviour modification techniques were used only to modify or correct or minimize the problem behaviours and not for developing of enhancing skill behaviour.

5.12 SAMPLE

In any research, proper selection of the sample has the highest importance. Sample should be selected in such a way that it represents mass population except some rare instances in which the whole population is taken. Research is almost invariably conducted by means of a sample, on the basis of which some general conclusions are drawn which are applicable to the population from which the sample was obtained. Taking the whole population is generally much costly and difficult and many a times impossible. Modern statisticians now-a-days feel that taking the whole population is an indication of statistical incompetence. Taking a sample is not mere practical but it further permits a

greater control over some other variables as well. It is to be admitted that a major reason for taking a sample is to reduce time, effort and money. There are two characteristics of a good sample –

- (1) It should be representative
- (2) It should be adequate

Some of the methods of sampling are suggested by H.E. Garrett as follows–

- (i) Random Sampling
- (ii) Stratified or quota sampling
- (iii) Incidental sampling
- (iv) Purposive sampling

Out of these techniques purposive sampling was selected for the study.

5.12.1 Details about the sample (Population)

All the cases registered at ARPAN – A centre for children with multiple disabilities constituted the population for the study.

ARPAN – A centre for children with multiple disabilities is a non government organization (NGO) which was established in December, 1993. It is a Diagnostic and Development Centre which renders a unique centre based and home based integrated service oriented programme for children with multiple disabilities. A multi disciplinary team of specialists comprising of pediatrician, physiotherapist, psychologist, special educator, vocational rehabilitator, speech therapist render their services at ARPAN for making the child as much independent as possible. Till December, 2007 ARPAN had catered to the needs of 1263 children with multiple disabilities which comprised of Mental Retardation, Cerebral Palsy, Autism, Downs, Syndrome, Children with Attention Deficit Hyperactive Disorder and many more except totally visual impaired and the hearing impaired. After a brief survey of institutions working in the area of mental retardation, children from Arpan were selected for the present study. As this being a longitudinal study for an year the researcher had to seek permission, which was granted by the authorities of Arpan.

The researcher also had to work with the parents during the implementation phase which was only possible at Arpan as parents come along with their children almost daily.

Also all the categories of children could be found at Arpan, which were needed for the study. So this institution was selected.

5.13 TOOLS AND TECHNIQUES

Tools are the instruments or devices through which the process of data collection is done. For the present study the tools used by the researcher were–

- (i) A case study Performa
- (ii) Basic – MR
- (iii) Anecdotal Records
- (iv) Diary

5.14 PROCEDURE OF DATA COLLECTION

The data for the study was collected in three phases.

5.14.1 Phase – 1

Phase – 1 involved identifying the children having mild to moderate level of mental retardation with behaviour problems. These children were selected from ARPAN – an institution working for children having multiple disabilities. Out of all the children registered in the institution fifty children were selected for the study. Case studies of these children were taken and the problem behaviours as perceived by their parents and teachers, were noted (step – 1 of behaviour modification technique).

5.14.2 Phase – 2

Phase – 2 – It comprised of selecting thirty children having mild to moderate mental retardation with common behaviour problems out of fifty. These children were selected on the basis of their regularity in the institution and the co-operation and willingness shown by their parents for the study.

Before the actual administration of the tools and the intervention programme, the parents of these selected children were briefed about the study and its objectives.

The actual problem behaviours i.e. problem behaviours in objective terms were identified after administering the BASIC-MR – A problem behaviour checklist developed at NIMH (1992). The problem behaviours were then listed according to the priority and the need of the child. Which were simple and which could be easily achieved by the child. (step-2 Behaviour modification Technique).

After the problem behaviours were identified and prioritized, behaviour modification techniques were applied in the institution to each child. Parents as well as professionals working with the child were briefed about the techniques. These techniques were applied for one whole year and in between every three months BASIC – MR was administered to study the progress in the child. (step 3 and 4 of behaviour modification technique).

A diary regarding the observation and changes in the behaviour of each child was maintained. Parents were also asked to note the change in the behaviour or anything related to the behaviour in a separate diary.

5.14.3 Phase – 3

In phase – 3 at the end of the year, after the implementation of the behaviour modification techniques, the outcomes were observed in the child. The effectiveness of the techniques was also studied. The investigator also observed (1) the extent to which the problems were modified – whether totally or partially, (2) the time taken by each child to overcome a particular problem behaviour if resolved totally. (3) the type of Behaviour Modification Technique effective on the child.

In the final stage of, the researcher made follow-ups every three months till December 2007; The follow-ups were regarding the presence, frequency, intensity of the problem behaviours and the sustainability seen in the desired behaviour (step – 5 of behaviours modification technique).

5.15 ANALYSIS OF THE DATA

The data obtained was analyzed case wise. A profile of each child was developed throughout the year. A chart of frequency and intensity of the

occurrence of behaviour problems was developed. Descriptive analysis of each child was done on the basis of this table. On the whole it was qualitative analysis of the data.

5.16 MAJOR FINDINGS

Majority of the children comprising the sample had neonatal convulsion (seizures) and infections as the major cause for their present condition.

The second major cause for mental retardation was birth asphyxia. Even if the child did not cry for a minute then he develops risk of developing mental retardation. For the present study the cases taken for the sample reveals that all the eight cases discussed cried after 10 minutes or more time.

Mother's condition has also come out to be a cause of mental retardation. Here majority of the mothers suffered from high blood pressure, had some trauma or an accident while expecting.

Prematurity is another cause. Here the children were born before the due date due to which as they are not fully developed physiologically there chances of being at risk for mental retardation increases. For the present study also five children comprising the sample have prematurity as the cause of their present condition.

The other causes of mental retardation in the sample for the present study are Genetic, low birth weight, neonatal jaundice and respiratory distress due to aspirating the amniotic fluid.

Each child comprising the sample for the present study was assessed for the presence of problem behaviours using BASIC-MR. Analysis of each case reveals that –

All the children had more than one domain of problem behaviours. These behaviours did vary from child to child as far as its frequency and intensity was concerned.

On further analysis it was found that majority of the children i.e. twenty seven children from a sample of thirty had hyperactivity in varying degrees. This means that they have problems in paying attention to any particular task, could

not pay attention to a particular task for required time and that they could not complete a given task. They were quiet restless and had difficulty in concentrating on any particular activity. Due to hyperactivity, restlessness and lack of concentration they had problems in sitting in the classroom, had difficulty following the instructions given by the teachers. At home also they had many adjustment problems. People did not accept them readily and they felt neglected as a result their overall development was affected.

The second major problem behaviour observed was misbehaviour with others, which was observed in twenty five children. During investigation, it was seen that this behaviour is associated with hyperactivity in the sense that due to hyperactivity they were ignored and neglected. So to mark their presence they got involved into misbehaving with others. In this, they would not allow others to perform their task, make loud noise when others were working, dominate on others etc. Further it was noted that one of the causes of problem behaviour is for seeking attention and through this type of behaviours the children tried to seek attention of others.

The other problem behaviour observed was rebellious behaviour. Many times it has been found that children indulge into these kinds of problem behaviours in order to escape from any particular task. As such the sample comprised of children having mental retardation whose level of understanding is lower as compared to their normal counter parts. So they face problems in comprehending things. When comprehension is lower, creative expression is also less. So they indulge into rebellious behaviour.

Further more they also showed repetitive and odd behaviours. These behaviours occur due to self stimulating factors in which they get pleasure by indulging into these kinds of behaviours and they are reinforcing for them. So in order to seek pleasure they indulge into repetitive behaviour.

Odd behaviours in these children were observed when they wanted to seek attention from others. The other reason found was they lack that potential to comprehend things at proper time and place due to lower intelligence quotient.

Violent and destructive behaviour was another major problem behaviour which was identified in twenty three children. On analysis and anecdotal records provided by parents it was found that when children had problems in verbal or gestural expressions i.e. skill deficit cause they got indulged into these kinds of behaviours. Also children with hyperactivity showed this kind of behaviour. As due to hyperactivity they had those extra energies which were not fully or properly channelized then children indulged into violent and destructive behaviours. So it was a mode of expression for them and the outburst of those extra energies.

The other problem behaviour identified was temper tantrums. During the process of investigation it was found that children engaged in these kinds of behaviours when they have problems in verbal expression skill deficit and when their needs were not fulfilled by the concerned persons. For four children it was also found that over pampering and over attentiveness had been the cause of temper tantrums.

The next in the list was self injurious behaviours. Those behaviours occurred as a consequence of throwing tantrums, when others were inattentive towards the child, when he was left under stimulated or un-stimulated or due to self stimulating factors. Each child showing this problem behaviour had a different cause for it.

At the end of the list were the anti-social behaviours and fears. These children comprising the sample had problems in judging what is right or wrong as they have poor reasoning skills. As a result of this they got engaged into anti-social behaviours like telling lies, stealing. Further it was also found that when they did not like any particular activity, in order to escape from that they indulged into antisocial behaviours like wandering outside the classroom. Two children even ran away from house when they were forced to sit and study.

Basically these children do not have fear of anything but while interviewing parents it was found that when these children did not listen to their parents or

were being hyperactive then their parents induced some kind of fear in them. This fear then slowly accumulated in them and they developed fear for any person, object or place.

After the techniques were implemented for reducing and resolving the problem behaviours the analysis and interpretation of these techniques was done in terms of its implementation with the children and its effectiveness for each child. This can be seen from the bar graph.

It was found that reinforcement technique has been effective with all the children comprising the sample except for one child. Further more it was also found that for young children that is till the age of eight years, primary reinforcement was more effective wherein they were reinforced by giving any eatable which they liked. Children older than eight years preferred secondary reinforcement in which apart from social reinforcement which included praising words, they also preferred privileges in the form of any activity like crayoning, painting, listening to music. It could also be interpreted that majority of the children (7 out of 10) having mild mental retardation showed preference for secondary reinforcers rather than primary ones. Whereas children having moderate mental retardation had preference for primary reinforcers.

The selection of the reinforcers was done by observing the child (that is his likes and dislikes and his preferences shown during the class activities), directly by asking them, asking their parents, siblings or teachers concerned. After all this if the preference was not judged by the researcher then the reward preference check list was used. Thus it could be stated that mostly primary rewards were effective for younger children and for children having moderate mental retardation. While secondary rewards were used and were effective for older children and for those having mild degree of mental retardation. Overall whether the reinforcement was primary or secondary, it was the most effective technique to reduce and resolve problem behaviours in children having mental retardation.

The other technique which was implemented upon majority of the children (twenty eight) in terms of its effectiveness for resolving the problem behaviours was conveying displeasure. Here while implementing this technique it was found that even though children having mental retardation have lower intelligence quotient as compared to their normal counter parts, they did possess the potentiality to know when and for what reason displeasure was conveyed. So due to this, no doubt the results obtained through this technique were slower, the problem behaviours got completely resolved at the long run and it was more effective with the older children and with those having mild mental retardation as their comprehension was better than children having moderate mental retardation. Thus whether the child is having mild or moderate mental retardation, this technique of conveying displeasure was quiet effective in reducing and resolving the problem behaviours.

Similarly timeout technique was also effective with the older children and with those having mild retardation. The reason found was that children having moderate retardation had difficulty in comprehending as to why they were segregated from their fellow mates or were not allowed to perform any particular activity and they could not relate its importance. Considering this it was applied to only fifteen children comprising the sample for the study. For these fifteen children it has been very effective in reducing and resolving their problem behaviours especially with children having violent and destructive behaviours, hyperactivity and misbehaving with others.

Physical restraint was the technique which was more effective with children having violent and destructive behaviours and with hyperactivity as through this technique their physical movements were restricted. As a result of which it got reduced and slowly got resolved.

Even though response cost was implemented upon twelve children, its effectiveness was not as much as reinforcement and conveying displeasure. The reason was that these children had difficulties in understanding as to why he had to pay a fine or part away with the thing which they liked or which they had

earned as tokens while indulging into desirable behaviours. This technique was also much effective with the older children and with those having mild mental retardation.

While using the technique of ignoring it was noted that during the initial stages that is for four to five days the problem behaviours in children increased.

But than gradually they got decreased and finally got resolved. One major constraint found while using this technique was that it was implemented only when the behaviours shown by the child were that of seeking attention. It became very difficult for the researcher to decide which behaviours were just for seeking attention and which were because of some other causes. Further this technique was strictly not applicable with those behaviours which were harmful to self or to others that is it was not useful and implemented for behaviours like self injurious behaviours, violent and destructive behaviours, hyperactivity, anti social behaviours and for fears. It was mainly used when the child indulged in some kind of odd behaviours especially like talking to self, laughing to self and laughing inappropriately.

For those children having fears of any kind, graduated exposure to fears was the most effective technique which gave very good results and the problem behaviours could be reduced to a very large extent.

Two techniques of changing the antecedents that is changing the cause of the problem behaviours and over correction could not be used with the children for the present study. Extinction as a technique was implemented with all the children for the study as it involved gradual decrease in use of techniques as and when the child indulged into desirable behaviours and finally the use of other techniques was completely stopped when the problem behaviour had resolved completely.

Further it could also be analyzed that all these techniques were used in combination of one or more than one other techniques in order to obtain

desirable change in the problem behaviours of the children. Any one technique was not used for complete resolution of the problem behaviours.

The implementation could be possible only with the support and cooperation of the parents. It was because of their sincere efforts and regular follow ups that the problem behaviours in their children could be resolved. Had the parents not being regular and sincere in their follow ups and cooperative in implementing the techniques, the desired change could not have been possible.

Even the scores obtained by assessing the child every three months on BASIC-MR are also suggestive that the techniques which were implemented have been effective in reducing and resolving the problem behaviours in the children with mental retardation.

This being a longitudinal study, the children were observed for a whole year while the techniques were being implemented and their effectiveness was studied. Apart from this actual study the children were also observed till December 2007 and the changes and the occurrence of problem behaviours were studied. During this observation and follow up period it was found that there was no increase in the other problem behaviours. The problem behaviours which were observed at the end of the third quarter were maintained and there was no increase in the occurrence of the already existing problem behaviours. As a result of this the child became more functional and participative.

5.17 CONCLUSIONS

There are different causes for the occurrence of mental retardation.

There has been one or more than one cause for the occurrence of mental retardation in the children selected for the study.

The categorization of causes does overlap due to more than one cause for the occurrence of mental retardation.

Majority of the cases selected for the study have the post natal factors as the causes of mental retardation.

There is no difference in the types of problem behaviours as far as gender is concerned.

The intensity and frequency of occurrence of problem behaviours differed from child to child.

Variety of problem behaviours was identified amongst each child under study.

Majority of the children had hyperactivity, misbehaves with others and rebellious behaviours.

No single modification technique was effective with the children. They were used in combinations of one another.

The use of the techniques also depended upon the intensity and frequency of the occurrence of problem behaviours.

Reinforcement when combined with other techniques was very effective. The other techniques which were implemented were mostly aversive techniques that are they were sort of punishment techniques. But these techniques were found to be very effective with the sample for the study.

The scores obtained at the end of the third quarter were suggestive of the effectiveness of the techniques.

The effectiveness of the techniques also depended upon the age, the mental levels and the intelligence quotients of the children.

Parent's cooperation, regularity and sincerity in implementing the techniques also had an impact on its effectiveness and the change observed in the children.

The study has helped parents and teachers in understanding the child, identifying his problem behaviours and managing them.



It has helped them to become self reliant in case if in future problem behaviours occurred.

5.18 RECOMMENDATIONS AND SUGGESTIONS –

Following recommendations are made on the basis of the in depth study of the literature available in this area.

- Along with the rehabilitation of persons with disabilities, there should be rehabilitation of the society so as to help them accept the persons with disabilities as they are.
- This rehabilitation can only be possible by organizing more awareness generating programmes in both urban and rural areas wherein the issues relating to disabilities be covered.
- Parents are the key people for the overall development of persons with disabilities. So the role and participation of every parent should be emphasized more.
- Along with parents, their siblings and special teachers too play a major role. So their involvement should be increased.
- Each and every parent, siblings and the special teachers of the persons with disabilities be trained in identifying the problem behaviours and implementing the techniques so that they know the correct procedures for managing the special child. Thereby making them more functional and accepted in the society.
- More support should be provided to the parents belonging to low socio economic status so as to properly train their child by sending them to special schools. Thereby maintaining the regularity and punctuality of the child in attending special or integrated schools.
- More involvement of siblings and other family members will relax the parents for a while and their anxieties for the future of their special child can be reduced. It would also keep the family bound together and every person understands their responsibilities towards the person with disability.

- Persons with disabilities should be empathized rather than sympathized and so try and make them as independent as possible. The motto should be “Total dependence to inter dependence to complete independence”.
- More progressive practices rather than the old traditional ones be applied and implemented.
- Proper barrier free infrastructure for the overall development of persons with disabilities and for their better participation in the society should be emphasized.
- More in-service training programmes for special teachers and professionals working for persons with disabilities be organized at the local levels.
- More employment avenues be opened for the persons with disabilities in the private sectors.
- Employers also should be sensitized about the different aspects of persons with disabilities and the problems faced by them.
- More integration programmes should be planned.
- The young generation needs to be sensitized more about persons with disabilities so as to accept them easily without labeling, bullying or making fun of them.

Although there has been a steady increase in the support system for the persons with disabilities, the above recommendations further reveals its intensive need as the existing support system is not adequate enough to meet the needs of the increasing numbers of persons with disabilities.

In the light of the findings that have emerged from the present study, following suggestions are drawn for further research.

- Same study can be carried out with the larger population so as to come to more generalizable findings.
- Present study was only focused on children availing the services of one organization working in the area of disability. Another study of the same kind could be conducted by taking sample from other organizations in which the existing infra structure and services provided are taken into account.

- Present study focuses on the mild and moderate mentally retarded children. Another study of the similar kind should be taken up for other disabilities like autism, learning disability, slow learners, orthopedically handicapped, visual and hearing impaired could be conducted.
- Present study aims at actually working with the children having mental retardation. Another study could be conducted taking the intervention programmes only for the parents and or special teachers.