

**ADDIS ABABA UNIVERSITY
SCHOOL OF GRADUATES STUDIES**

**ATTITUDES OF PARENTS ON THE INCLUSION OF CHILDREN
WITH MENTAL RETARDATION
(The case of 6 parents in and around Addis Ababa.)**

MEKDES GEBRETENSAY
June, 2000

ATTITUDES OF PARENTS ON THE INCLUSION OF CHILDREN WITH MENTAL RETARDATION

(The case of 6 children in and around A.A)

A Thesis Presented to the School of Graduate Studies
Addis ABABA university

IN partial Fulfillment of the requirement of the Degree of Masters
of Arts In Special Needs Education

By

Mekdes Gebretensay
June, 2000

Abstract

This study focused on the attitudes of parents on the inclusion of children with mental retardation with objectives of finding out the scene on the inclusion of the children at home level, neighborhood and the school or training in the community. The method used was qualitative including feelings of 6 parents in Addis Ababa and the surrounding rural community. Their statuses are one educated and high economical status, two medium level with farm economy; two single mothers and a couple with low education and low economy. Variety is observed among the children whose problem of intensity ranges from mild to sever levels of adaptive behaviors. Their types and chronological age levels were; two girls with Down Syndromes of age 7&11; a girl with microcephally of age 23; age 7 boy of multiple disability with brain damage; a boy with hydrocephally of age 27, with multiple disability; and a boy of age 25 with an unidentified type but with moderate retardation.

The findings showed the parents' attitudes to be very similar but one parent although uneducated and from low income is positive and has a quality relationship with the child. This created the possibility for the inclusion of her child at home and as well as in a regular school, except the isolation in the neighborhood. The major factors for generation and maintenance of positive attitudes were; parental style of the mother's (the way the parents were brought up), educational background, exposure during childhood development to have virtues like intuition, love and tolerant behavior together with the existence of a CBR intervention of an NGO in the area. The prevalent attitudes on the inclusion of the children at all levels are surprisingly negative. It was also observed that there was a distinct gender difference when it comes to sharing of responsibility and caring for children. The roles played by fathers is negligible. The contributing causes are the psychological coping mechanism of the parents, lack of awareness on the causes and treatment, lack of early intervention, and any community programs concerning training or education to the children, parents, the neighbors and siblings.

The study has recommended detail intervention strategies from macro to micro level with the implementation of the rights of children with disabilities, parent empowerment, sensitization of the community and the neighborhood, individual intervention to parents (counseling), early intervention, training of education to the child, Child to child programs to the siblings in the neighborhood and in the school.

ACKNOWLEDGMENTS

This study has gained from the collective wisdom of friends, colleagues and instructors and the subjects. Specially I would like to express my heartfelt gratitude to Dr.Yusuf Omar Abdi, my thesis advisor that provided me with sincere guides, truthful advises, encouragement and sharing of ideas from his rich and long years of invaluable experiences. I would like to thank Ato Chernet Tekle, who had shown sincerity in sharing his experiences during the research proposal and the designing of the methods

I am grateful to the Swedish Radda Barnen Ethiopia for the financial support and encouragement resulted from it's concern for children in difficult circumstances, the staff of the organization for their ceaseless cooperation to the study. To my friends Hiruth Teferi, Alemtsehay Mulat and Gilinesh Haile who were my closest allies in good and bad times.

Many thanks to the facilitators Yirgalem and Adamsu and Sefiw who were smart enough to identify the proper parents who could satisfy the selection criteria.

Thanks to the staff of the Ethiopian Federation of Persons with Disabilities (EFPD) for their cooperation in the final work (Printing) of the thesis.

Finally I would like to express my deep appreciation to Tsegaye kassa my dear husband who was a reliable support at the various stages of the research and my academic career. I owe a lot of credit to my beloved two sons Yonathan and Leul (Foni) for allowing me sufficient time to mind my business.

Acronym

1. AAMR -----	American Association of Mental Retardation	—
2. AAU -----	Addis Ababa University	-
3. CCF -----	Christian Children's Fund.	
4. CSA -----	Central Statistics Authority	
5. EFPD -----	Ethiopian Federation of the Disabled	
6. ENAB -----	The Ethiopian National Association of the Blind	
7. ENAD -----	The Ethiopian National Association of the Deaf	
8. ENAPH -----	The Ethiopian National Association of the physically handicap	
9. ENAELP-----	The Ethiopian National Association for Ex-Leprosy Patient	
10. IER -----	Institution of Educational Research	
11. IQ -----	Intelligent Quotient	
12. MR-----	Mental Retardation	
13. NGO-----	Non Government Organization	
14. RAD-----	Rehabilitation Agency for the Disabled	
15. SOOM-----	Support Organization Of Mentally handicapped children	
16. UN-----	United Nations	
17. UNICEF-----	United Nations Children's Fund	
18. WHO-----	World Health Organization.	

Figures & Tables

Figures

Page

1. Formation of defense Mechanism Diagram -----	34
2. Diagram of Echosystemic approach -----	-40

Tables

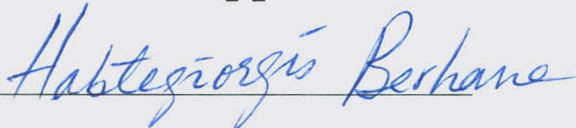
1 Children By age and sex phase 1 -----	22
2. Children By age and sex phase 2 -----	23
3. Table one: Parent's profile -----	63
4. Table two Children's Profile -----	64

ADDIS ABABA UNIVERSITY
SCHOOL OF GRADUATES STUDIES

ATTITUDES OF PARENTS ON THE INCLUSION of CHILDREN
WITH MENTAL RETARDATION
(The case of 6 parents in and around Addis Ababa.)

BY
MEKDES GEBRETENSAY

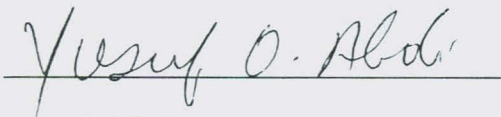
Approval of Board Examiners



Chairman, Department Graduate
Committee



Signature



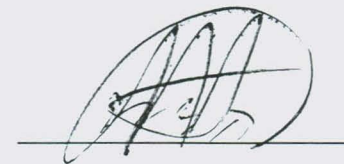
Advisor



Signature



Examiner



Signature



Examiner



Signature

Table of contents

	<u>Page</u>
Abstract	
Acknowledgement	
Acronyms	
Tables & Figures	
Approval of Board Examiners	
 Chapter I	
1. Background Of The Problem.....	1
2. Statement Of The Problem.....	6
3. Objective.....	8
General Objective	
Specific Objective	
4. Significance.....	9
5. Operational Definition.....	10
 Chapter II	
6. LITERATURE REVIEW	
Overview.....	12
6.1. Factors Of Mental Retardation.....	13
6.1.1 Current Situation.....	16
6.1.2 Prevalence.....	21
6.1.3 Concepts Of Mental Retardation.....	23
6.1.4 Types Of Mental Retardation.....	25
Cranial Malformation	
Children With Multiple Disability	
Down's Syndrom	
6.1.5 Causative Factors.....	27
Chromosomal Malformation	
Genetic Errors	
Birth Trauma	
6.1.6 Classification And Definition.....	28
7. Theoretical Frame Work.....	32
7.1 Psychosomatic Approach.....	32
7.1.1 Emotion And Attitudes of Parents after having A Child With Mental Retardation Denial, Projection Of Blame, Fear, Guilt, Mourning Or Grief Withdrawal, Rejection, Acceptance	32

	page
7.1.2 Erick H. Erikson's theory of identity.....	38
<i>Basic trust VS Mistrust; Autonomy VS Shame and doubt;</i>	
<i>Initiative VS shame and Guilt; Industry VS Inferiority;</i>	
<i>Identity VS Identity diffusion.</i>	
7.2 Ecosystemic Approach.....	39
7.2.1 Microsystems, Mesosystem, Macrosystem	
7.2.2 The Ecosystem in reference to the Subjects	
7.3 Intervention.....	43
7.3.1 The rights of children, Parent Empowerment.	
The Early Childhood Intervention.....	45
7.3.2 Methods of Early Intervention Program.....	46
7.3.4 Intervention with the child	48

Chapter III

8.METHODOLOGY

8.1 The Research Design.....	51
8.2 The Selected Parents and their Living Area.....	52
8.3 Instruments applied to collect the Data.....	54
8.3.1. Semi Structured Interview.....	54
8.3.2. Observation (participant and Non participant).....	55
8.3.3. Additional Sources of Data.....	56
8.4 Procedure.....	58
8.4.1 procedures of the data collection	58
8.4.2 Settings and Timing.....	59
8.5 Categorization Methods.....	60
8.5.1 Transcribing Tape Recorder and Video, data notes, categorizing observation schedules and issues for the outcome.....	60
8.6 Methods of Analysis.....	60

Chapter IV

9.FINDINGS OF THE STUDY

Overview.....	62
9.1 Demographic and Socio Economic profile of the Parents and the Children.....	63

	Page
9.2 Background of the parents and the Children.....	65
Parent 1.....	66
Parent 2	69
Parents 3.....	71
Parents 4.....	72
Parent 5.....	75
Parents 6.....	77
 9.3 Responses to particular Questions	
9.3.2 Q 1; The causes of Mental retardation of the Child	79
9.3.1 Q 2; Attitudes to Mental retardation.....	82
9.3.1 Q 3; Inclusion of the child with Mental retardation, within the family and Neighborhood.-----	85
9.3.1 Q 4; Inclusion in the School /Training and the future-----	87
 9.4 Responses of Siblings -----	89
9.5 The result of the Observation -----	91
9.5.1 The Child.....	91
9.5.2 Interaction	92

CHAPTER V

10. DISCUSSION AND ANALYSIS OF THE FINDING

10.1 Method of the Research and Nature of the	
Parents.....	94
10.1.1 Timing.....	94
10.1.2 Challenges of the information needs.....	95
10.2 The Background of the Parents.....	96
10.3 The Parents' Knowledge about Mental Retardation.....	97
10.4 Attitudes on the Causes and Treatment of Mental	
Retardation about their Children.....	98
10.5 Psychological Adjustment of the Parents	
Towards their Children's Problems.....	98
10.6 The Effects of the Parents' Attitudes on their	
Children's Performance	102
10.7 Attitudes Towards the Future.....	104
10.8 Parental Attitudes from the Point of	
View of Theoretical Basis.....	104
10.9 The Impact of Parental Attitudes on the	
Inclusion of the Children.....	106
10.9.1 The Opportunity of Wagaye.....	106

10.9.2 The Opportunity of Emebeth.....	108
10.9.3 The Opportunity of Zelalem.....	111
10.9.4 The Opportunity of Azeb.....	112
10.9.5 The Opportunity of Yitbarek.....	113
10.9.6 The Opportunity of Mesfin.....	114
.	
11. CHAPTER VI	
SUMMARY, CONCLUSION & RECOMMENDATION	
Overview	116
11.1 Summary	117
11.2 Conclusion.....	123
11.3 Recommendation.....	126
11.3.1 Specific Recommendation to the Cases in the Study.....	126
11.3.2 Specific Recommendation to the Children with Mental Retardation in General.....	127
11.3.3 Short Term.....	128
12. Appendix	
Appendix I Reference	131
Appendix II Observation Checklist.....	136
Declaration	

Chapter I

BACKGROUND OF THE PROBLEM

Mental Retardation had been on the records of history that goes back as early as 4000 BC (Laura Dolce, 1994). During the early times people used cruelty and coercion to treat the problem due to misconceptions to the etiology. In the 1st century AD during the Roman Empire the severely retarded were bitten and starved to death (Ibid.). In these periods in most cultures it was believed that mental retardation was caused by hereditary problem which led to the exclusion and ostracizing of certain groups of people to avoid the spread of the problem. The trend continued until the 11th century when epileptics and people with mental retardation were collected and put to death.

During the middle age, the church and the state begun to support the abandoned, children with mental retardation and the mentally ill in custody, which was a worst situation to the inmates in most cases (Ibid.). Gradually people started to differentiate mental retardation from mental illnesses. Some individuals in England and France in the 17th century like, Jean Itard and Pinel contributed to the development of a better treatment ((Mary Berne, 1994). During the 19th century one English Physician studied people with mental retardation in an asylum and identified the Mongolian type of retardation, later named after him as *Down's Syndrome*. He believed the phenomenon existed on certain ethnic groups.(Max L.,1967)

The education of children with mental retardation and the possibility of developing their capacities was experimented by an Italian Physician and a humanitarian, Maria

Montessori,(1952). She demonstrated a remarkable result specifically on their cognitive development through structured symbolic educational materials. She believed that children have an innate sense of dignity and that education needs to be facilitated by revelation and is more of a spontaneous process.

After these land marks and other efforts (the humanitarian movement in Europe and America) special schools flourished to train children with mental retardation although exclusively from the regular schools. IQ tests and the sense of segregation warranted unfavorable results for these schools and parents were not happy about the social stigma. As a result, in 1950s changes were made especially in the United States by the collaborative efforts of parents to stop special schools as a means of segregation. Rather integrating the children in the normal schools and eventually allow them to enter the community as well as live and work among their normal peers. This mode of providing education to this category of children has persisted to the present time. Hence the rights of the child declared and ratified by many countries with the strong argument of Inclusive and *Integrative* education as well as social and economical equity issues as basic principles.(DICAG, 1998)

The United Nations have exercised various types of human rights that included children's rights, the rights of persons with disability, gender equality, the rights with the list restriction of the environment if there is infringement of the individual's movement or other type of special needs.

Article 23 of the UN Convention provides for:

- Acknowledgment of the disabled child's right to a full and dignified life which promote self-reliance and active participation in community life;
- Recognition of the disabled child's right to special care and the extension of assistance to both child and care-giver;

- Recognition of the disabled child's right to equal access to education, training, health care services, rehabilitation services, vocational training and recreation opportunities in a manner which will facilitate full participation and individual development of the child.(Ibid.)

Accordingly many countries in the other parts of the world and in Africa had ratified the rights of the child which also included the right of the child with disability. But there are marked differences in practicing this right. From the African countries some like South Africa, Uganda and some from south east and central Africa have progressed in these activities to the extent of forming implementing committees for the rights of children with disability with practical methods such as empowering the parents (DICAG, 1998 & UNICE, 1990)

Ethiopia has ratified and signed the UN declaration on the rights of the child. In view of the ratification as well as the pressing needs to reach all children the government has considered the education of children and young people with disabilities, including children with mental retardation in its general Education and Training Policy (MOE, 1994). One of the policy guidelines is the provision of basic education for all that ensures the right to education for all children regardless of the degree of their disability. According to this general guideline, all categories of children with disabilities are entitled to this educational opportunity from early assessment to early intervention, through schooling, prevocational, and vocational education. The other policy guideline is provision of education for children with special needs (i.e. with the disability and gifted) in accordance with their potential and needs, which suggests appropriate education for children with special needs including children with mental retardation. According to the General Education and policy strategies, the special education and regular schools need to meet the educational needs of diverse groups and common interests, aspirations, and

background of all pupils. These undertakings are in fact very important for all children but their implementation in Ethiopia at this moment, is unpractical as the country is still suffering from long periods of sever drought and the effects of civil and external conflicts. Despite these problems the Government has expressed its' interest to implement the ideals indicated in the education and training policy document. However, the government may face several problems to change these plans into realities with its limited financial, trained manpower and material resources. It needs the involvement of non-government organizations and community members in order to bring about desirable changes of attitudes to the most important unit of the community, the family (the parents). Since the family is the first school for the child to learn about the environment without being segregated and excluded. To change the ideals of the policy into practice, need assessment and thorough studies of the issue need to be undertaken in order to have a clear understanding about the deep rooted believes about mental retardation and find out practical solutions.

The definition and number of persons with mental retardation varies depending on the country's specific situations of the socioeconomic levels that have direct impact on the level of understanding the problem, provision of qualitative rehabilitation programs and early intervention aspects. The UN estimation for mental retardation is 3 persons out of 100 in a given population.

In the developed countries this figure is by ten fold less (0.3% in the United States, Chazan,1982)

The censuses made in 1994 and prior did not clearly count persons with mental retardation Usually *confused with 'mental disorder' or it is not identified at all* (Tirussew and his

associates, 1995). In the general estimation of persons with disability, there were 3.6% with all types of disability in the 1984 census and, among 52.08 million there were 988,849 persons with disability and those with mental problems were 64,081. The Addis Ababa figure in this census showed among the pop. of 2.1 mill., the disabled group to be 45,936 and those classified as mental problems to be 5,912. But the difference from the figures that can be calculated by 3% UN estimation is very high. Like the possibility of having 63,000 persons with mental retardation in Addis Ababa alone.

Some Non Governmental Organizations made their own particular surveys in order to carryout their activities. An association of parents known as SOOM conducted a sample survey on mental retardation in the 27 woredas of A.A. (SOOM,1997 and 1988) in two phases. In phase I in a total of 131 Kebeles 418 house holds were registered and 169 were visited. In phase II, 565 samples in 150 kebeles were visited. These two samples were estimated to be 80 % of the total pop. of children with Mental Retardation.

From this figures we can observe still there might be children who were not counted as having mental retardation since it is far less than the 1994 census estimation. The need for further assessment is vital in order to identify and get clear information on the number of persons with mental retardation.

Statement of the Problem

The present era is assumed to be the period of liberation, democratization as well as equality from discriminations due to gender, race, color disability etc. and Ethiopia too ratified the UN declaration on the rights of the child. Effective rehabilitation measures permit most children and youth with mental retardation to become self-supporting members of the society and helping to improve the economic level of their communities. Unfortunately, in developing countries, such as Ethiopia, with low standards of living the level of educational and related services are generally insufficient and with economic constraints. This mean that priority is given to normal children even though with minimum distribution. However the chance for many children with mental retardation is to be denied of basic education and training services. At present, not more than 300 children and youth with mental retardation receive education and related services in two special day care centers, and two special classes within regular schools in Addis Ababa. This figure is very insignificant when it is compared to the total number of children and youth with mental retardation in the region, Some of the needs that are lacking are:-

- Shortage of educational facilities for children with mental retardation
- Lack of early care, health facilities and educational opportunities
- Lack of pre-vocational program for children and youth with mental retardation, aimed at developing their talents & competence in language, mathematics, motor & social skills
- Lack of vocational training program for school lever children with mental retardation and physical disability.
- Shortage of employment opportunities in areas which are not primarily agrarian.

- Prejudice by some employers in hiring students who have been educated through existing educational programs for children with mental retardation and physical disability.
- Serious lack of vocational/career counseling services to help students with mental retardation to locate appropriate work placement.
- Lack of sheltered workshop for children and youth with severe mental retardation and physical disability.
- Lack of parent support and guidance programs in the education and training of their children.

Above all, girls with mental retardation and severe physical disability are the most disadvantaged group in the society, suffering even greater hardships than boys. Their difficulties are aggravated by unfavorable attitudes, which cause their lives to be more restricted than disability warrants.

In looking for education and work, they suffer double discrimination, on account of their disabilities and on account of their gender. They rarely benefit from education and related services. Otherwise, the chances for many of these children in mental retardation is to be hidden behind doors due to poor understanding of the causes of the problems and negative attitudes of the parents and the community in our country (Mekdes,1995).

Thus:

Children with mental retardation on various levels are considered as valueless, helpless and dependent on others. Such beliefs deprive the children's normal interactions, free choices and freedom of movement to learn from the environment. Such considerations are the reflections of wrongly established attitudes and beliefs of the parents family (parents), neighborhood and the society in general.

Therefore, this study will focus on inquiring about the following study questions.

What are the attitudes of parents that are affecting the child's needs of the normal inclusive interactions in the family beginning from early childhood period?

2. What do parents believe in the inclusion of their children in the neighborhoods with peers?

3. What are the parents attitudes about the inclusive education in the regular schools, vocational training, social interactions and career ?

Objectives

General objectives

The general objective of the study is to find out and show the attitudes of parents of children with mental retardation to be included in the given services rendered at home, neighbor hoods and the community. So as to provide the information to interesting groups, individuals and organizations in the field.

Specific Objective

- To identify the specific attitudes and believes of parents on the inclusion of their children in the interactions of the family, neighborhood and schools.
- If there are negative attitudes on the inclusion of their children, to find out the root causes and reasons and give hints on the spot (at the end of information gathering) for the parents that will bring positive attitudes.

- To propose possible and implimentable recommendations in the areas of changing negative attitudes (if there are), support positive attitudes and provisions of services for the inclusion of children with mental retardation.
- To provide first hand information to interested researchers in the field of area and initiate for further studies /researches.

Significance

The nature of the study is in-depth inquiry made with sufficient time to inquire the issue that deals with the most marginalized sector of the society. So this study is the first in it's kind and will serve those who will be interested in the field area.

It's methods that helped to find out the deep rooted feelings of parents that influence their attitudes are exemplary to future studies that will focus on qualitative methodology and the documentation of the research findings will assist students, teachers and the other graduate students.

The findings and the recommendations provided will also assist interested organizations, associations of different groups and NGO's for intervention programs.

The parent's experiences will help other parents, and groups in focusing on the already existing traditional means of caring and treatment (medical Vs traditional) for children with mental retardation. It will also influence the views and attitudes of policy makers, teachers and other parents who will get the information from the study and it is also believed to bring about a positive perspective of the issue and it's relevance.

As the parent's participation in this study was high, it possibility will bring to light the already present wealth of experiences for others to share.

Operational Definitions

Mental Retardation

The definition of mental retardation as well as the classifications provided by American Association of Mental Retardation (AAMR) is adopted by this study is as follows:

***Mental Retardation** refers to significantly sub-average general intellectual functioning resulting in or associated with concurrent impairments in adaptive behavior manifested during the developmental period.*

Similarly the classification in this study is adopted as mild, moderate, severe and profound retardation

Inclusion

Inclusion in this study means the parents' acceptance on the child's rights and capacities to participate in the daily social interactions and educational opportunities as well as in the productive activities.

Attitudes (**Adopted** from the Encyclopedia of special education)

Attitudes are learned beliefs that develop over time. They are feelings that develop from experiences with others and the environment and they influence the way people behave towards

others, feel about, and accept others. In addition the attitudes of others will affect the way we view our capabilities and ourselves. People with a positive self attitude or self concept will have a much better chance of achieving success than people with a negative self concept (Smith, Price & Marsh 1986)

Qualitative Research

It is the interpretative study of a specified issue or problem in which the researcher is central to the sense that is made. (Peter Banister, 1994)

Chapter II

LITERATURE REVIEW

Overview

*This chapter is constituted with three basic backgrounds of the study. (A) The first part is **about factors** concerning Mental retardation. These factors are about the historical and the current situation of mental retardation; prevalence, concepts, classification definitions and the development of interventions.*

*(B) The second part is the **theoretical framework** of this study and it is mainly based on following two theories.*

1. Psychotherapy theory. The researcher used this theory in order to understand and analyze the deep-rooted feelings of the families and their defense mechanisms developed during the occurrence of the problem. This is like denial of the retardation of the child has, or rejection behavior, etc which contribute to the development of the concomitant attitudes.

*Within the trend of this theory the theory of Identity of Erick Erickson's (1980) **BASIC TRUST VERSUS MISTRUST, ETC** is included. The need of this theory is to identify the factors affecting mostly the personality development of children with mental retardation.*

2. Ecosystemic approach which sees behavior or attitudes as part of an interaction nature of human behavior and the way in which changes within one part of a system of relationships will affect the other parts of the system. (Paul Cooper 1994, Colin J. Smith 1997 and Graham Upton). Thus the general frame of reference could be the Ecosystem approach. But using the other two theories for individual analysis, simultaneously looking in the directions of interactions in micro level and macro level. This could provide the whole picture of a person's attitudes whether negative that need to be changed or positive that needs to be encouraged through one or two of the theoretical frame works and the methodology of intervention in relations to the theories.

*C) The third part is about the **intervention programs** that are given attention as a worldwide issue and the particular developments of countries in providing the basic needs of children with mental retardation. Such interventions start from the UN rights of children and ratification, parent empowerment and intervention with the child.*

1. Factors Concerning Mental Retardation

Historically Mental Retardation is traced back to the ancient times and then to the civilizations of Egypt, Greek, Romans and others. It is also mentioned in the Bible while describing people who were possessed by evil spirits brought to authorities for healing. There is no evidence to indicate that it is a new phenomenon in history except that the difference is in the interpretation given at various levels of the civilization. According to the writer Mary Berne-Smith and her associates (1994), the history of mental retardation can be traced as early as human civilization but due to brief documented history, the explainable history revolves around the period of the past 200 years. These writers classified into nine eras starting from 1700 to the present. These classifications take the major events in each era. The first era represents the period before the 18th century (Antiquity period). The main idea in this and other literature's (Encyclopedia of MR,1994.), mental retardation before the 18th century was growing from its gravest level to be taken care of the religious organizations and the families. However, the conceptuality about the possibilities of training and education was nil. The era of the 18th century brought changes of programs specifically for the people with mental retardation. The two most significant features were the advent of *sensationalism* and the revolutionary changes

that took place both in Europe and America through the efforts of the philosophers such as J. Locke and Rousseau stressed the 'importance of the senses in human development.

These ideas provided new ways of perceiving the nature of the human mind and ultimately influenced educational reform' (Mary Berne Smith, Page 29). The other event that brought the dramatic influence came after the work of Jean Mark Itard (1774-1838), a French doctor concerned with ear diseases that met the wild boy of Aveyron and tried to educate him from the wildness to a civilized behavior. The work of Itard brought a dramatic change to special education of the children with mental retardation.

The era identified with the beginning of the 19th century was significant with the development of a test material for the identification of the mental ability of the regular students in France by Alfred Binet and Theodor Simon (1905) known as Intelligent Quotient(IQ) test. The test was intended to identify and help students who can benefit from special classes. After sometime this was changed and started to be used for excluding the low IQ students. Children with severe and profound mental retardation were not even included in the regular schools they were left in the custodial care, Although this has an impact on their special training, these children were isolated, deprived from family love and care.

The other era is the period where initiatives came from individuals who were close to their children (parents) who started to question the legislation on the rights of their children to be included. The movement started in America that involved the president (Kennedy) and an association was formed. This trend continued in Europe and today the developed countries and some developing countries are working towards "*Normalization*" and *inclusive education*'. This movement provided the opportunity to see the differences of development when care and education are started at earlier than late ages leading to the importance of early intervention

programs specifically for children with severe and profound mental retardation. The clear understanding of Mental retardation was not established until fifty years ago. It has been a misinterpreted concept according to the cultural, social, economical and political conditions of a given society. . In the different stages of history people described persons with Mental retardation as evil possessed and the treatment applied was to punish the evil by flogging, starving, burning etc. Hypocrites described it as an imbalance in the body fluid. Later on in the seventeen to eighteen century philosophers like John Locke and Rousseau emerged with humanistic view and this led to the idea of giving attention to human mind and the importance of the senses. The contributions of these philosophies initiated a French man known as Jean Mark Itard in the eighteen thirties and worked towards the education of children with mental retardation. Later Marian Montessori an Italian Doctor worked with children with mental retardation both the works of Itard and Marian Montessori brought a dramatic change in the education and the development of special education program. The new revival initiated others and the development of intelligence test by Alfred Binet and Theodor Simon (American 1904). This intelligence test was contributing in identifying all children with mental deficiencies including those who had mild retardation. The impact was positive as well as negative depending on it's application due to that it was also used for discriminating these children from the regular schools since they were placed immediately to special schools (.Mary Beirne, etal,1994). From 1960s onwards the push of organized parents and human right movements in Europe & America impacted on the UN declarations to ratify the right of every child to get equal opportunities. Therefore currently children with special needs including with mental retardation are in the inclusive and integrative education programs in the developed countries.

Current situations

1. The development of Early child hood interventions

The need for early child hood intervention programs had been emphasized in recent decades and are getting increased acceptance in many nations who got the chances of exposures to similar programs. This early childhood program focuses on the age level from birth to 6 specifically benefiting children with special needs including children at risk and developmentally delayed during birth. Children with Mild, Moderate, Severe and profound mental Retardation. *'...in recent times childhood special education has experienced phenomenal growth. Today the focus is clearly on programming for children in the birth to 5 year age range'* (Mary, Beren, 1994).

'The significance of studying the post and prenatal factors in the development of behavior for every child is brought into sharper focus by recent prenatal studies involving sensitive assessment of the functioning of the new born infants' (Catherine Landreth, 1987).

On this line the experiences of the **developed countries shows the** emphasis to be given to early intervention is so fast expanding. Countries like the United States of America a country that contributed a lot for the development of special care needs education and early intervention, from early times as of conception, (Drew, Logan & Hardman, 1984) and Canada in North America, countries in Europe like Scandinavian and the United Kingdom are spending a lot of resource on researches and pilot programs. Maurice chazzan and Alice Laing, who wrote a book on early years, mentioned about the growing interest in England at the time of their writing.

'In recent years interest has increasingly come to be focused on the educational needs of young children prior to formal school with no exception to children with special needs. The

importance of the early years for future development is vital. Any loss of experience which may result from a handicapping condition is compounded as children grow older' (1982). Further the book cleared out the importance of early education to prevent some adverse features of handicap in the early years, that very often persists.

In the case of **developing countries**, **although** traditional believes and practices are not favoring a child with special needs, there are better traditional methods and ways of caring that can be improvised for a better treatment and care for children in special needs in general. When the case of severe and profound mental retardation come into focus all available means should be used to change the attitudes of parents who are fortunately very close with children at any time than the parents in developed countries.

In general the trend of the developing countries including Asia, Latin America and some African countries are looking for possible solutions around these issues. Today countries with high population like India and china are also advancing children's programs (Profile of the child in India 1982) starting intervention for their children education as early as possible.

Current Situation in Africa: Countries like South Africa, Uganda Tanzania and Kenya in Africa are showing progressive results in special needs education and in related innovative programs such as inclusive education and early intervention programs through Community Based Rehabilitation programs. On the other hand although many of the African countries had ratified the UN declarations of the rights of the child, the educational level of the people and low level of socioeconomic gives way to traditional believes which dominates the modern attitudes on the causes and treatment methods. Due to this factor many of such children get traditional treatments which could have adverse effect on their development. However, there are differences among countries within the African continent. There are some that had developed

educational and social services to their citizens and have scored better results in the special needs education. Some of these from Eastern Africa are Uganda, Kenya, and Zambia. Uganda and South Africa are putting an exemplary progress for many of countries in Africa. To emulate, etc.(Inclusive Education, African journal of Special Needs Education vol. 4) E.g. SOUTH AFRICAN CONTEXT. The Bill of Rights contained in the 1996 South African Constitution provides for both political and socioeconomic rights for all South Africans within a framework of non-discrimination and equality. The establishment of UNICE in Uganda which is an educational and demonstrative center for people with special needs is a contributing factor in Africa.

In Ethiopia as in many of the developing countries, addressing the special needs of persons with disabilities in general and mental retardation in particular are used to be the responsibilities of the parents without support programs. Parents are not aware and have no access to modern treatment methods so are bounded with traditional believes and practices and use their own measures such as witch crafts, traditional medicines and/or spiritually believed holy water. Having gone through these methods and being exhausted of traditional practices mostly hoping for cure that never comes true leave the children alone with regrets, or denying the problems or loosing hope totally. Parents of children with mental retardation usually fall into this category. On the other hand the traditional method of treating the children with special needs such as with sever case is worse as it can be expected from many developing countries where the traditional believes are dominating and is more harming than helping. Parents take their children as punishments of God and feel segregated themselves (Chernet, 1999). The positive element is

the parental closeness and the protection to be under the family rather than custodial care programs exercised in Europe some decades ago.

The recent phenomena in the activities of Non governmental Organizations is the development of Community Based Rehabilitation (CBR) programs that are working at home levels by including early care programs. These CBR's are operating in major urban area although the rural community is still not reached. This trend is exemplary and provides optimism that it will lead the NGOs to include such programs along with their other community development activities.

The case of Ethiopia is similar to most developing countries where the traditional believes and practices are dominating even those exposed to modern education. While this is the case, the government policy, the services of certain groups such as associations of people with disabilities as well as the Non Government Organizations are trying to make some progress on the issue of disability in the country. The major associations are – The EFPD (Federation of Persons with Disabilities on the country level and the individual organizations of disabled persons ENAB for the blind; ENAD for the deaf; ENAPH for physically Disabled; RAPL for those with leprosy disability; and SOOM for the association of the parents of children with mental retardation.

The EFPD is working with these individual associations at the national level Most of these have organized similar associations on regional level. EFPD is now trying to work for the implementation of the rights of persons with the disability in order to adopt the Standard Rules on the Equalization of Opportunities for Persons with Disabilities

UN Standard Rules On The Equalization Of Opportunities For Persons With Disabilities (UN, 1993)

- 1.Awareness raising of the society*
- 2.Medical Care to persons with the disabilities*
- 3.Rehabilitation*
- 4.Support Services*
- 5.Accesibility*

- 6. Education
- 7. Employment
- 8. Income maintenance and Social Security
- 9. Family Life and Personal Integrity
- 10. Culture
- 11. Recreation And Sports
- 12. Religion

.(see annex II for the details)

As it was mentioned in the South African international seminar,(DICAG ,April 1998) it further elaborates on the rules with the rights of children.

The Convention on the Rights of the Child is one of the instruments, which constitute the political and moral foundation for the standard Rules. The Rules have as its central purpose to ensure that girls, boys, women and men with disabilities, as members of their societies, exercise the same rights and obligations as others, and provide for, among others, that:-

- *Governments recognize the principle of equal primary and secondary educational opportunities for children and youth with disabilities in integrated settings(where appropriate), and that parent organizations be involved in the education process;*
- *Special attention be given to very young children with disabilities;*
- *Provision for social security protection to care-givers is made;*
- *Children with disabilities are enabled to live with their families, and that families are fully informed about taking precautions against sexual and other forms of abuse;*
- *Children with disabilities are provided with the same level of medical care within the same system as other members of society*

The case of children with disabilities in Ethiopia needs understanding, commitment and contribution of the community at the grass root level and knowledge of the believes and traditions of families which requires further study.

Prevalence

The prevalence of Persons with mental retardation varies from country to country. The UN estimation is 3 out of 100 in a given population. This estimation is by ten folds more for the United States population, which is 0.3 % or 30/10,000. Out of this the figure for sever/profound retardation is only 0.1%. The population is classified under mild level to be 86%, at the moderate level, 10% and at sever/profound level 3-4%. (Chazan 1982, P. 3).

In our country mental retardation is not clearly counted in the censuses and is usually confused with 'mental disorder' or it is not identified at all (Tirussew and his associates,1995). In the general estimation of persons with disability, there were 3.6% with all types of disability in the 1984 census. In the 1994 census, among 52.08 million there were 988,849 persons with disability and those with mental problems were 64,081. The Addis Ababa figure in this census showed among the pop. Of 2.1 mill., the disabled group to be 45,936 and those classified as mental problems to be 5,912. But the difference from the figures below in the calculated by 3% UN estimation is very high. This is usually happening to difficulties of identifying mental retardation especially from multiple disabilities so that a person with mental retardation might be counted for his/her movement or sight or hearing problems only. A child with mild mental retardation usually is not identified as having the problems. These and other problems might affect the figure of persons with mental retardation to be very minor. Similarly the classification of retardation level and the specific estimation for mild, moderate and sever/profound mental retardation is unknown in our country. However, the figure for sever and profound could possibly be small from the given population of persons with mental retardation. This emanates

from the likelihood that children from the early ages could die due to poor handling in medical and other relevant case (also reported by a MMM a Non Government Organization with CBR program in AA). The possibility of having a large number of children with mild mental retardation is very high. Because of the low attention given to the general population of children during the fetal stage and the first 6 years when they need proper medical, nutritional and other relevant psychosocial cares as well as early educational interventions and appropriate training.

Figures calculated from the 1994 census by UN estimation of 3%.

Children under the age of 15		Pop. of A.A	Pop. of persons with MR in AA	Pop. of Persons with MR from the pop of the country/60 mill
Genral pop.	Children with MR	2.1 million	63,000	180,000
700,000	20,000			

Population of persons with mental retardation in the specific area of the study

An association of parents known as “Support Organization of the mentally handicapped Children” conducted two surveys on the “Situation of Children with Mental Retardation. 14 woredas of Addis Ababa as the first phase (1997), and on the remaining 13 woredas of Addis Ababa, in 1999. The results of these were compiled in July 1999. (SOOM, 1999)

Children with Mental Retardation by age and sex (phase I)

Age	Male		Female		Total	
0-9 years	4	2.45%	1	0.6%	5	3 %
5-9 “	25	14.9 %	12	7.1%	37	22%
10-14 “	42	24.8%	24	14.2%	66	39%
15-19 “	34	20.1%	27	15.9 %	61	36%
Total	105	62.2%	64	37.8%	169	100

Children with Mental Retardation by age and sex (phase 2)

Age	Male		Female		Total	
1-2 years	2	0.4 %	-	-	2	0.4 %
3-4 “	28	4.9 %	24	4.3 %	52	9.2 %
8-12 “	78	13.8 %	61	10.8 %	139	24.6 %
13-15 “	71	12.6 %	30	5.3 %	101	17.9 %
16-20 “	95	16.8 %	56	9.9 %	151	26.7 %
20-30 “	82	14.5 %	38	6.7 %	120	21.2%
Total	356	63.1 %	209	36.9 %	565	100

22,24, and 28. While Phase II was conducted in December 1998, in Woredas: 4,5,6,7,8, 12,13,15,18,20,23,25and 26.

The samples were 418 households in a total of 131 Kebeles in Phase I and 565 samples in phase II in 150 kebeles. These samples were estimated to be 80 % of the total population of children with Mental Retardation.

Concepts of Mental Retardation:

Mental retardation is conceived and understood in many different ways. These differences occur mainly from many philosophical and theoretical backgrounds of the authors in one hand and the lack of clear knowledge on the identifications of the complex nature of Mental Retardation on the other hand. There are controversial explanations on the causes and treatment

approaches of mental retardation. This being the arguments given by professionals from different disciplines reflecting more of their narrow outlooks. These viewpoints Originate from clinical and developmental stages, behavioral, humanistic and ecological, etc. theoretical viewpoints.

The theoretical basis of the conceptual frame work for this study is taken from the summarized book of Drew et al (Mental Retardation a Life cycle Approach, 1984).

‘The concept of mental retardation is made more complex because of the varying disciplines involved, which represent widely divergent viewpoints. These different disciplines involve psychiatrists, sociologists, psychologists educators, anthropologists and many others, each with a somewhat separate perspective and language’. (p 5). Due to this perspective the theoretical basis and definitions are given out. Even from one discipline such as psychology, there are differences, like the developmental psychology explaining Mental retardation from the point of view of development delay while the behavioral approach consider the treatment from the point of view of stimulus response behavior. The subject has to be taken into consideration with their whole personality rather than the emphasis on the respective disciplines. The controversy specifically affects the programs to be rendered if one sticks on to one discipline. However, with flexibility on the treatment methods one can observe that each has it’s own contribution to the knowledge and understanding of problem. The controversy is aggravated if one is specifically is confined to the programs to be rendered with narrow mindedness of sticking to only one discipline. Besides there are always differences from one person to the other among as to the the treatment of the subjects even within the same discipline. In view of Drew et al., the child should be viewed as developing human being with varying needs and characteristic who live within a contemporary society that has fluid and complex performance standards. This view

is the cardinal point of this study while trying to identify and level the type of retardation with the consideration of the specificity of each subject.

Types of Mental Retardation

The children with sever and profound mental retardation can easily be identified physically. One of the common type of retardation in both levels is Downs Syndrome.

1-Downs Syndrome

The physical features of a child with Down syndrome have similar characteristics one child seems similar to the other. These physical characteristics are: the head flatter on the top, slanted eye lids with folded skin, flattened nose bridge, absence of definite patterns in the lines of the palm, thick hands, very short fingers, narrow mouth, protruded tongue subnormal weight, lax bon joints, and short neck. There are differences in the sizes many of them are short stature and some of them are thin and long. (Max L & Robert G.Gibby,1976).

Drew and his associates added other factors like the common problems in the infernal metabolism such as heart defects, susceptibility to upper respiratory infections, incomplete or delayed sexual development. Although most Downs are in the moderate and sever retardation level, Their physical characteristics do not necessarily indicate their level of intelligence to be in the sever stage.

But when a child is born with Down syndrome in addition to the above symptoms the baby can have the following features (David Werner,1987) at birth in infancy and at the early years -

- *The baby seems floppy and weak.*
- *The Baby does not cry.*
- *The baby is slower to turn over, grasp things, sit up, talk, walk or may not perform at all unless intervention is provided.*
- *When suddenly lowered, the baby does not react by spreading his/her arms.*
A fold of skin covers the eye and eye lids may be swollen and red.
- *The Iris of the eye has many little white specks like sand. these usually go away by 12 months of age.*

2-Cranial Malformation(anencephaly, microcephally, hydrocephalic)

Small cranial skull (Microcephally) abnormally big cranium (Hydrocephalic) and sometimes loss of major portion of the brain characterize this.

Characteristics at birth can be similar to the Downs but the difference can be observed by the Unusually small or big sizes of the cranium. In the case of hydrocephalic there are children who are not caused to have retardation., there are also with hydrocephalus whose retardation level is in the mild and moderate retardation .But in case of arrested brain development the case mostly falls to severity and profound retardation.(Max L., and his associates)

3-Children with multiple Disability

Some children can be born with several severe disabilities in addition to mental retardation. There could be also an after birth effect when one disability may cause the other e.g. child can have mental retardation with visual, hearing, speech and mobility problem. In addition to his / her problems due to the UN addressed needs can develop behavioral problems Therefore these

kinds of children can have several special needs that calls for multidisciplinary approach with the parents.(David Warner)

Causative factors.

Many social and medical scientists have spent a lot of research to know more about the causative factors of mental retardation. Over 70% of the causes of Mental retardation are not known. For the 30% various explanations are given. These are chromosomal malformations and congenital factors in the prenatal stage, Birth trauma and environmental factors after birth.

Chromosomal malformations.

A lot of mental retardation happens particularly during the prenatal period, One of the causes are chromosomal and genetic errors. These chromosome errors rarely happen. At the time of conception, the two parental chromosomes x and y meet each having 23 chromosomes and forming a pair of two in the normal condition. Sometimes instead of two pairs a single chromosome or a three chromosome pairs can happen usually causing Downs syndrome.(David Warner,)

Genetic errors ‘these are these conditions that occurs as the result of inheritance factor involving specific genes. Such disorders are rather understood poorly.’(Drew..P107).

Phenylkonria is one of recessive genetic deficit. Researches are trying to improve recessive defects in the early years of the child. Phenylkonria is usually a case in mild retardation level.

Congenital factors. *Mental* retardation caused by this factor is when the child is affected in the prenatal stage due to problems occurred in the interaction process between the mother and the child. Such factors are maternal infection and drug. Infections include measles and other diseases the mother contracts and affect the child in the early periods of pregnancy.

Malnutrition of the pregnant mother is also the other factor for low birth weight and low brain weight. (Max L. & associates).

Birth trauma is the most common cause of brain damage is birth trauma. Despite the plasticity of the child's brain at birth, prolonged labor, severe physical stress or pressure, or the use of instruments may cause serious brain injury. The causes of birth trauma are: Asphyxia, (lack of oxygen), Injuries to the cerebrum, Peripheral nerve injuries, fractures, soft tissue damage and injuries to the viscera. (Ibid., p.63).

Causes of retardation in severe level after birth sometimes can happen when severe malnutrition and diseases such as meningitis happened to the child.

Classification and Definition

Classification of Mental Retardation has its own differences in using various parameters. The parameters according to Drew et al, are symptom severity, symptom etiology, syndrome description, adaptive behavior, reducibility expectations and behavioral manifestation.

The American Association of Mental Retardation.(AAMR) classifies by mental retardation into four with IQ level a little lower than the previous classifications and with acceptable terminology

<u>AAMR classification</u>	<u>Others(Terman1916,Wechler,1958)</u>	<u>Educational</u>
• Mildly mentally retarded IQ 50-70	previously refereed as Borderline	Dull normal
• Moderate mentally IQ 35-49	“ Moron	Educable
• Severely Mentally retarded I20-34	“ Imbecile	Trainable
• Profoundly mentally retarded IQ below 20	“ Idiot	Custodial

Definition

1. Mental retardation

Mental retardation in the general terms was defined as low level of intelligence in countries like Europe where special programs were designed for the education of children with mental retardation. This low level of intelligence is directly related with tests of intellectual ability tests as mentioned in the above classification.. The definitions given by these tests were different to the different levels of mental retardation.

The AAMR studied on the classification and the suitable definition. This definition combines two important factors in defining mental retardation. The IQ and the adaptive behavior.

Therefore, *Mental Retardation refers to significantly sub average general intellectual functioning resulting in or associated with concurrent impairments in adoptive behavior manifested during the developmental period.*

The AAMR further explains what it means by sub average general intellectual functioning means,(Ibid. p.15)

The intelligence test was once believed to measure the whole capability and classify the level of retardation however, as researches increase children with mental retardation could have other aspects of performances that can be reflected in adoptive behavior rather than performances by intelligence tests.

Adoptive behavior

According to AAMR (Ibid, p.25)for children with sever and profound mental retardation highest level of adoptive behavior is illustrated in relative terms to the level of retardation. There are gaps among children with profoundly retardation to mild retardation in performing tasks of *independent functioning* and *communication* level. Such gaps are a **12** years profoundly retarded is on the level of a **9** years severely retarded, a **6 years** old moderately retarded and a **3** years old mildly retarded child. By this level of functioning, there is a possibility of training a child with sever retardation to take care of himself in independent functioning such as feeding on and off clothes, ask for what he wants, go to the toilet, etc from the age of 9. Before, this age level he/she is totally dependent on others, if the training starts earlier the performance can be more refined.

Definitions of Impairment, Disability, and Handicapped

(a) **An Impairment** is any loss or abnormality of psychological, physiological, or anatomical loss of function.

An impairment can be temporary or permanent. This includes the existence or occurrence of an anomaly, defect or loss in limbs, organ, tissue or other structural of the body, including the systems of mental function.

(b) **A disability** is any restriction, on lack of ability (resulting from an impairment) to perform an activity within the range of considered normal for a human being. A disability may be temporary or permanent reversible or irreversible, and progressive or regressive.

(c) **A handicap** results from impairment or a disability and limits or prevents the fulfillment of a function, which is considered normal for a human being. Handicap is there fore, seen in the relationship between disabled persons and their environment. Cultural physical or social barriers to mobility within the built environment are handicaps.

2.Theoretical Framework

2.1.Psychodynamic Approach

Emotions and attitudes of parents after having a child with retardation

Parents usually pass through different psychological stags ranging from awareness to accepting their child's problem. According to Rosen (1955) as sighted by Drew, Logan & Hardman parents of children with mental retardation may move progressively through a serious of stage.

These are: -

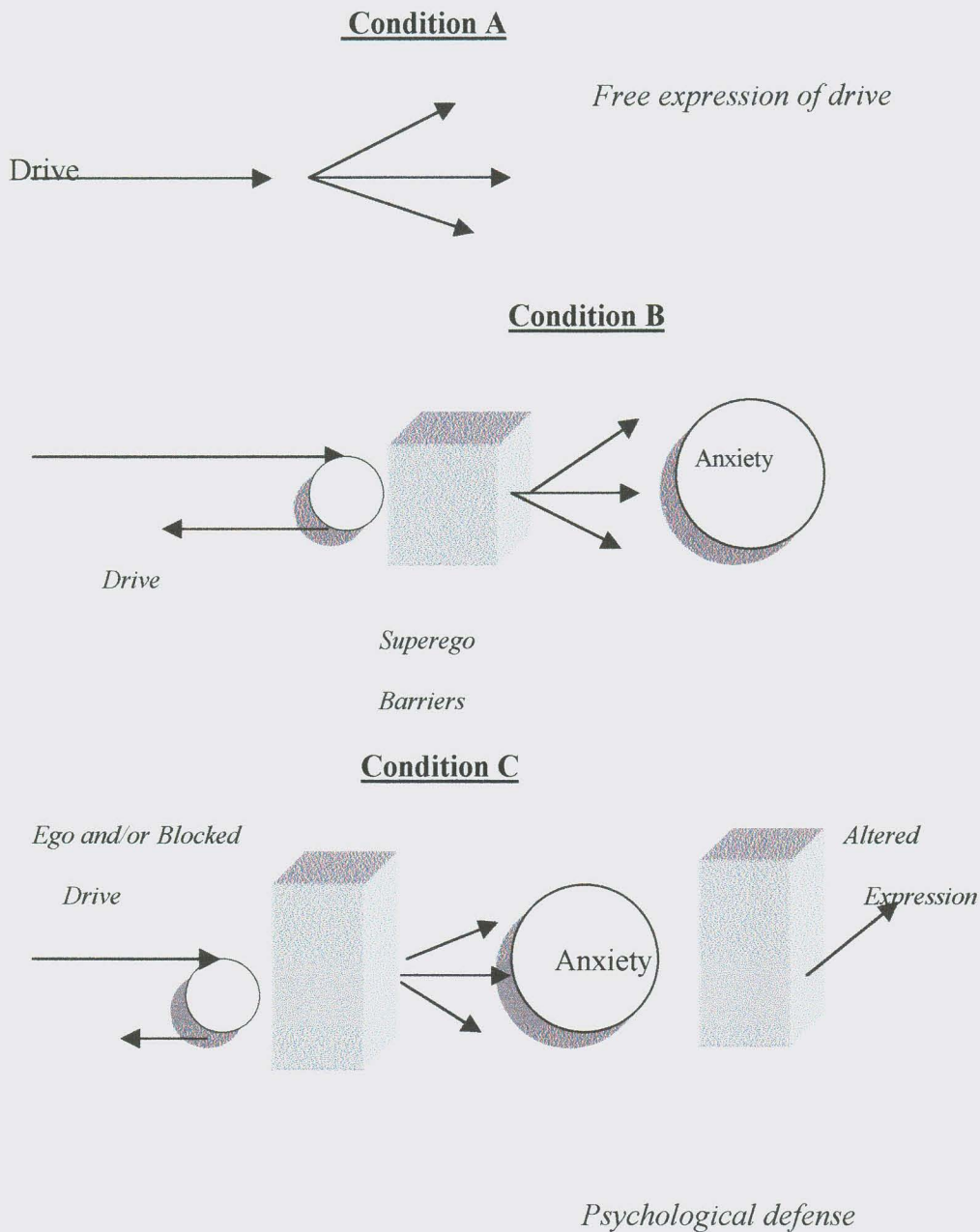
- 1.Awareness of a problem
- 2.Recognition of the basic problem
3. Search for a cause
4. Search for a cure
5. Acceptance of a problem.

The degree of severity and the explicability of the type of the retardation as well as the parents' backgrounds can have an effect on the degree of the above stages. The background can be the cultural, socioeconomic and educational level.

The degree of severity is usually one main factor for parents adjustment problems a child with only mild mental retardation may not be recognized in early periods so parents may not be aware until the child fails in school performance. Some parents again may face crisis for not locating the main problems. Parents of children with sever or profound retardation may have serious problems into reach acceptance of the child

The cultural, educational and economical background of the families can make a lot of differences in the acceptance of the child with different stages of retardation. Parents with higher educational level may have higher expectation and may not tolerate their child's low intellectual functioning. They may be also sensitive to the social stigma and may not expose the child to the neighborhood. Parents with low economy and low education may have a better tolerance to family crisis. But can be prone to prejudice to traditional believes and act in the same way. According to Drew, Loban & Hardseman, Parents of low intellectual and economical level may give more emphasis on the development of the physical attributes than the intellectual capacity of the child. So their reactions may be more affected when a child has additional physical disabilities or deformities. It is evident that the majority of parents seeks and searches the explanations of the causes and the cure of the retardation of their children. Most of them try the appropriate measures while in countries where parental counseling services and early intervention programs are not available, the seeking of remedies remain unfulfilled as the child is no more becoming as the normal child. So accepting what can not be changed is not easily consumed. Therefore parents again go to a serious of emotional reactions that are specified below. But every parent does not necessarily experience these emotional reactions. However, it is also important to identify the origins of concepts and possible emotional reactions of parents in order to understand the origins of their attitudes while trying to make interpretations with the background information.

Diagram1:- Formation of Defense Mechanisms



Expression of drives Operation of psychological Defense (source: MaxL hutt & Robert G.gibby)

Defense mechanisms are commonly experienced by human brain even in a normal situation temporarily. But when it has permanent occurrence it may need to be counseled

Major defense Mechanisms or reactions of having a child with mental retardation:-

adopted by Drew, Logan & Hardsman (p 385-392)

Denial:- “ Denial provides a form of self protection against the painful realities. Parents may minimize the degree of handicap or simply deny that any problem exists. They close their minds to the child’s limitation or may attribute the limitations to the child’s laziness,

Indifference or lack of motivation" further the writers explain the effect of denial on the child's needs of interventions. These parents may not tell to any organization about the problem of their child and the necessary impute on the needs of the child is deprived. Besides the interaction with the child is worsened since their acts are also influenced by the defense mechanism.

Projection of Blame, “Another reaction that parents may exhibit is the projection of blame. Frequently, the targets for attack are individuals who are associated with the parents’ considerable frustration and agony. Their negative feelings may be understandable in some instance, but they are not reasons to justify projection of blame. Physicians are frequently the objects of parental attack. Attacks often directed at an allegedly incompetent obstetrician commonly include.’ ‘If only the doctors have taken care of....’ type of blame are common’.

This projection of blame is also common in our case mostly the fathers blaming the mothers for being responsible in many ways one common blame is the taking of contraceptive before conceiving.

Fear as summarized by the authors “fear of parents is commonly associated with having another child with mental retardation, loss of friends, a life time of caring for the child and impact on the family unit” Further it says ‘the unknown generates anxiety in the individual. Anxiety intern may generate fear. ’Many parents may have little knowledge about mental retardation before the birth of the child, if adequate answers are not provided by professionals

fear will overcome their inner feelings. This fear may divert the actual understanding of the problem.

Guilt It says again 'if parents are unable to blame someone else, they may place the guilt on themselves...they begin to look for and eventually find something in their lives or their

behavior that may be responsible for the handicapping situation. Guilt may take place in the form of self - incrimination for past wrongs. In the case of our parents it is commonly believed

that the family is punished by God for their wrong deeds believes which are no more useful for the child or the parents instead parents needs to get counseling services for a better adjustment measures.

Morning or Grief. The authors again defined what it means by grief as a natural reaction to situations that bring extreme pain and disappointment. it says 'We all grieve when we lose something that we cherish or value. The birth of a child with a handicap represents the loss of a dream a hope for a normal healthy son or daughter. it may also represent death of the parents' positive self image... sometimes parents may react to the birth of a child with the retardation with death wishes". Parents have to be closely followed and appropriate counseling program is essential to prevent the child's total rejection.

Withdrawal: 'Parents may choose to isolate themselves because of their feelings of shame and guilt. Withdrawal can be potentially damage in, it is a form of isolation, and a prolonged isolation can be harmful' Parents may withdraw from useful individuals who can have imputes for the child's development.

Parents can also show completely opposite image of their negative feelings to the public. calcified as *reaction formation*. Their negative feelings are contrary to their consciously held values, and they cannot accept themselves as anything but, kind, loving, warm parents. This is dangerous to the child since others as well as parents themselves are not clear on their rejection of the child.

As the authors explained parents of children with mental retardation are the same patterns of any parent in the community, but the difference is these parents most of the time do have problems in getting the necessary services. They are denied of what is provided in the normal conditions.

The condition of these parents is worsened in our country. Parents of the children with mental retardation suffer from getting programs from early occurrence of the problem. They do not have the access even to know the medical explanation of mental retardation, how to handle it and how to help the child, is not advised to the mother as well as the father. Parents have no where to go to for advice the only alternative is to go to the traditional healer who usually relates it to unrealistic phenomena. The prescriptions given by the traditional healers can be harmful to both the child and the family although parents obey it since they have no other means of getting information that are appropriate to the problem.

Erik Erickson's theory of identity

Erik Erickson puts the psychoanalysis and social sciences together and enables one to get the clear understanding of the socialization process in a family together with the positive or negative psychological effects they can make on their children's personality. According to the theory the factors affecting in the childhood personality development are: **BASIC TRUST VERSUS MISTRUST; AUTONOMY VERSUS SHAME AND DOUBT; INITIATIVE VERSUS SHAME AND GUILT; INDUSTRY VERSUS INFERIORITY; IDENTITY VERSUS IDENTITY DIFFUSION.**

This theory is closely applicable to analyze the behavior of the child with mental retardation. This theory identifies how a child is affected in his/her development of the personality (ego

identity) while interacting with the first socializing agents –the parents to fall into the factors mentioned that are basic to the child's personality.

This means a child who doesn't develop basic thrust in his /her early development will develop mistrust. A neglected child with mental retardation will develop ***Mistrust*** on adults; A child who is not allowed to try his own activities will develop ***Shame and Doubt***.

Similarity ,many of the children are not allowed to take their own initiatives therefore, these category of children are commonly fall into having ***Shame and Guilt***. *Again as any restricted child will develop feelings of inferiority a child with mental retardation commonly faced with judgement of not being capable to work correctly so others take their roles . This will live them to feelings of inferiority than being industrious.*

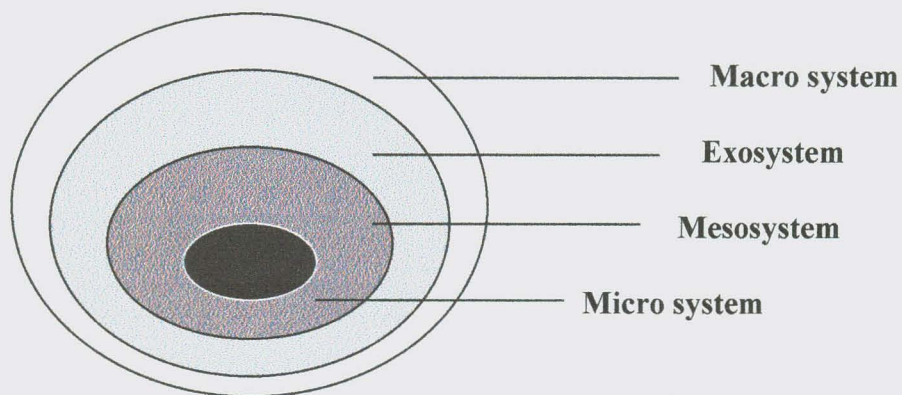
Therefore, when one try to make analysis of children with mental retardation it has to be known that whatever affects the personality development of the other children can affect equally or more the children with mental retardation due to it's multiplied effect with the general socialization process.

2. ECOSYSTEMIC APPROACH

When one is working on attitudes; the generations of attitudes the environment, i.e. the community's comments and attitudes can have direct effects on the parental views and attitudes. This is how cultural backgrounds are maintained throughout the years unless effective educational and other intervention programs are provided. Therefore, this study bases it's theoretical frame on the mentioned theories. However the concept, classification, definition and intervention programs of metal retardation are adopted from the books written on the subject by

different writers, who reviewed various investigations and explanations on the etiology, classification, development and education of children with mental retardation. The researcher found these literature to be complimentary to the mentioned theoretical basis and suitable to her conceptual framework. This is due to the validity of knowledge they have in differentiating the child's needs with particularities and with holistic view that includes the parents' roles and the community roles that are interrelated in taking measures of attitudes changing as the first measures. Then intervening in provisions of early treatment, education and training opportunities from the periods of conception, infancy and to school age as well as adulthood. Therefore, although the focus of this study is on investigation of the parents' attitudes; the nature of the study is to indicate further intervention programs for each of the subjects in the study as well as give hints for action programs for similar cases.

Diagram of Echo systemic Approach



According to Bronfenbrenner; (quoted by Cherinet,1999), Human development and behavior can not be understood independently of the social, cultural, environmental and historical context in which it occurs Hornby, 1995.Again,

The effects on parents of caring from a child with any kind of special need [e.g. a child with mental retardation] are strongly

immersed by the social environment in which they are living, including the extended family, services available and community attitudes. Horn by (1995: 45)

According to these explanations an individual can not be seen without his / her social context from the smallest group **Micro level** to the highest **Macro level**

Microsystems

The child with mental retardation is interrelated with the closest social relationship (Family, Extended family, Relatives, neighbors ,church, mosque, school edit, Iquib, local associations etc. This Level. of relationship is the lowest and according to the theory of ecosystem is known as micro system.

“The micro system is the complex of relations between the developing person and the environment in the person’s immediate setting, I.e., the person’s home, school, work, etc. (Apter, 1982)”. Quoted by cherinet. .

The child’s immediate setting in this context is the mother, the father, the siblings and the extended family members if they are living in close relation, then the life style as well as the provisions of his/ her basic needs, social needs and educational needs are determined by these members. The positive or the negative. sociocultural impacts on the development of the child are transferred by these members of the micro system. If the child gets the chance of going to school the school is the agent that has a direct impact on the child. The church, the mosque or the local associations, are interrelated with the parents or the child in various aspects, Therefore, the micro system has an important factor on the child’s behavior to the child.

Meso system

Another set of micro system may be interrelated with the other. This can be seen when a family is having a social group with the other and are interrelated for a common interest. In the case of the subjects in this study,

parents of children can have interrelation with the other families for a common interest of religious ceremonies, saving groups (Iquib), or . Idir a group that serves for death ceremonies of members. Sometimes parents may meet together in associations of parents of children with mental retardation.

Exosystem

Ecosystem is not directly related to the child but can have an indirect impact on the child. The constitution of meso system is the social structures that are formed to maintain each member in the mesosystem. These can be offices, organizations, mass media and the like

The exosystem is an extension of the mesosystem embracing other specification structures, both formal and informal, that do not themselves contain the developing person but impinge upon or encompass the immediate settings in which the person is found, and there by influence, delimit, or even determine what goes on there (Apter, 1982; Seligman & Darling, 1989; Hornby, 1995). These structures include such social institutions as mass media, welfare services, employment, etc. Even though family members do not directly involve themselves in exosystem, Cherinet, (1999)

Macro system

The macro system is the superstructure that includes the cultural economical and social systems of a country. The level of education of the society, the cultural believes, and the economy levels have the direct and the indirect effect on the individual child development.

The Ecosystem in Reference to the Subjects

The parents of children with mental retardation are as any of the parents of the children with

non-retardation. As any of the parents in the society their socioeconomic and cultural context can vary. Due to this factor the micro system, of children can have different contexts from family to family. In the case of this particular subjects in the study most of the parents are in the low economical status, low educational level and are from the central Ethiopia cultures. Their attitudes are the products of their particular life styles in the family and among the neighborhood (**Microsystems**), the social relations with the other groups in their social roles and contacts (**Meso system**), their interactions with the information system, work places or organizations that have direct and indirect contacts, like the Zonal administrations and the Woreda who involve in taxes collections, provision of schools, roads etc. (**Hexo system**), and the sociocultural and educational system of the ethnic groups and the country (**Macro system**).

Therefore, trying to see the child and the parents from this context and the other relevant theoretical basis s will help to have a clear picture on how one factor can lead to the other in any given social systems. Besides more relevant interventions can be planned.

3. Intervention

“Disabled children are marginalized from the principal function of welfare organization. The health service marginalizes them because it cannot cure them. The education services marginalize them because it is geared to putting as many children as possible through its examination sausage machine. The focus of child protection services is able-bodied children. The social services for elderly and physically handicapped sections focus on adults.”
(DICAC1988)

1.The rights of children

The UN submit for the right of people as a whole and for the right of the children with disabilities is the spring board for the intervention programs of children with mental retardation and their families.

The rights of children with disability in particular reference to children with mental retardation should be seen from the point of a program from country level to the community and then to the family level. The rights of children with disability means;

The right of a Child with Disabilities to have the same rights and obligations as able – bodied people- the need for shelter, for food, for education, for relationship, the right to equality, to dignity, to respect, as well as the responsibility to contribute to development Within their communities. Children and adults with disabilities therefore do not need different or separate development from the rest of the community, but rather enabling mechanisms aimed at removing barriers within community development processes (Ibid).

Article 23 of the UN Convention provides for:

- *Acknowledgment of the disabled child's right to a full and dignified life which promote self-reliance and active participating in community life;*
- *Recognition of the disabled child's right to special care and the extension of assistance to both child and care-giver;*
- *Recognition of the disabled child's right to equal access to education, training, health care services, rehabilitation services, and vocational training and recreation opportunities in a manner, which will facilitate full participation and individual development of the child.*

Articles 2 (Non-discrimination), 3 (Best interest of the child), 6(Survival and Development), and 12 (Participation) provide the ethical and ideological dimension to the content of the Convention, i.e. they are the most important to all children which always should be taken in to consideration. So although only Articles 2 and 23 specifically mention children with disabilities,

it is important to remember that every article which refers to “the child” also applies to the disabled child. Article 6 deals with the child’s right to survive and not to be killed- a key obligation for governments is to “ensure to the maximum extent possible development of the child” (Ibid.)

Parent Empowerment. In any society the situation of children is the most sensitive barometer of a country’s state of development. Children are the ones who are the most vulnerable and whose rights are denied when poverty and social disintegration deepens

When children are affected by disability, they, together with their families become the poorest of the poor.

‘Most of the parents with disabilities are faced with the challenges of trying to meet the needs of their disabled child together with those of the child’s siblings equally and effectively also providing the daily needs They however experience increasingly high levels of stress, coupled with mental and physical ill health’. (Ibid.)

This is the fact seen in most of the mothers with children in disability in our country. *The magazine, (DICAC), the condition to be similar with most of the African counties.*

Then it suggests for the best intervention programs the empowerment of parents and the movement for it should be revived in the whole of Africa

2. The early child hood intervention

The intervention program should begin from the time of prenatal stage through medical follow-up and counseling of the mother and the family. Here the collaboration of the gynecologist and the family if available the social worker is very essential. This is to prevent further disability on the expected child. Once the child is born with the disability the process of assessment with diagnosis and identification should continue with the involvement of the parents and multidisciplinary team if possible. Then the method of approaching regularly in home visits should be started ignored to plan and implement intervention. The positive attitude of neighbors can minimize the burden of the parents as well as the siblings therefore,

community participatory and child to child programs have to be designed to create awareness. Team formation based on the specific needs of the child is very essential.

Children with sever and profound retardation can have serious mobility problems, therefore until they develop home based preschooler education system need to be programmed and every change of behavior has to be followed by the same team for the continuity of the intervention

(Drew,Max L, and Maurice)

The early childhood intervention programs for children with mental retardation contain the following components

- Identification and assessment with the involvement of parents
- Family involvement and Support for parents.
- Intervention with the child

Methods of Early intervention program

Identification and Assessment

Identification and assessment is a process of action taken to know the specific deficiencies and the specific capabilities of a child in early periods from birth in this context or immediately after the onset of the problem. This process is always continues in order to find out the effect of intervention provided along with the developmental changes of the child. Children born with identifiable brain damage or damaged during birth may need to see their particularities before generalizing their needs as common to the other similar type of child. Therefore assessment of the *type* of the problem, the *specific behavior*, the *parent child interaction*, the *physical and psychological environment*, need to be assessed. Identification is the first step of assessment but may need to be repeated in case of the appearance new

observable behavior. Assessment of a child with severe and profound stage of mental retardation requires the involvement of multidisciplinary professionals if available due to the sensitive areas that need the explanations of the expertise. Labeling a child is not the work of this group but using the labeling for the purpose of temporary intervention is the better way. Maurice Chazan comments in this idea 'Affixing a label to a child is not only unacceptable, but also may give a false impression that the case has been dealt with. The label is only the basis of continuing discussion, particularly aimed at charting and encouraging the child's development in all possible aspect.

Family involvement and Support for the parents

Family involvement from assessment throughout the work of the intervention is very essential for a better result. According to Michael J.Guralnick, (1987). The family is the integral part of the intervention team, for the development of IEP plans to the implementation parents in particular are consulted and involved. It says, "Parents in particular should involve for two principles. To begin intervention sufficiently early in order to prevent or minimize potentially difficult or distressing parent -child and or child-family relationships from developing. The second is on the need for an ecological approach to intervention in order to assuring maximum development in the young delayed child.'

Therefore, supporting families should be one of the intervention programs. It is not easy to accept and handle such a problem in the first stage. During the first assessment stage of the identification, parents need to be involved with careful approach that soothes the feeling of loss in facing the problem of the child .The parents slowly must be helped to overcome the psychological crisis and start to work with the team for the benefit of both the children and

themselves. The type of service which parents require is **counseling** while involving in the diagnosis of their children's problem. Side by side they need the support of the neighborhood and the community in both the psychological and the necessary medical or other support according to their specific needs.

INTERVENTION WITH THE CHILD

The early intervention program for the children in various types of mental retardation Mild, Moderate, Severe and Profound differs according to their particular problems

In general the provisions of *physical care, meeting emotional needs, extending social relationships, providing appropriate stimulation, massages, speech therapy, mobility training (increasing adoptive behavior) special needs education etc.* could be some of the intervention programs commonly required.

Educational Needs

The educational opportunity for preschooler and school level child with mental retardation needs to be taken into consideration of parents and the community. The majority of children with mental retardation are capable of joining preschools and schools that have educational programs designed in their capacities. The recent development of **Education For All** slogan includes these children. UN declarations and proclamations of advanced countries are advocating about educational opportunities that includes everyone irrespective of disability, color, or creed.(UN, World Summit for children, 1990). When we try to see this even with the Ethiopian context, the majority of children who are intellectually challenged can get education in inclusive terms with additional support from the school system.

When considering education for children with mental retardation, there needs to be attention on the perspectives related with education these special attentions from the school is the level of the child's intellectual development should be measured in order to design the particular educational needs of the child . In doing this process the cognitive level is one aspect . As stated in Drew, Logan & Hardsman (1984),

Cognitive Development is an individual's developing capacity to formulate mental patterns. Cognitive development during infancy and early childhood involves many complex processes and includes areas where mentally retarded children have great difficulty. Perception refers to sensory experiences received from the environment whereas cognition refers to the meaning and thought patterns that emerge as a result of combinations of the perception.

Children with mental retardation have difficulties in their perceptual development since perception depends on what one hear, see, touch, taste or smell. The child may have impaired sense organs to receive all information to the brain. More than this the people around may tell to the child that he /she is not capable of doing things or understanding. Therefore, the child is not free to learn about his/her environment on the level he /she has.

The parents attitudes play the greatest role in the advancement or delay of the education of the children with mental retardation.

Social Needs

The other aspect of the needs of the child is his /her social interactions.

The child with Mental Retardation has the same needs as any child has. One of these needs is to be **included** in the social group by being allowed to interact with their peers.

Many parents in our situation are more comfortable when their children are confined at home. This idea is originated from fear of abuse by the other children or adults. The child without mobility problem comes out of control when he /she grows up. However, the socially deprived child may not be happy to the outside people's responses due to the negativity of comments and attitudes or abuses that he/ she may be confronted.

The restrictions from the parents and the school system can be minimized when appropriate awareness programs are provided. Besides the fear of the child in practicing his/her potentials needs to get attitude change about one self through pre vocational and vocational training or psychotherapy and counseling programs, depending on the individual needs. Changing the attitudes of peers needs to be given attention. Children are fast to cooperate with positive attitudes, as it has been observed in many child-to child programs. Using peers for the change of attitudes of adults and the future society is more economical and progressive. Therefore, one of the intervention program should focus on these aspects (Disabled Village Children , 1987).

Chapter III

Methodology

The research Design

The methods of data collection and the analysis of the research were planned to be based on **qualitative research methods** during the designing period. This was due to the following major reasons:

- The researcher was gathering information from previous researches in similar cases. As the result it was convincing to use only the qualitative method for in-depth information on attitudes of parents who are not used to interviews of a questionnaire.
- The validity of using standardized tests developed in other cultures and trying to adopt it in this context was still questionable in quantitative methods although the Questionnaires could be more useful to large number of samples.

The researcher had previous experiences with parents of children with special needs and knows that a one time observation and filling out of questionnaire do not give satisfactory information since their attitudes are the reflections of their deep rooted emotions, believes and experiences. Besides parents with such experiences are uncomfortable to express their feelings in the classical type of interview methods and observations. It was easier to be friendly for sometimes and gather whatever is

observable concerning the child and make comments or questions that are fit and natural to the situation rather than preparing structured interview schedule which has its drawbacks.

- Time in this study was not concerned except the general frame of the schedule. The main mission was to know the parents well and their actions in their natural style of life, whether it is related to one another or not.
- It was advisable to limit the number and make in-depth study to find out a better or closer data on the real attitudes the parents have with children with mental retardation.

The research is about a particular real world problem rather than to be used for generalization as in many sample surveys. So the method allows to recommend and even to design interventions for that particular family after the research is accomplished.

- It was Possible to intervene during the process of data gathering at least with advises. So the researcher's objectives could include bringing about some differences in their believes about their children that might affect the development of the child negatively. However, the researcher handled this opportunity carefully in order not to influence the respondents to the education, experience and believes of the researcher so that the validity of the research is not affected. The necessary comments were given during the end of the data collection.

b. The selected parents and their living areas

This study focuses on the attitudes of parents with different backgrounds of economical status, education and training including those living in the semi urban area, those who were not in educate and awareness programs and those who were exposed to community work program. This are those working with an NGO and for the purpose of getting different views from the point of

the services related awareness programs in the community. Their children have differences in type and level of retardation. This is to get different types of attitudes and catch most of the relevant factors.

These areas were selected for their convenience in the various needs of the study and the research group. The subjects are 6 parents of different family categories. Out of these 3 are from urban community, 1 from semi urban community and 2 are more of from the rural communities in and around Addis **Ababa**. Those from the urban and semi urban are:- woreda 2 kebele 13, woreda 13 kebele 15, woreda 17 kebele 03 and woreda 19 kebele 58. These various kebeles were selected carefully so as not to focus only on those parents whose views and attitudes are in the process of changing by the interventions of NGO's in the area. Attention was also paid to the accessibility of finding informants or facilitators that could assist in identifying the exact types of families as the specification of the researcher. Therefore, for the six parents there were six informants who had assisted in the familiarization process. These informants were two male and two females who were the members in the neighborhood of the respective subjects.

Parents from the rural community were selected from the peasants residing around the suburb area of Addis Ababa. The final decision to include Akaki in the south of Addis Ababa on the way to Debrezeit town was made prior to assessment. People are not open to strangers concerning their child with disability so informants who were familiar with the area were sought but it was not possible to accomplish the assessment within the given research schedule. So the areas in the south west of Addis Ababa was found to be more convenient to conduct the study because an informant who had relatives in the peasant associations of “**furi**” was willing to join the team. ‘Furi’ is adjacent to woreda 19 Kebele 58 & 60. A two hours walk from the last taxi station. So it was not a minor challenge to make a one-week visit for the researcher. The Peasant Associations of furi woreda where each of the parents belong to are known as “**Eartu Modjo**” & “**Hana Mariam**”

Concerning **Ethnicity**, and cultures all of the groups are more or less exposed to the cultures and believes that are very similar to the people living in Addis Ababa, although they have differences in the composition of ethnicity. Their ethnic group is from Amhara Guraghe, and Oromo.

c. Instruments applied to collect the Data

The qualitative data collection needs to assess the deep feelings and views of the parents about their children with mental retardation. Therefore, the study employed: -

1 Semi Structured Interview,

This instrument is prepared with the intention of having some points as starting the interview with targets so as not to miss information on specific areas. However, the sequences or the way of presentations were mostly depending on the parents' readiness in their mood to be interviewed. However, the researcher was keen to pull the discussion or comment to the needed points. Besides as there was the tape recording the researcher was mostly a listening type. These were focusing on the following interview points.

A Back grounds and profiles.

- Background of the parents (the close parent to the child)
- Profile of the parents, the child, the siblings and the neighborhood.
- Profile of the services for the child around the community.

B. Attitudes and feelings of the parents on:

- The etiology of mental retardation in general and on their children in particular.
- The treatment of mental retardation (Medical vs. traditional)
- The situation of mental retardation in the present time

Factors of Attitudes that directly or indirectly affect the inclusion of the child.

- ◇ Having the child, what do parents feel in terms of various socio economic factors in the family.
- ◇ The development of the child (social, educational, emotional)
- ◇ Behavior of the child.
- ◇ Additional problems of the child
- ◇ Measures taken to improve his/her situation.
- ◇ The schooling of the child
- ◇ The interaction of the child with the family
- ◇ The interaction of the child with the neighbor hood
- ◇ The interaction of the child with the siblings
- ◇ The daily performance of the child(adaptive behavior)
- ◇ The child's capacities,
- ◇ Possibilities of improving the capabilities
- ◇ Different roles of the family (father, mother siblings, other members) in caring to the child and training of the child.
- ◇ The future of the child in terms of being included in the general society

2. Observation (Participant and Non participant)

The researcher used observation in two ways one by being a non-participant just by trying to divert their attention from the researcher and try to observe the natural situation. The other method of observation is by participation like in group discussion, plays with the children and chatting (some times the researcher created these settings).

The researcher mostly used the method of the participant and the non-participant observation alternatively. Since the parents were curios to see their children to play or interact with the team in the research, their verbal and physical reactions to the child were observable.

Observation through video tape recorder was tried in some instances however, the parents were conscious of the record and its information was only useful about those members who were not giving attention of the recording. The frequency of recording was less than the planned time. However, there was less attention to the sound recording and all verbal comments were recorded successfully.

Point of Focus in the Observation

Main focus: Non verbal actions and reactions of parents observable on issues of: -

- The child's interactions and being allowed to be included in the family matters, neighborhood and schooling.
- Verbal and non verbal behaviors of each parent ,family and the Neighborhood towards the child with mental retardation.
- The parent's comments on the children with mental retardation.
- Parents interactions with the children with mental retardation vs. the non-retardation.
- Performances and interactions of siblings in the family, neighbors, etc.
- Behavior of the child
- Activities of the child with himself/ herself and with others.
- The child's closeness or comfort with members of the family.

3. Additional sources of data

Focus group discussions were applied with all of the parents in their own respective areas. The participants of the focus group had some differences from family to family. For e.g. the focus group of the parent living in woreda 2 kebele 13 was consisting of the elder sister, the mother, a neighbor and the facilitator himself since the he was also having a daughter with mental

retardation and share the same attitude with his neighbor. The other example is the case of the parent who is living in woreda 19 kebele 58, where the elder sibling, the mother the father and the informant sit together and start to discuss. The researcher involved in all of the discussion took notes and recorded with the tape.

Story telling, sayings and role-plays

This method was planned in the design of the research to know more about the attitudes of parents, family members neighborhood and the children themselves.

The reactions of the parents expressed in sayings were recorded. Six of the parents including the grand mother in woreda 15 kebele 13 were adding some sayings as to needing to express their deep-rooted resentment feelings. ”ይሆንልኛል ብለሽ ነገር? ልፈ ሲልሽ እቴ! ይላል ያገራልጅ፣ የኔግ ምን ተወርቶ ያልቃል” etc meaning “Do you think it will work?”; “Your trying is good for nothing” “My problem is not easy to be told” type of expressions were observed. All the sayings expressed the negative attitudes that are commonly believed about mental retardation in the community.

Role-play (dramas) was performed by the older children with mental retardation and it was easy to find out what parents and other adults or children commented on them. Story telling was also applied just like the drama.

Siblings. Siblings specifically in the family were considered as the second informants in the study since each was found to be an observant as well as sharing of responsibilities with the parents about his or her sister, brother or niece with mental retardation.

Neighbors. The neighbor's children and adults were found to have some significant roles in the lives of the children and their families, therefore to a certain extent neighbors were included in the research mostly while they were having the usual interactions with the parents. \

D. Procedures of the Study

The research procedures are based on the following general areas.

1. Review of different research papers and literature on the area.
2. Preparation of instruments that will be used to collect relevant and qualitative data Thai are like a semi structured interview schedule, discussion points, role-plays and songs for the qualitative data.
3. Preparations of materials as guiding points for observations on various levels (participatory and non participant)
4. Locating informants and selection of subjects.
5. Preliminary inquiry on the community around the selected parents.
6. Collecting data.
7. Analysis by qualitative categorization of the different information gathered from the parents and focus more on the responses of the research questions.

Procedures Of the data collection

- Selection of parents for pre testing and the main study.
- Locating an informant and accessing the setting.
- Understanding the family's behavior and life style.
- Preparing on how to present myself. Establishing rapport.

- Preparing materials (log book, cassette recorder, video tape when possible to record)
- Modifying the materials and aspects of timing.
- Scheduling the period and appointing informants according to the schedule.
- Conducting the data collection process.

Settings and Timing

The setting was mainly natural and home based. This was in any ordinary time the parents have while they are interacting with their children, relaxing, working in the nearby or house chores, coffee ceremony and meal time. The meal, playing, bathing, toileting and bedtime interactions of the children were also in the settings.

The researcher's creations of settings were on interviewing time, focus group discussion and the children's activities in dramas or story telling activities.

The time spend in each parent's house is not equal to everyone. Some of them were giving full attention and collaboration and had a lot to share and take time and others were not so attentive specially to the verbal responses; while others needed some more times to interact therefore, the period of time spend with each of the parent was as follows:

Parent 1= about 30 hours (11days 2-3 hours /day) for both interviewing and observation.

Parent 2= “ 23 “ (8 “ “ “) “ “ “

Parent 3 = “ 26 “ (9 “ “ “) “ “ “

Parent 4= “ 32 “ (10 “ “ “) “ “ “

Parent 5= “ 28 “ (9 “ “ “) “ “ “

Parent 6= “ 32 “ (10 “ “ “) “ “ “

Altogether the data collection took a period of 7 weeks (Feb.- March 2000) with simultaneous visits to two families in a day. This is after attending for two or three hours in one family I move to the nearby family in the afternoon interchanging the time.

E. Categorization Methods

Transcribing Tape recorder and video, data notes,

Categorizing Observation schedules and issues for the outcome (Finding) of the study

The questions guided the interview and responses were various elaborated more and more in the subsequent sessions. Then categorized in the following subheadings,

1. The parents' understandings of mental retardation,
2. Their beliefs and attitudes on the causes of mental retardation
3. Their beliefs and attitude on the treatment,
4. Their attitude on the development and behavior of the child.
5. Their attitude on problems of the child
6. Their attitude on acceptance of the child
7. Their attitude on the interaction of the child with themselves; siblings at home and neighbors
8. Their attitude on the capacities of the child
9. Their attitude on training and education of the child
10. Their attitude on the future of the child

F. Method of Analysis

The method of analysis utilized in this study is reflective and descriptive type that follows after the qualitative data collection. Then the analyzed information of each family are inferred and discussed to the theoretical backgrounds used by the researcher.

On issues related to validity and reliability the following explanations are worth mentioning “ this is basically a qualitative research oriented approach. The focus is mainly on attitude,

feelings and emotions of parents to their mentally retarded children. Scholars in the field of psychometrics (Lehman and Mehrenn 1969) argue that when it comes to the questions of validity and reliability the balance is skewed towards the cognitive assessment rather than to non-cognitive instruments. In the present qualitative research, non-cognitive or affective assessment such as attitude survey was focused upon. Therefore, the issue of validity and reliability in this respect was not basically significant. However, content and predictive validity was found to be highly sufficient for the purpose.

Chapter IV

Findings of the Study

Overview

The finding of this study includes 1, The demographic and socio-economic Profiles; 2, The background; 3, Responses to the particular Research Questions; 4, Responses of Siblings; 5, The result of the observation with the interaction of the parents and siblings to the children with mental retardation.

The profiles in the table form provide the general information about the parents' age education, occupation, etc.; the siblings as well as the target children age and level of retardation..

The background of parents is presented so as to give the reader the profile scenarios before the birth of the child with mental retardation. Then after the birth of the child; on the onset of the child's retardation, on the child's social interactions, education, and the future of each child. etc
As to the relation to the research question, the parents attitudes on the cause, & treatment of mental retardation in general and to their children in particular. Their attitudes on the inclusion in the family, neighborhood and schooling /training/ are presented.

The researcher had got opportunity to observe the child's interaction in a natural setting in the family and the parents' responses as well as the siblings' responses.

The siblings' comments were also taken as an important view to know more about the actual life style of the family in relation to the child in focus.

The children with mental retardation were also interviewed to find out their feelings towards their parents or any other important agent in their lives and any striking comment or view of people put in their minds, which might have positively or negatively affected their inclusiveness to the social group

1.DEMOGRAPHIC AND SOCIO ECONOMIC PROFILE OF THE PARENTS AND THE CHILDREN

Table one: Parent's Profile

Parents	Age	Sex	Woreda, Kebele	Community	Education	Income
p 1	47	F	2 13	A.A (Urban)	Mother = Gr 3	Children's support
p_2	70 28	F F	15 13	" "	G. mother= Illiterate Mother = Gr 8	'Kollo' selling Commercial sex work
_p 3	43 59	F M	17 03	" "	Mother = 12, Father = College	House wife Private Business
_p4	52 61	F M	19 58	" (Semi Urban)	Mother = illiterate Father = Gr 6	Dairy farm Pensioner
p5	28 39	F M	(Furi) (Eartu Mojo)	Peasant Association	Mother = illiterate Father = R & write	Bread selling Daily laborer
p6	28 37	F M	(Furi) (Hana Mariam)	Peasant Association	Mother = illiterate. Father = GR6	Both engaged in Dairy Farm

The six parents in the study are consisted four married and two single mothers. Those who were directly under the study are, 6 mothers, 4 fathers and a Grand mother who is also taking the responsibility of her daughter engaged in commercial sex work. The age range of the mothers is from 24 to 52. The single mothers are from the center of Addis Ababa community with the lowest economic status. The third married parent living in the center (A.A.) are from the higher economical status. The semi urban parents living in the suburb area of Addis Ababa are of from the lowest economy since they live on dairy farm by providing milk for the surrounding community.

The parents who are living in **Furi** make their earning from farming have different economical status. The one from 'Eartu Modjo' peasant association have better living standard due to the

hard work and productivity of the family members. They have dairy farms and also work on crops like wheat and 'Teff'. The father served in the army for many years but recently during the government change joined his family and engaged his life on farming. The eldest son now grown ups and is working hard as a mechanic in Debrezeit and is assisting his family. The mother and the other son as well as the elder sister are closely working in the dairy farm, house chores and take care of their son with mental retardation who sometimes needs assistance. There is a young boy at the age of seven who is the grand son in the family (the son of the elder sister)

Table two: Profile of the children.

Parents	The Child With Mental Retardation		No. of siblings Living together	Birth order	Type & Level of Retardation
	Age	Sex			
p 1	7	F	2	6th (Last)	Downs syndrome, mild
p_2	11	F	1	1st	“ moderate
p 3	25	M	2	2nd	Microcephallus, mild
p 4	23	F	4	3rd	Microcephalus, Moderate
p 5	7	M	2	3rd	Hydrocephalus, Sever
p 6	27	M	2	1st	Brain Damage, moderate

The children in each of the six families have different stages of mental retardation and behaviors. Their ages are between 7-27, Their sexes are equally distributed. Their birth orders are also distributed two are first born, one in the second order, two are in the third birth order and there is one who is in the last birth order up to the moment of the study.

The children's retardation can be identified easily since their physical and facial structures are distinctly observable. The two girls age 7&11 from the center are with down syndromes of mild

and moderate stages. One of the boys in the age of 27 and from Eartu *Modjo* of the peasant groups has bigger head is in a sever stage both in his physical ability and mental stage. The other girl of age 23, has smaller head and is mild in her physical ability and moderate stage in her social and mental stages. But is serving her family in cleaning the cow trench. The child in the age of seven and who lives in the other peasant association is not easily identifiable in his physical forms but can easily be discerned from his repeated noise and hyperactivity as having autistic behavior with mental retardation.

Siblings and neighborhood profile

All of the children with mental retardation in this study have one or more of siblings in the family. All of the siblings have special concern for their sisters or brothers with the mental retardation. Many of them are involved in direct services of care and protection while the one living in the suburb with dairy farm does not have close siblings who share her feelings. The mother of this girl is also a rejecting and punitive type to the girl with the retardation while giving special attention and support to the other children in the family.

2. BACKGROUND OF THE PARENTS AND THE CHILDREN

Parents (P1) of Wagaye, age, 7, From the center of A.A. (Piazza)

Interviewed: Mother (single parent) & elder sister.

P1 was born in 1949 in Wolkite' woreda and was from the 'Guraghe' ethnic group. She was from the peasant family. Her mother died when she was an infant and was brought by the father. She was the only child in the family her father was taking a role of both parents to P1 and when she reached the age of schooling the father wanted her to join a church school. So

she joined the church school and accomplished the lesson given properly. Later she wanted to join the regular school and she attended up to grade 3. Then her father arranged a marriage to an elderly man. She didn't like the marriage and run away to Addis with her first born son to live with her aunt, Her father was not happy by this but, later agreed and she was in good terms with him. Her father died while trying to stop a fire in his village. She said he fall down while he was reflecting a mirror on the fire on the top of the roof. This kind of traditional method was believed to be effective to stop fire in the mentioned times. P1 then gave birth to 4 children from different fathers. She was working in a hotel while raising her children before the birth of her last daughter with mental retardation. Then she left her job in order to provide the care of her daughter.

The onset of the problem as explained by P1

P1 said during her pregnancy time she was sick for the whole of the 9-month period visiting the hospital frequently. She said she was taking a contraceptive before pregnancy. The delivery was not normal either. She was admitted in the Gandhi Hospital and was unable to have proper labor due to he child's failure to push. So she was transferred to the Black Lion Hospital. There she was operated and the baby was delivered, with low birth weight and immediately the doctors put her under intensive care. The baby was deprived for a period 9 days the sustenance of her mother's breast. Then the mother nourished her for 3 months with breast-fed. After the first 3 months the child developed skin eruption. The mother taught it could be an evil eye and she was giving her traditional medicine. Then the mother was worried more since her daughter was not able to develop physically rather she was having law appetite became thinner and thinner from day to day her head was loosing hair. She stopped breast-feeding and was taking only bottle fed. At the age of 2 she was not able to

walk, the mother worrying increased and took her to the hospital. There she was identified to have heart problems and was treated but was not improving regularly she was visiting a Hospital (Yekatit 12). P1 remembers there in the hospital she was observed by practitioners about the heart problem. A senior doctor (female) made a good following and presented 3 types of diagnosis. Although P1 was following the hospital visiting for 3 years she was not improving and was not able to talk or develop good appetite. Then at the age of five, the mother tried another alternatives of traditional medicines. She took her daughter to many such areas. At last she was told a person in Arat killo who was known for his success (as she has said). Then she took the girl to the man. He saw her and said this is caused by the sky evil (*Yesemayu*). He explained that while she was pregnant she must have been traveling in the countryside she said it was true. So the 'sky evil' (*Yesemayu*) has looked at her from over head and the power has passed directly to womb over the child's head and had caused the opening in the middle of the child's head. This opening was observable, as she had explained it to be the major cause of the problem. The remedy is to follow his instruction and give the child the traditional medicine. Then he gave her a small bottle with a kind of substance mixed with honey. He told her to mix it with milk and give that to the child for 3 days. Then the mother performed as per the instruction for 3 days. As she explained after the medicine her daughter was sick and was having diarrhea. The mother believed the disease was expelled by the diarrhea. Then after a month the child was dehydrated near to death. Immediately she looks her to the previous hospital. Then the doctor gave her the proper medication. As P1 said her heart failure was cured by the traditional medicine because the doctor, checked the child and suggested to stop the medicine she was taking for two years Then the mother was happy and was astonished by the effectiveness of the traditional medicine. The child began to have a

better appetite. There is the branch of CCF (Christian children's Fund) in the Kebele. It supports poor children with foster families. She took her there then CCF supported the child with nutritional food as a supplement until she gains weight. Soon she gained weight and became strong.

Social interaction and schooling

In the kebele, CCF arranged for a program with the 'Kasangis' Lutheran church Special school for children with mental retardation. Wagaye was a lucky child that the attitude of the mother for the better of her development is always open so she started physiotherapy and physical exercises, which the program conducted once in week. She gained her weight and started to walk at the age of 5. The mother was excited then even believed that her child is not like any of those attending the special school. So she asked CCF to support her for schooling. CCF arranged with an elementary school around the village. So the child is still attending this regular school. This was done by the effort of the mother since she believed her daughter has a better stage than the other children. Concerning her social interaction Wagaye is a free girl as any healthy child. She interacts with her mother, sister and neighborhood as well. But due to some children's abuse the mother has fear to allow her to play outside in her absence.

P1 at present has no occupation except caring for her two daughters (with the elder sister who is attending the same school in grade 4). P1 believed the elder sister is not progressing in her grades due to the reason that she is caring for her sister both at home and school. The other one is a boy working and helping them. The other 2 daughters are married.

P1 strongly believes that parents must try their best to find remedy for their children specially they must try traditional medicine side by side with the modern medical treatment.

In recent times P1 has some doubt about her daughter, she suspected that there is some problem in her that she is decreasing her activities as she is not as fast as before. The reason she mentioned is the attention given from her is not as much as before, because at present she wanted to work for their livelihood.

Parents (P2) of Emebeth, age, 11, from (Filwha) the Center area of Addis Ababa

Interviewed: Mother & Grand Mother.

P2 was born in Addis Ababa. She was brought up by her aunt due to her mother's poverty to care. When she reached the age of 14, she was in grade six and she stopped her school. Then when she was 17 she gave birth to a daughter. At this time she was living by bread selling. She was working by putting her child at her back for the whole period of the first 18 months. She either didn't allow her to get sunshine due to the fear of evil eyes.

The onset of the problem

When her daughter was 18 months old suddenly she became seriously sick with chronic infection on her legs. The mother didn't know what to do so she took her to the hospital; she was not helped much. She suspected the problem to be caused by Evil Eye 'I was carrying my daughter at my back usually cover her by a piece of cloth, on the contrary on that day a woman saw my daughter and said, "Oh! How beautiful she is?" then I returned home there was no hope, my daughter was sick.' After this problem she tried the traditional medicine. But there was no hope. Then she left her to the grand mother care changed her leaving area and was having other children from different fathers. The next child died due to low birth weight. The third one (a boy) was healthy and survived. Then she saw her daughter was not improving she took her to one

of the catholic centers. While attending to her daughter P2 was temporarily employed to take care for the other inpatient children with chronic illness.

However P2 could not stay long in her job since she wanted to care for her son who was left with his grand mother. She took out her sick daughter and put her under the trust of the grand mother. Then due to frustration she left the children with her mother and run away. Started to lead a life on commercial sex work. Eventually one day her elder brother came and identified the infection as a skin rash (ፕሊ), which is usually cured by traditional medicine. The help of the uncle of the child applied the medicine, she was cured from the infection.

The present living area of P2 is nearer to her family living area. But she seldom go to them. Instead her son comes here and there since his grand mother had complained of caring for two children. The younger boy spends his nights with the grand mother and his days with his mother. The grandmother is a peddler of ‘ፍላ’ (roasted cereals) in small scale.

Social interaction and adaptive behavior.

Concerning the social interactions the mother explained that Emebeth likes to obey to the neighborhood and likes to have everything that other are doing. So the grand mother is fed up of this behaviors. She likes to make coffee although she does not make it properly. She goes to the toilet and she has problems of sitting on the latrine because of her legs and she wets her bed every night.

The grand mother explained her grand child condition in the day life while she is engaged in selling “ፍላ”, the neighborhood sending her to the garbage, cleaning rubbish, by giving her a small piece of bread etc sometimes. The Grandmother does not like it but couldn’t do anything since herself is toiling everyday and there is no enough food for all of them including the younger

brothers of Emebeth. She complained about the bed wetting of Emebeth and the mother's irresponsibility to leave both children with her.

Parents (P3) Zelalem age, 25, from the center area of Addis Ababa (Bole)

P3 is living in the center of the city and they are from the modern group. Both are educated. They have good contacts with their relative in America and had send their child with mental retardation - Zelalem once for a better medication.

P3 have only two children. Zelalem is the second to his sister. Zelalem's problem was identified at his birth. The mother recognized the floppiness of his body .He was delivered in the Black lion hospital and he was in intensive care for two weeks.

P3 got information from the doctors and they were trying their best including the holly water. Then at his age of one he developed epilepsy (Grandmal). He was medicated for about 20 years and it's only 4 years ago that he had stopped the tablets by the doctors' advise. When he was sent to the USA for remedy the parents were informed to take care of him at home since his retardation could not be cured but his epilepsy can be controlled. The tablets prescribed in the U.S.A. was the same as the doctor has prescribed here in Black Lion. Later they started the follow up with a private nerve specialist. The tablet side effects caused Zelalem to have swollen gum and misplaced teeth.

Social Relation

The parents said his social relation is good he is obedient. He takes care of himself from the age of seven onwards when he started walking properly. When he was 12 a lady came and gave information about the 'መካነ የሱስ' (Lutheran church) special education program in 'Kasangis' for children with mental retardation. He attended this special school until his 18 years. The parents believe the center has helped him to develop his muscles, to walk properly and to know

directions. However he knows nothing about alphabets and as they commented his memory is very low.

Parents (P4) of Azeb, age, 17, from the peripheral area of Addis Ababa.

Interviewed: Mother, Brother, Father & Azeb.

The parents of Azeb are married couples and lived in the suburb area of A.A. for long periods of years. Their living quarter is owned by them with their dairy farm, they have an average economy status. There are 8 people in the family with one brother and three sisters. Azeb is the 3rd in the sibling order the brother and one sister are her younger siblings. Her brother is attending the AA University while the sisters have completed 12th grade and two of them are employed.

Azeb has a smaller head circumference and speech problem but her mobility and physical structure is normal. She actively works in the family.

The cause of the problem as explained by P2

According to the mother's response, she did not have problems during the pregnancy and the birth of Azeb was normal. But lately when she was expected to talk she was not able, besides even when she was physically growing her thinking was like a child or what she was doing was always clumsy. The mother doesn't care about the evil spirit or traditional medicine. She believes that it is Gods work (punishment) may be they had sorrowed him before, otherwise although neighbors comment about the effects of evil spirit they don't believes (የቤት ግግ) in it. But she said God punished us through our daughter. The mother didn't notice Azeb's small head circumference as abnormal. Azeb's father has similar attitude on the causes of the problem but with less emphasis to the idea of God's punishment more on God's will. He believed God has given her to them for remembering him she is in their hands to do good for her is like to please God.

Social Relation of Azeb

The mother is in contrary terms with Azeb. Azeb already know how to fight back by refusing and saying 'I'm sick' when her mother wants her to do some house chores.

Concerning her interaction with others some younger children play with her and some make fun out of her. She is angry and crying when she is bitten but, she likes to be with others than the family members. She is not allowed to go further. Recently in baptizing ceremony she was allowed to go to the nearby church with her sisters and she was so happy on that day as the mother reported. She said Azeb is in good terms with her father than any of them. The mother fears HIV and rape so do not allow her further than the surrounding of the gate.

- Azeb works the cleaning and releasing of the animals (donkeys and cows). She clears the house and makes the beds.
- Her father does not like her being out with the other children frequently. He believes if there are activities of handicraft that she can make at home would not be boring for her to stay at home He said Azeb knows his heart and obeys him. He comments about the others too by saying, they do not know how to handle her they put her in anger.

Schooling and the future of Azeb

Both parents said School was not tried because of her speech problem or her childish acts nobody would allow her even if we try. Besides children would laugh at her.

For the future of Azeb her mother's hope is not bright as she was amazed by the idea of Azeb's being productive if given the opportunity. What she said was 'no she can't help herself let alone being productive she knows how to eat only'. She added 'Azeb has a good appetite although she doesn't know how to prepare food'.

Azeb's father is open and positive for the future of his daughter. He believed if organizations provide her with training she can learn and can help herself.

Azeb. She communicated with us. She was happy to our coming expecting for us from day to day during the data collection period. Even she was expecting us every day after we finished the visit. She was asking the research assistant who is living in the neighborhood and passing by her gate. During the interview she told us about her mother beatings her being afraid of her. Azeb tried to make 'kiroche' ኪሮሽ work when we brought her the material and she was very happy at our friendly and accepting behavior.

But she was careful to her mother's comment which says (ምን ታውቃለች ብለን ነው) even she was afraid that the mother can beat her and take her materials/ the 'Kiroch' away.

She mentioned about a man in the neighborhood whom she is afraid of always calling her to come to him while she goes out to drop the garbage.

Azeb's Brother

He is her next younger brother- His comment about her social relations is her being better closer to the neighbors than the family members.

Concerning his relationship and playing together from childhood period, he responded by saying he doesn't remember about her child hood when he was small, he didn't play with her because she is always like a small child and her friends were very small children. He never played together with her then after due to various reasons. Some of the reasons were, as he was a boy and did not want to play with female children. She was playing like silly and with small children that he didn't want to be laughed at by his friends. When asked with whom she is playing at the present times, his response was 'with children 5-15 age groups more'. But also she is a friend to the adults in the neighborhood. He believes also mostly she is happy, but becomes angry when

her youngsters do not respect her or insult her. She has interests in working and learning new things. The brother mentioned about her eagerness to new experiences such as the 'Kiroch', which the research team gave her to observe her performance.

Parents (P5) of Yitbarek age, 7. Hanna Mariam Peasant Association

The mother of Yitbarek (The child with mental retardation) was displaced from northern shawa due to famine, she came to Addis Ababa in 1982. She married to a man who was working in the former building construction. They were again displaced by the change of Government and they had nowhere to live they came to the present peripheral area of A.A. as a rural community member her husband started to work as a daily labor and the mother engaged in bread selling. Then She gave birth to two children and the child with mental retardation (Yitbarek) is the first sibling. Her pregnancy period and the first year and half for Yitbarek were normal and healthy. But, at 18th month, he was caught by a disease, which the mother believed was a kind of cold. The problem associated was a very high fever. The parents took him to the hospital, then after a while he was cured from his cold but not from the retardation. The boy lost his hearing, his legs and hands became floppy and he lost his speech. The doctor also told her that there will not be much change in his retardation although physically he will improve as he grows and prescribed for regular checkups. However, after she knew the problem she didn't return back to the clinic due to shortage of money but deep inside her heart lost hopes in the medications. So the mother took him to the holy water. Later after his age of 4 although he never regained his speech his legs and hands as well as his ear problems improved. She said there are big improvements in his legs and hands but couldn't talk. She believed this might be enough rather than taking him to many centers.

Social Relations

She said he has good relationship with his father even he is spoiled in his presence since he gives him attention more than his brother.

- He knows new people, is hyperactive and does not stay at home if there is no activity at home. If he once goes out he may no return for a longtime and he does not have fear of harmful situations. Sometimes he has tantrums and the mother knows it. He doesn't speak but has an intelligent look. He beats his mother many of the times in the day .The younger brother who is 5 is understandable as the mother comments, although he is younger he tolerates his brother's aggressive behaviors and hyperactivity. Yitbarek likes to play with others but aggressively and since many can't tolerate him they kick him back so he is not allowed to play with the peers. So the mother is afraid to allow him to go out of her sight or his aunt's supervision.

Her future idea is to send him to an institution or to the special school in Mekanisa, she hoped for their support of medical expenses. But the problem is with transportation Her idea about the nearby school as an alternative is not acceptable because she believes they will not allow him or he will not be capable of attending properly due to his behaviors. But in Mechanisa there are some like him who are attending regularly'.

Her idea about the problem she still suspects his problem can be identified by doctors.

Bizuayehu (aunt) age 15.

Yitbarek's aunt is the youngest sister (age 15) of the mother and she lives in the family attending Yitbarek after school. According to her report, Yitbarek is aggressive like when he wants something he cries or kicks. If some one talks with him he suddenly slaps his/ her

face. He bangs the door, he throws plates, he easily becomes angry. Some times he is lost unless we run after him because if animals (donkeys) pass by he goes out of the gate and follows. He cares for animals better. He plays with children but sometimes he has a problem of easily fighting. She said he talks some words the village children run away while he starts to fight. Her friends also sometimes involve to help her. His aunt wishes for a better care.

Parents (P6) of Mesfin, age, 27, 'Eartu Modjo' Peasant Association

Interviewed – mother, father & sister.

Problem of Mesfin- Sever Mental retardation and physical deformity with one leg functioning He has big head (Macrocephally) with unfocused sight and walking in a sitting position with support. He doesn't talk properly. Mesfin was more communicative and moving around the village some years ago. He is deteriorating in his social contact and start to pass the whole day by sitting at the back corner of their house. This happened when he is not allowed to go out since people are expanding their houses and their village becomes crowded.

Causes of the problem

The mother had explained when and how the problem occurred. First they were living in Bale province and Addis Ababa. Here they have been for 26 years they had 7 children one has died; Mesfin is the 6th child. One of the brothers is working and supporting the family well. There are two married sisters and one is having a son only and living in the family. This sister is close to Mesfin. Her son is also sometimes is close to Mesfin. Mesfin is One of the younger brother is also close to him he is 3rd younger brother to Mesfin. Mesfin usually calls his name.

Interview with Mesfin's father

Mesfin's father was most of the times absent while he was serving as a soldier. He came back and started dairy farm as well as crop farming from the past 7 years on wards.

The father believes about his son's problem as it might be related to various reasons. As he has observed the child was found to be sick and lumpy when he was baptized at his 2nd month from birth. They thought he will improve but he was not able to talk and walk at his age 2. His head was heavy to his neck and couldn't put up his head straight. At the age of 3 he was able to uplift his head. Even though he was not physically strong he was careful in caring for himself like going to toilet asking for food and putting his cloth. Then the father was away for many years and when he was returned 7 years ago he found him in the present situation with decreasing of social interactions from day to day.

Interview with the elder sister

She regrets about his withdrawal and regressing because she believed he didn't get enough attention for his physical exercise, no attention is given while he was younger. Even though he himself was trying to walk and interact with people he was not allowed to walk around. In the rainy season especially he is imprisoned at home for fear of his being wet and sick. He used to play, talk saying and dance among peers. Lately we started to feel the social stigma which may not be acceptable and follow him right to his home. She said She always asks God for his death or his cure she has watched a television program that shows the progress of others with similar problems through interventions.

After our first visit She has seen a response from Mesfin .She told us he was inquiring why we were there and why. She saw hope in his face and she was also thinking his older times

before he withdrew from talking with them. By this she understood his needs to talk to someone and get a friend who understands and accepts. She believed there might be some hope if he has the chance of communication. He spends the whole day at the corner with all the sun heat sometimes he is forgotten even for his food.

Interview with Mesfin-

He told us his name is Abay- Nesays. He likes to sing and sang one song, which has only one word ‘ነይ ነዳ ነዳ’ He mentioned many names that were fixed in his mind. He said he is sick with his leg only and some people commented on how fat he is becoming.

The mother was curious and wondering about our conversation she was showing signs of becoming impatience and nervous. She thought our attempt was useless. But according to our observation and his sister’s view it was not nonsense it was the comment given to him by the people in the surrounding and that was fixed in his mind. She was laughing and saying ‘ቢቸግርኸ እቴ!’ never accepting his ideas and commenting, ‘ይለፈልፋል’, She believed he is having some evil vision that talk with him.. At last she was convinced and she also believed there may be some improvement if a small house is made for him to pass the day and do some hand works.

3. RESPONSES TO PARTICULAR QUESTIONS.

Q1, Attitudes to the causes & Treatment of mental retardation

P1’The Mother’s response

‘In general It is a disease caused by evil spirit of different kinds some control waist and legs, others speech, others makes openings in the head. She said ‘I was not sure when people were explaining this in the countryside but became certain when the traditional healer explained for

my own case. Parents have to try their best in all aspects like beating waist by a flours of certain cereal known as ‘አብሽ’ and trying with the modern medical treatments as well’.

With particular reference to her daughter, She explained, 'The cause is an evil spirit of a bird like (a bat) it is known as 'Yesemay' (የሰማይ). As to the treatment traditional method is more effective and I believe the parents have to try in all means.'

P2' Mother's response

In general P2 believed it is disease caused by evil eye and possession of evil spirit. Or a family's spirit to be worshipped by the family members (የቤት ጣጣ). She added 'otherwise people have to stick to the Son of God, the redeemer of the world'

The causes for own daughter she believes it to be the evil eye mainly caught when one day she said was invited to a group celebration (ማህበር). Besides there is a family that of ritualizing for a spirit. There is one ritual when I didn't fulfill- (ጨለ) a kind of necklace made by beads

They believe the spirit is on the beads. Because of this reason sometimes I wonder what might be in my womb since my second daughter was so low birth weight that she didn't survive. So I suspect my womb is cursed.'

Additionally P2 has some suspicion to the problem to be aggravated by her not allowing the child when she was one year due to that she was always carrying her at her back and covering her face with cloth in fear of evil eye. 'She said my daughter was beautiful and heavy, every one who saw her puts a longer gaze or wants to play with her.'

P3' Mother's & father's response

Both believed whatever medical explanation is given to the cause, it is the will of God. Other wise they don't have the traits in the family, But added some points.

The Mother's response

She explained she had not known about mental retardation before her own child. However, as doctors told her it might be caused by heredity or damage during pregnancy.

Father- He said medically the causes could be various but contraceptive can be one. He believed pregnant women have to be careful and doctors have to be careful during delivery.

The remedy can depend on the services available in the country. Sufficient medical specialists are essential to help the child.

P 4' Mother's & father's response

Both believe it is caused by the punishment of God. They don't know what they have done but it is his work. The mother regrets of having this girl as a child and why they are punished. All other children in the family are healthy but this girl is given to them as a punishment.

The remedy is also God's will, as both believe.

P5' Mother's response

She believed that it happens by evil for those who are born with physical deformities. But don't have further knowledge about how it could be helped.

She didn't have any explanation to the type of the disease but the only thing she knew was he was having high fever he was cured for his cold but his mental health never regained. The medication as she believes is to try in medical treatment in a good hospital, and then after trying this she has to go to the holy water, which she has done already and saw some improvement.

P6 Mother-

She never has seen cases with mental retardation before her son. Later she started to make observations on others. Concerning of causes of mental retardation there is no other cause than the will of God.

Father- He has no idea on the causes or on services given to such children. But he thinks holy water and traditional methods at early age can help.

Mother's & father's response

Both parents believed it is the will of God. Besides they regret about their not going to the various traditional healers who might have answers to the improvement of the problem.

Q2. Attitudes on the Performances of the child

P1-Mother's response

She believes her daughter's performance is improving even to the extent that her daughter has no any of similarity to the other children with mental retardation. She had observed the others in the 'kazangis' Lutheran special school and that is why she had put her in the regular school. She don't want the neighbors to call her sick or 'በሽተኛ' she fights against the idea that her daughter has some abnormalities, even still she believes no one is aware of her daughter's retardation, although she is sometimes is confusion when the neighbor children makes fun of her. She aggressively fights as was reported by the elder sister. The mother has a reason since the child is almost a mild down syndrome and in fact this was unfair to any child to tease with what weak points he/she has.

P2 Mother's response

She has completely lost hope on her daughters performance she counts every failures of the child even she believe there may be a wrong thing in her brain. She also suspects she might have madness since she scratches her leg and puts the blood in her mouth. She explains about the child's bed-wetting she believed. Earlier, she thought the best way is to leave her to her mother (Grand mother of the child) and run away. The main reason for her commercial sex work is to run away from the child and live alone quietly. But it is different from what she thought. The feeling of guilt persists even at her work time.

P2- doesn't even appreciate many of the performances of her daughter. But what she knew is the daughter's craziness even not to know when she is exploited by the neighbors while they send her to dump garages. They make her clean their dirty and can not protect her or she can not confine her at home. She said her mother is selling 'ΦΛ' and is becoming old. She could not be much bothered about her grand daughter.

P3' Mother's & father's response

Both parents believe their son has shown improvement after he returned, but since his right hand is week he is not able to do things by his hand. But as they were trying for his academic achievement before and failed they were low hearted and showed hopelessness on the moment of the interview. 'He is forgetting what has been thought to him and he is hopeless to education or training' was the mother's response.

P4, Mother-

She doesn't know much about others but it is with God's punishment that a child becomes abnormal. The remedy is not clear to her.

Father- He believed is the method of God that he wants the family to remember him.

So far the father doesn't have any idea how they can be helped except showing them love and care because, one will be asked in the Gods judgment.

Mother- Although the girl has grown she is silly, knew nothing. Besides, she is shrewd many times when she is asked to work she immediately says she is sick. What ever she does it is clumsy except cleaning and the donkeys releasing. That is not even satisfactorily accomplished.'

Father- 'She is in fact does not perform activities that need wise thinking but she is working many things like cleaning in the animals leftovers, dumping garbage out of the gate. Her behavior is good but when someone nags or insults her she is not cooperative as anyone does. She needs good handling that encourages her to work'.

P5 Mother's response

The mother is having in dilemma in her attitude about her son's performance; She mentioned his capabilities as well as incapability as opposing to his development. As the child is having additional problem of speech and hyperactivity, she feels of seeking further medical treatment to his problem.

P6' The Mother's & the father's response

The mother of P6 has a minimal regard to the performances of her son because some very limited routine activities can be seen. As she explains he goes to the toilet and to his sitting stone near the back corner of the house. Spends the whole day there when given food he eats. She even explains he is deteriorating from day to day.

The father- He explains he is sick and does nothing and he is not capable. However if he gets a better chance he might improve.

Q3. Inclusion of the child with MR. within the family & Neighborhood

P1'The Mother's response

The mother believes her daughter is well and active. She said there are all possibilities that consider her as any of her other children. She said again 'in fact I am giving attention more to her than to the others. Even I send her to play in the neighbor hood and school, however, I have fear that some children will harm her so unless I am at home I won't allow her to go and play with others. She plays with her sister at home mostly.

P2'The Mother's response

The mother is not closely living with her daughter so she is not included in her life. In the actual life the grand mother is closer to the child. However, the grand mother has no time. Both the mother and the grandmother have left and neglected the child on her own. She is not part of their lives. She just gets shelter and her food (one or two breads) from the grandmother and sometimes from the neighbors. Therefore, both expressed her neglecton but they believe she has no sense (ምን ታውቃለች ብለኝ ነው?) whether she is with friends or not, she does what others say to her, and she is exploited by the neighbors. The grand mother mentioned that she has no means to keep her at home since herself is always vendering for the livelihood

P3'The Mother's & the father's response

The parents of Zelalem are highly protective and do not allow him to join the neighbor hood at any cost. Themselves specially the mothers is isolated from social activities, and spends her time at home (she is not at present employed). Her response about Zelalem's involvement in the family's activity is as it is very limited. She said 'He keeps quite mostly and does something with asking for permission so he is good at that'. Although he is an adult his physical development and chronological age are adequate she believes he is not capable for any thing

except caring for himself such as for food, going to the toilet, putting his cloth, walking etc. She also mentions 'due to his one hand weakness he is not even able to clean the house so he simply sits, while we discuss on family matters'. But she agrees there are times when he comments on some thing he shows a reasoning capability we may not allowed him to do so.' The *father* said 'I didn't have time to think of such things. Zelalem is mostly spending time on himself or with his elder sister or Mother. So I didn't observe if he can participate or not in the family matters'. Was his response.

P4'The Mother's & the father's response

The mother's response about Azeb's inclusive interaction in the family matters. She was almost laughing even at the idea. Her reason was 'Azeb is not knowledgeable of anything. Her intelligence is to negate me or to be disobedient to my words and to her brothers and sisters. She is better to her father. Besides although she involves in some physical working she is not capable of doing it nicely. So we even didn't thought of discussing or talking with her as a grown up. Our conversation is limited'.

'In fact if someone talks with her she doesn't care she easily interacts. There is a neighborhood that she is close like a friend in our compound. Sometimes I wonder how they are talking as adult friends. The younger children are more of her friends and she plays together. We allow her to do so even it is not appropriate for her age to play with small children what can I do God gave me such a daughter to remember him., (ማን ከሰካይ አሰብህ የሰጠኝን ምን አደርገዋለሁ ሰው ጣቴን ቆርጦ አይጥስ? ይችን በሽተኛ የሰጠኝ ሰዚሁ አይደለ?

The father of Azeb has a different idea about her Inclusion and interaction. He believed she can understand many things and she can easily see when the other in the family talk about her badly or when they insult her. He said 'she quarrels with her mother and some of the siblings because

they don't respect her even when they want her to do some activities. So she had already some smart out lets such as to be quiet and seem dull or to say I'm sick. For me she has a better relationship because I talk with her in respect to her adult hood.

P5'The Mother's response The mother of Yitabarek said 'The child is needing my attention too much and he is also hyperactive and mostly he does not know what he is doing, we all are engaged in his problem. Even our younger son didn't get the proper care I was running here and there to for Yitbarek specially after his illness, so the whole family is disrupted. With his behavior we do not allow him to be involved with neighborhood siblings'.

P6'The Mother's & the Father's response

The parent of Mesfin confessed by saying 'The only interaction we have is when we think he needs food, Otherwise he puts his cloths, he goes to the toilet and sits at the back corner of the house for the whole day. Even sometimes we forget to give him food for the whole day' The mother was sorry when she expressed this feelings. The reason for him to be forgotten was he becoming more and more withdrawn lately. But when he was younger he used to go out get with other people and come happily, singing since he was fond of cultural songs. At present even his legs do not seem to be strong to go out further'. They became used to his problems and live with it as parents and the family got relief in a way that their son is not demanding to go out and interact with people as he used to do. At that time he was interacting so they were ashamed of him. At present no body knows about him, the old neighbors have forgotten him. So this is the best adjustment for the family while it is the worst isolation and exclusion for the child.

Q4. Inclusion in the School/Training and the future

P1. The mother believes the importance of her child's inclusion in the regular school although there are some problems reported by her elder daughter. She said the school is the best way for

the interaction of her child than the excluding special schools. She believed the children will worse in their development if they are put together. For the future she had observed her daughter's interest in photographs and the mother with her elder daughter believed she will become a photographer.

P2. The mother and the grand mother of Emebeth had not thought of schooling or training for Emebeth. Still they do not believe that she can be send to special school. Her mother agreed it could be possible if God gives her daughter good health (ስሱ ምን ይሳነዋል) but have negative attitude to the p possibilities of schooling and training since she suspects evil spirits might have possessed her daughter.

P3-the couples believed the necessity of special school rather than regular school for their Zelalem due to this belief they had put him in Kazangis (Lutheran Church) special school for about 10 years. He left the special school when he reached the age of 18. They believed he had improved in many respects. However, If he could have been put with the normal children he couldn't make it since he is by far different from them and they could have made fun of him & heart him. Besides he could not remember and is not capable of academic education. So it is not advisable to put him in the regular school. Training is also impossible because of his hand' His future is to live with them confined at home. The mother fears what will happen to him after they pass away.

P4. The mother of Azeb expressed about Azeb's failure and weaknesses even to be in any simple training like the embroidery although this showed her capacity, Her mother even seeing she was making it, considered her as being unable. Commenting negative (ምን ትችላለች ብለሽ ነው?) Azeb just after her mother's comment sensitively stopped and said she don't know how to make it.

However, the mother agreed to cooperate if there is a possibility for Azeb's improvements in any training.

P5. The mother believed the best education is the 'Mechanisa' special school where his types are many. The normal school even it is found so closely is not good mainly no one can handle him and the children can hurt him because he has a habit of slapping any one around him unexpectedly. But the mechanisa school is very far I can't take him that long distance she believed the mechanisa is a school which provides medical check ups.

P6. The Parents said for Mesfin school is unthinkable but they are flexible for any type of exercise that he can make with his hands, although his eyes are not focusing he could see round him.

The father hoped that Mesfin might regain his past development if some contacts are made with him with the help of specialists. They expressed their willingness to cooperate and work what is required.

4.RESPONSES OF SIBLINGS

P1- immediate elder sister with age 12 she commented about her sister she said she plays with her sister mostly after school since they are in the same school she couldn't tolerate when some of the children, make fun of her speech. Some times they put dust at her head. Her sister becomes mad and kicks them. She is also not happy to play with the neighborhood if her sister is around. She is so sensitive to comments or mocking about her sister. She tells her mother to fight for this and she believes the best way is to sit at home only playing together with her sister.

She wants to be a computer expert when she grows up. Her sister she guessed can be a photographer since she is very fascinating about cameras.

P2- younger brother of age 9

He is more close to his mother and gets attention from his mother as well as his grand mother. He looks at his sister as an insane. He doesn't play together. He meets her only in the evening. In the daytime he goes to his mother. He was attending a public school but has stopped due to financial problems. He is mostly spending his time on the street corners and is on the way to street life to feed himself.

P3- The elder sister was interviewed about her brother. She is not expressive type. But she explained about his respect to her. He performs when she says so.

From childhood onwards she had made an input of his adaptive behavior on toileting and other accomplishments for self-care. She agrees with her parents he should not be allowed to go out alone

P4- A university-student an Immediate younger brother was interviewed. His response about Azeb is as she is thinking as small children, play with very young children who are not her age. As for him he never played with Azeb. He was a boy and did not want to be together with her because his friends could mock him he has observed her engagement at home she is the one who takes care of the animals (donkey, cow, sheep) by cleaning their places and dumping the dirt. But she is not happy when she is asked with inappropriate way. So once she is not willing she is rigid. Their mother beats her on these terms.

P5. The young brother expressed his disliking about his brother because he slaps him. He said even he doesn't like to play together.

The girl who is the youngest aunt to Yitbarck is positively engaged with him although she is slapped sometimes she even has hopes if he could join the school in the nearby.

P6. The immediate elder sister who has a child of age 6 herself in the house has a special concern for Mesfin. She believed he better communicates with her and she knew he is not as severe as he seems but he shuts himself. His sister remembers their childhood when they were playing together and she was protecting him. She hopes for his improvement with some kind of interaction.

5. THE RESULT OF THE OBSERVATION

5.1 THE TARGET CHILD

Wagaye (P1's daughter) is a child with moderate to mild level of mental retardation with symptoms of Down's syndrome. Her height is a little less than her age; she looks a 3-4 year old child in her performances, except her speech which is not clear (but her mother and sister can understand and well) she has a good social development and easily interacts with people. She has a good interaction with her sister and she has no additional behavior or disabilities.

Emebeth (P2' daughter) She is a girl in the age of 12. She looks some two years younger than her age; she is a neglected child observable on her physical conditions. Her feet are not properly walking. She talks but is not much clear. She spends the whole day outside her home working for the neighbors. They say she eats from garbage sometimes. Her retardation level looks moderate but aggravated the neglect.

Zelalem (P3' Son) He is a grown up and looks a young man as his age ((25 years)). His level of retardation is severe to moderate. He has no physical symptoms except his teeth inappropriate due to the long years medication for his epilepsy. At present his epilepsy is controlled. Zelalem is a very quiet boy specially when he is at home with his parents.

Azeb (P4's Daughter)

Azeb is a grown up girl physically appropriate for her age. Her head is smaller, her lips are thick and has spoiled teeth that made her speech more unclear. Socially she easily interacts. She is sensitive to negative comments of the family members. She fears her mother. She is eager to new things.

Yitbarek (P5's Son) He is a small boy with age 7. He is physically well but seem to be affected on his brain. He frequently gives a sound which has no meaning he sometimes talks a word like give me (ክምጢ). He seems to have an autistic behavior.

Mesfin (P6's Son) He is a young man physically small for his age. He has a head bigger in size. He seems he could not see well but he finds his way easily. His one leg is short and walks with the help of a stick. His retardation is in sever level and may deteriorate to profound if his life continues, as it is Mesfin shows responses to strangers who are talking about him

5.2 INTERACTION

P1. Mother - child: Positive interaction observed during mealtime bed time and leisure time. Verbally as well as touch are normal and supportive.

Sibling-child. There is a lot of interaction between the sister and Wagaye. The interaction is positive and protective.

Neighborhood /school/- the child: The neighborhood is indifferent to the whole family. The mother and the sister are insecure to live freely so they lock from inside and check things or knockings by the window. Both sisters are used to be absentees from the school. There are interactions with peers as any of the children have but some like to play with her to laugh at her/harm her etc /as reported by the sister/.

P2 Mother- child: The mother was loving and close to the child before her illness. Later after it she was hopefully seeking means for her cure. At last she had run away on her own leaving the children to her mother she once had hurted her feelings but she regrets for every thing. For the study period they were meeting after a long time. The girl was hugged by her mother although she is bigger she was hesitating but was happy to be hugged. Both love each other. When the mother want to leave the girl was starting to cry and express her need to go together. There was a problem since the mother was weeping because of her feelings. At last the girl was tricked and the mother went away.

The neighbors' specially one lady used to exploit her labor and so was unhappy about the study suspecting that we might take her to an institution. This was observable from her since she was not cooperative and negativity, urging the grandmother to send us away.

P3. Zelalem has no verbal interaction normally as a boy of his age could have he is a very quiet one. There is normally interaction in the family but his elder sister interacts with him in or tells him to do this and that.

P4. Azeb's interaction is plenty as compared to the others especially in the neighbor.

The mother-daughter: interaction usually is suspicion for example, when Azeb was exercising her 'Kiroche' in the second day the mother came and Azeb was saying in fear 'she is coming! She will bit me! She will take my materials' was her response.

Azeb's and the siblings seem to be apart. No one gives importance to her but after her accomplishment of her work and during dumping of garbage she spends her time with a neighbor who is close her home.

Her father has a better interaction because Azebs asks his approval and attention frequently he mostly responds-positively during our observation.

P5. Yitbarek interacting with his mother and others with the type of commanding words because as a hyperactive Yitbarak touches now and then the materials at home and the parents eyes is on him to protect him from harm or from distracting materials.

P6 Mesfin and his parents as well as sibling are not mostly interacting with him since he sits and spends alone at the house corner. He is still remembering the neighbor's words who said 'It would have been better if he had been killed' (ደህንነ መግደል ነው) he respectfully mentioned this to us.

CHAPTER V

DISCUSSION AND ANALYSIS OF THE FINDING

1. Method of the research and nature of the parents

The method of data collection enabled the researcher to find out the whole picture of the respected families, their interaction and the underlining attitudes as well as feelings towards their children with mental retardation. As mentioned in the methodology these feelings couldn't be quantified or expressed. In this study the researcher has left various information but limited to certain research questions though tempted by the diversified data gathered.

Timing

Concerning the time limit, the researcher was attracted more and more to the family's life and also reinforced by the favorable conditions created for the behavior of changes in each family towards the betterment of each child with mental retardation. Therefore the researcher limited

the extent of involvement for the sake of the objective of the study, but with designing simple strategy for the near future meetings and discussion for interventions. Here the dilemma mentioned in the methodology was abiding the researcher.

Timing was also challenging during the data collection. This was due to the differences among the parents. Such differences for e.g. one parent was not patient enough to spend as much time as required to discuss matters of her son (p5). More time was required to wait and use the very limited spare time although the remaining time gave ample opportunity to observe the whole interactions in the specific period. It also helped to understand how hectic and busy the mothers' life is, especially those who have children with additional problems such as hyperactivity. Time allotted for parent 1 was not enough due to the quick and intelligent responsive behavior she had in explaining and analyzing the whole of the child's behavior as well as the family. This parent attracted the team to spend a lot of time since her ideas were rich and educate. The parents (p3 & p4) who wanted frequent visits before they start to talk their inner hearts' feelings was another constraints of time. The researcher had the challenge of simultaneously observing the time limits and the need to esquire more. However, there was minimum problem to get fast and gather as much information as possible within 26 - 32 hours in each family.

Challenges of the information needs

The other challenging situation was the effort needed to get the actual responses from the original believes/ attitudes/ that have existed within the parents and being careful not to influence their behavior by introducing new ideas or valuable information about their children. That is the parents of children with mental retardation are usually lack information and are not aware of the possible causes of mental retardation therefore, their attitudes are built based on their misinformed ideas. However, their attitudes can easily be penetrated if the right information are

provided because they are searching for answers. They are fast to understand the right way than any outsider who got the knowledge through formal education or other means. They have the best understanding of their children's behavior than any one else. Therefore, attitude change and interventions can easily be applied although this was avoided during the data collection in order to get the original believes and attitudes.

Therefore, for the purpose of the study concerning their attitudes of *inclusion* of their children in the family, neighborhood and the schooling, enough data have been gathered.

2.The Background of the Parents.

The parents' backgrounds have covered each family's picture and the trend of attitudes. The differences in education, economic status, living area (rural, semi urban & urban), exposure to NGOs and the type of mental retardation their children have, gives the reader of this study to have holistic picture about other parents in similar situation. There was equal sex distribution on the children side but female parents and siblings were more dominating on the study focus. This is due to the availability and interaction they have with the children as well as the fact that some of the households were headed by single female parents (mothers).

- **Education-** The parents' education has impacts on the early intervention but has not brought distinct differences in attitudes instead the case of one parent (P1) is outstanding although she believes in the traditional method she strongly strives to find solutions as fast as possible rather than leaving the problem as it is. Her attempt has helped her daughter to improve in addition to her loving care.
- **Economy-** All parents with the different economical status have common wish

i.e. to find a doctor that cures their children. so they have expressed their heavy investment to the medication of their children as compared to the family income.

However, the scarcity/ poverty causes someone to find a survival means even though it is not helping the child or any member of the family. The mother P2 is one who chose the commercial sex work in order to survive while trying to run out of the problem.

P1 and P5 have devoted their lives to their children and could not work since their children needed some one who looks after them. So they believed they are economically affected.

The economical status of P3 is higher so they were not mentioning about the problem. The common problem they share is what to do for the future of the child. The fear of what will happen to the child if they pass away?

The parents in the rural area 'Ertu Modjo' (P6) are productive. Both parents work and the elder son is a technician who is supporting his family. So they are actively engaged in their daily work. The family is ready for new idea and intervention although their son's condition in the sense of isolation and the need of inclusion is the most deprived than any of the other families.

2.The parents' knowledge about mental Retardation.

There are differences among the parents about their knowledge on mental retardation. All of them didn't have any idea before it happened to their own children then two of (P1, P3) the parents living in the center approached the special schools. P1 due to the availability of CCF (Christian Children's Fund) she got an advise to take her daughter for physiotherapy. The mother then got knowledge, about other children with similar children she recognized even her daughter by far better than most of the children in the special school (kazangis mekane Yesus). P3 was informed, by the doctors and even had sent the child to America for cure then to the special

school in kazangis) in A. A. The parent (P5) lives in the rural area but has some knowledge about the special school and the children with mental retardation as a result of a person advising her to go to the Mechanisa School. These three parents therefore, have an idea about their children's problem and decided to accept or not to accept the problem as compared to the others. P4 and P6 have no idea about others with mental retardation in general. This could be due to lack of awareness to the problem or may take it as if it had only happened to their children so they didn't take actions. Therefore, those parents who knew others with similar problems have better explanations concerning mental retardation in general.

4. Attitudes on the causes and treatment of mental retardation about their children

All of the parents were not certain about the causes of the problem. So their attitudes about the causes are connected with a supernatural power like evil eye, possession of evil spirit, God's will, & God's punishment. But, P5, although could not find further explanation, initially she was aware that her son was seriously sick with high fever and might caused his brain to damage.

Therefore, the dominant attitude about the causes of their children's mental retardation is concentrated with the supernatural believes.

These ideas are possibly been transferred to them from the attitudes of their relatives, or neighborhood, since this is supported by their own explanation to the question why they didn't

5. Psychological adjustment of the parents towards their children's problems

P1. Her personality is visionary and she is outspoken, positive outlook and is hopeful of the consequences of her actions. She was loved and well cared by her own father. Assertiveness and independence behavior were developed while she was young due to early death of her mother

and her taking care of the house for her father in earlier ages. As she explains her father had taught her various ethics and moral education since he was more of a priest. So as she grew and have her own children she closely developed their personality with interaction and close follow-ups. Although she is living in the slum area of piazza she mentioned about her success in raising her children in a good manner. With such background she had accepted her daughter and provided her with the best alternatives but with denial with to the problem (mental retardation). This means She has passed through one or two of the defense mechanisms mentioned earlier during the crisis. And she is a witness to her daughter's improvement So she doesn't want to take it into her mind again her daughter as having mental retardation so she mentioned 'I don't like any one calling my daughter (beshtegna) 'mentally sick or having a problem'. However, after trying her best, it was observable that she is on the way to accept the problem on it's present improved stage and also she was getting results in her previous trial she still is eager to learn more about her child's problem.

P2,

She was brought up in a poor family around filwha- A. A. by her single parent (mother). The place she where she grew up where commercial sex work is commonly observed by children. So she took the role easily and run away from the problem. However, she has a good heart and hopes for a better alternative. As she expresses the stress was extreme in every direction after her daughter's illness. Poverty, no means for treatment and the uneasiness feeling with all sorts of the problem. So running away both psychologically and physically was the best adjustment She felt she lost the original good looking heavy weight daughter, instead a daughter who had chronic wound and who does not know and not cooperative to the treatments of the wound resulted. So she even said she was contemplating suicide. At last she joined the commercial sex work in a

very narrow slum house sharing 50% of her income to the house owner. Still her heart is hammered by guilt feelings about her daughter since she knew how her daughter spends the day deprived of her mothers closeness and love. She has a feeling of being neglected and ignored in addition to her retardation. Even her grandmother ignores her. This is caused by the mothers feelings of denying the problem and run away. The mother's attitudes to this is sorrowful deep inside. She has guilt feeling about her deeds.

P3

Both parents have reached in the acceptance of the problem although they are in need of more information and awareness about the need of social inclusion and training of their son. Both parents have backgrounds from families of a better economic status. They own a house renting with high cost and the father runs some business. The elder sister also is employed but not comfortable psychologically about her brother's disability although she has accepted the problem. This was observable on her strong decision not to allow him to get out with neighbor's boys. The mother specially is isolated from the social interaction. Her behavior seems to be arrested by the idea that I'm not 'entitled' so there is a feeling of restriction in the family very less verbal interaction with subdued voice among the three of them.

P4

The family of Azeb is also influenced by the personality of the mother. She is a stubborn mother with less sensitivity, at the time of the study. She might have passed some psychological stages of defense mechanisms, and chose the defense of rejecting Azeb with high demand of the girl's performance. Due to this behavior the mother has made her other children ignore (reject) Azeb. Her father has a better acceptance but is not influential enough since he is out most of the time

and does not interact as such. With all this condition it was observable to have a possibility of behavior change with more awareness raising programs.

P5.

Although living in the rural, originally the mother was brought up in the urban (Cherkos area of AA) and has some education. Due to her son's problem she is disrupted from her decent life. All she thinks now is where to find cure. She is not psychologically well adjusted she hopes for his cure. However, although his retardation may not be cured, his frequent crying and hyperactivity needs to be calmed and the mother is seeking to the remedy. So she herself is not adjusting to the situation.

P6.

The psychological background of Mesfin's family is industrious and keen to new knowledge. But the family seem to accept his problem once in the earlier life of Mesfin' but relapsed to the other mechanisms. After the coming of neighborhoods around their villages they became ashamed of their son and shut him in the compound. Then he developed depression and withdrawal at the same time he was rejected. Wish for his death have developed this is mentioned by the mother that he is like a dead person. (kcmt btsh wy glo egfew) this kinds of expressions did not come because the mother is cruel but emerged from her wish to end up his sufferings.

Mesfin has then been wounded in his heart due to these types of expressions he mentioned by his own words.

Allow their children to interact with the outside society. It is also supported by previous studies (Cherinet, 1999). The theory of ecosystem which states that 'an individual is entitled by the

people in the surrounding', works here. When we take the case of medication as the believe to the causes.

Similarly for the treatment All the parents have tried the traditional medicine and religious methods- like the holly water, prayer although P1, P2, P3, and P5, have tried medical treatment additionally.

6.The effects of the parents' attitudes on their children's performance

All of the children have their own developments of adoptive behavior. There are differences of acceptability by their parents. Some of the parents accept their children to perform more and do not appreciate what their children have. Such parents are P2 and P4. P2 believed her daughter is controlled by the evil otherwise she was cute and active. P4 rejects her daughter as a whole and never recognize her best performance rather counts her weaknesses. She had taken the child's temper tantrum as a disobedience. So she beats her to discipline her behavior. This negative interaction between them was observable as well as expressed by the family members under the interview.

P1- The child of P1 is happy to interact with her mother or with her sister care she sings, asks for her needs, takes, care of herself etc, This is interrelated with what she has developed and the mother interaction of love and encouraging words.

P2's daughter takes care of herself in toileting during the day wetting continuously at night Performs some work but seem to be retarded more than her real problem due to lack of care and love. She is a neglected child and do not care about people. However, she performs neighbors assignments. Her clinging and sensitive behavior was observed when her mother came and hugged her she didn't want her to go back.

P3's son, takes care of himself but he was not expressive, he is quiet and cooperative, asks for permission to do every thing. This effect seems to be the result of the parent (mother) and the sister's attitude originated from the need of disciplining.

P4's. Daughter takes care of herself clean and is socially good to the neighbors she loves other people but is in different to her siblings at home and about her mother causing her to be less self confident to perform a simple task.

P'5 son Walks, feeds himself but he was a clinging type to his mother and loves his mother. However, he has continuous destructive behavior and hyperactivity and is frequently stopped by slapping and equally he slaps any one he gets around. This slapping is what he imitates from the adults. His mother's protection seems to have an effect on his clinging behavior.

P6's son is withdrawn has no interactions with any of the family members at the time of the study but heard his inquiry about the research group because he understood it was about him then when he was interviewed he was repeatedly expressing his past (five years back) negative as well as positive interactions. The family's consideration of him as senseless and non-responsive increased to make him more withdrawn.

P3 and P6 have been taken as useless and weak in performances. There are no additional behavior problems the parents' could complain since withdrawal behavior was not taken as serious problem (especially with Zelalem).

P5 is in serious problem because the child is continuously being followed because he is hyperactive as well as aggressive. He throws cups, plates or any thing unexpectedly. The mother's and her sister's attitude is sorrowful but they are more tolerant than his younger brother who expressed he hates him.

The model parent for accepting and encouraging lovingly her daughter's performances is P1. This had an effect her daughter to develop more and more.

Therefore, parents need to be aware of their children's capabilities rather than counting on the weaknesses. Besides for the weaknesses one can improve if support encouragement and training is added. So this is found to be highly interrelated with the attitudes of the parents. The solution is the change of attitudes.

7. Attitudes towards the future

Three of the parents (P1, P2, and P5,) were seeking for future remedy and hopes of improvement through all means they could. These parents were encouraged to the idea of possibilities of training or education

P3 and P4 were loosing hopes and still do not have positive out look for the development of their children's future. This is partially due to the ages of their children and due to their attitudes of negative thoughts on the performances to their children.

P6 parents are different from all. They seem to learn from their past deeds- forgetting their child from their lives. So they are regretting and are willing to cooperate for any supportive idea. So they believe he will improve again

8. Parental attitudes from the point of view of Theoretical Basis

1. Psychodynamic Theory

The parents defense system in stages of accepting of mental retardation on their children was distinctly observable. These were-

The acceptance of the problem through denial (P1), rejection and quiet (P2) acceptance through having feelings of worthlessness on own self (P3) rejection and hate (P4), hope for cure (P5) withdrawal and rejection (P6)

The parents are not all permanently having these defenses. But some have readiness to change (P1, P2, P5 and P6)

On behalf of the children The Erikson theory of Ego identify and the psychoanalytic explanation of depression is applicable. According to Erikson theory, the individual as he progresses through his / her developmental stage meets with a psychosocial crisis's and gets problem in identifying himself confused by the image given by the people around him when he or she develops. The children with mental retardation are victims of images given by misconceptions of the attitudes of the family and the neighborhood which usually negative images telling to the child he or she is useless, dependent, burdensome and punishment of God to the family. This has an adverse effect on the development of the child and contributes negatively to their learning capacities. Five out of the six children in this study are victims of this adverse effect.

2.Ecosystem Approach

The parents in the study have Socio cultural back grounds which has the greatest contributions to their believes and attitudes. Due to this reason the parents who are educated (P3) could have different out looks but the effect of the neighborhood has caused the mothers isolation from the community.

The ecosystem in the environment of P1 is more favorable due to the existence of the CCF (the intervention of an NGO) has an impact in the community attitudes. This is proved in the condition that the mother's comment when she was in the initial crisis CCF was helping her in various aspects such as for her daughters medical support and when the child was malnourished

the support of nutritional food. In general CCF was supporting P1 with all means including psychological support (advises). It also supports the community school to include the children with mental retardation.

The others do not have such intervention in their surrounding. So the thought and attitudes have not changed whether they live in the urban or rural community

9.The Impact of parental attitudes on the inclusion of children

9.1. The opportunity of Wagaye to be included (of P1)

(a) In her family

***Wagaye is included in her family** as any member of the siblings with more attention and love from her mother due to her being the youngest rather than considering her as weak and sick child.*

The inclusion is due to the mother's positive outlook and kind heart. Although her positivity is for the whole of her children. But her special attention is to Wagaye, which is necessary to the encouragement and addressing the special needs of the children.

Factors for the positive attitudes

- The mother's positive outlook due to her personality built in loving and happy childhood she had with her own father, expressed repeatedly while discussing her own childhood period.
- The additional moral education the mother got in spending her early years in a priest school.
- The contribution of an NGO intervention (CCF) in the area and her positive outlook and thankful behavior that might encourage to support Wagaye in medical expenses and the necessary supplementary food in times of need.

- Reciprocity of positive interactions of the two (mother and child) that resulted in fast development, again reinforcing the mother to have more and more positive attitude and be creative in all rounded measures.

1.2. Wagaye's inclusion in the neighborhood

Wagaye is not included as much as she is in the family

The mother of wagaye is fond of her children and is protective. He grown up of children have been closely observed, supervised and advised not to follow the village children life style since the area is a spoilt and a slum area known as ‘ሰራተኛ ሠፈር’. So she had an exemplary history to the better upbringing and welfare of her children.

Factors that create negative attitude towards neighborhood interaction

- Although the mother used to allow Wagaye to play outside, the neighborhood are provoking type and the neighbor children and grown ups try to make fun of Wagaye.
- The neighbors' lack of understanding of the true nature of mental retardation and ignorance causes to gossip and ostracize Wagaye or some to insult and abuse her childish behavior, which the mother couldn't tolerate at any cost.
- It seems also there could be an underlined reason that restricts Wagaye indoors. That is the mother's psychological defense stage to accept her daughter's mental retardation.

1.3 Attitudes on the Inclusive education of Wagaye

Wagaye is included in the regular school as a result of the positive attitude and effort of the mother. The other was informed and had tried the special school for children with mental retardation only. However after her child got the basic physical exercise and advises from the office had changed to the regular school in the nearby area where her elder sister is attending. The school caters a lot of the village children coming from low-income families. Wagaye's sister

is in fourth grade and closely watches Wagaye. Therefore for the inclusion of schooling and acceptance of admittance the following can be the **factors: -**

- *The parent i.e. the mother is positive for her child's education in the first hand and tried her best to differentiate her daughter's retardation level as compared to the others in the special school.*
- *The mother didn't like her daughter to be considered as a child with mental retardation and wants her to be included as any normal child.*
- *The child's retardation level and the fast improvement seen encouraged the mother to push her daughter to continue.*
- *The involvement of the organizations in this case the CCF to convince the school administration to accept Wagaye and the others with similar situation.*
- *The advantage of her elder sister's presence in the same school helped Wagaye to be protected from abuse although for the sister is unfavorable condition.*

2. The opportunity of 'Emebeth to be included -The daughter of P2

a). in her family

Emebeth is not included in her family as her brother either in the life of her mother or her grand mother.

The mother of Emebeth has run away physically and psychologically mainly from her daughter's problem.

Factors

- The mother chose running away due to the psychological crisis (conflict) she faced while the problem was on setting and the coping mechanism she chose was to go away and live with the worst type of occupation as she explained 'third stag' commercial sex work.

- Luck of financial and psychological support while she was in the crisis. The poverty while living together with the two of her children and mother was so grievous to adjust such scarcity was unbearable to her.
 - The rejection she faced from the neighborhood and her brother who was in a better economical status. Later this brother was a little considerate to take her daughter to the traditional medication to the bleeding on her leg to the chronic infection. He took this action while he saw her mother is no more there and his mother (the grand mother to the child) is incapable of any thing.
 - The mother's upbringing system and the living area she had grown up had contributed to the acceptance of her present life than suffering with a 'sick child'. Although she is not comfortable to her solution. This is due to the guilty feeling in her heart the attachment she had with her daughter earlier before the onset of the problem. This was reflected in her expression 'My daughter was not like this she was beautiful and people were saying ' is her father a Cuba? (The mentioning of Cuba is to express half cast children with a white foreigner and many white Cubans were having affairs with the bar ladies here during the Ethio-Somale war some twenty years ago
 - The factors for the grand mother's rejection are:-
 - Mystification of the etiology of the mental retardation and considering the child to be possessed by the evil spirit. So she believes until God says it is enough or takes away her nothing can be done.
 - Her old age and the poverty had made her not to see a better future.
3. She run here and there to provide the daily needs of the three of them and does not get time to sit and look after her. So she left her out of her bothering. She had mentioned 'I don't know about her, go and ask her mother I'm an old lady I'm not ready to talk with you'.

- The impact of the neighbors is so strong that the grand mother has no say about her daughter. This was observed in the time of the study while a neighbor was strongly resisting our coming and the study questions which were about Emebeth as mentioned in the methodology. She was against any better attitude about Emebeth her main reason was to stop her from religious affiliation. She was saying it is better if she die than your religion although we were explaining our objectives. The resistance had something related with the fear that we may take the child to a better place and she won't have the chance to exploit her labor as we discovered later from her mother.

1. Emebeth's inclusion in the neighborhood

Emebeth is included but only Physically

Emebeth is not confounded at home as many of the children with mental retardation are but left to the neighborhoods without the necessary follow up and care. No one provides her food or any other thing necessary for her daily needs. So Emebeth is highly deprived of the basic necessities. Above all the psychosocial support and parental love are denied to her. She does not have the chance of proper learning from adults since no one is concerned to teach her properly except sending her to fetch this and that. She might have gained new knowledge from working and fulfilling other's commands in order to get some food and survive the other from fear of being beaten. All this and the longing for her dear loving mother, the nagging of her grand mother for her bed wetting made Emebeth's life worse and worse than getting a better chance of being let out to the neighbors freely.

2 Attitudes on the Inclusive education of Emebeth

a) Emebeth is not included in school or there is no previous idea about education

The mother of Emebeth never thought of sending her daughter to any of the available special schools. In the time of the interview the mother started to see this new idea and get hope that might help her child to pass the day instead of being the garbage dumper of the people around her living area. The mother then revived her hope to try again even the neighbors were saying ' Oh! Whose daughter is this? She left such sick child for prostitution? Let her die' How iron hearted she is?' Was what they were saying so she was afraid of going back and change her life style and start to care for her daughter. The new idea is to reinforce her room and start a small business, like selling bread or any item and get some medical care and training for her daughter.

The opportunity of Zelalem to be included -The Son of P3

a) in his family

Zelalem is partially included in his Family with restrictions of certain programs

Zelalem is a grown up boy who might have an input in the family matters if he was included in any simple task and allowed for his comment. But the parents are strictly decision-makers and his sister is stricter concerning Zelalem 's activities at home. Even he is not allowed to talk and laugh. The sister believe she had made a difference in his life by training him like this. So Zelalem's involvement is so restricted and he is not psyche socially included in the family.

2,Zelalem's inclusion in the neighborhood

b) Zelalelem is not included with his neighbors

Zelalem is from a family of a high economical status with a living style of nuclear family and less emphasis given to neighborhood relation like having coffee ceremony with neighbors, or

getting time to visit someone in the neighbor. In addition to this the parent (mother) and the elder sister have restricted themselves with no contact with their neighbors with their confounded gate.

3 Attitudes on the Inclusive education of Zelalem

c) Zelalem was included in special school established for children with mental retardation.

During the child hood period of Zelalem his parents were able to get information about the special schools so he was admitted in kazangis Mekane Yesus School. But zelalem has never the chance to be included with the non-retarded peers, which may have an effect on his social interactions. The attitude of the parents and the sister on the issue of interaction with the other children is very negative. They were sighting various problems that are related with the youngsters Such as he will be cheated easily, or they will make him an instrument to steal things, they will kick him etc.

4. The opportunity of Azeb to be included -The daughter of P4

1. in her family

a)Azeb is not included in her family as her siblings. This is due to the main reason of the mother's hate and negative attitude towards Azeb. Azeb is always ridiculed for what she is doing and no one accepts her work as relevant except her father. So Azeb is always on her own excluded from the family matter.

2, Azeb's inclusion in the neighborhood

b) Azeb is partially included with her neighbors

Azeb has a personality, which does not accept every thing said by others. She developed this kind of self-assertiveness while being in contradiction with her mother. Due to this behavior, she had developed better relationship with the near neighbor and some younger children around her house. Her regular service to the animals has capacitated her to go out of the gate and be

friendly with some neighbors. But the mother's attitude to allow Azeb to be with them is negative but she does not follow strictly since she can't control it.

3 Attitudes on the Inclusive education of Azeb

c) The parents of Azeb had never tried to put Azeb in special school or any other type of training

Factors

- *They were not accessible to get the awareness and information about the special schools.*
- *They (the mother) is ashamed of Azeb rather than trying any intervention program to Azeb.*
- *The family of Azeb consider her as a handicap that can not perform such capabilities.*

Due to this and other reasons Azeb is ignored for education or training

The opportunity of Yitbarek to be included -The son of P5

a) in his family

Yitbarek is the center of everybody's attention in the family due to his problem. But as he is not talking and is young as well as hyperactive. **No one is expecting to his inclusion in the family matters.** The mother's attitude towards the inclusion of Yitbarek is not clearly identified due to her unsettled attitude on her son since she still wait to his cure and accept him as a member.

2, Yitbarek's inclusion in the Neighborhood

b) Yitbarek is not included with the neighbor peers

Yitbarek is rebelliously used to go out to the children in the neighborhood and try to play. But with a very small reason he fights with the peers so the mother's attitude to confine him at home increased from time to time.

The other reason is lack of support from any group although the parents are in a crisis of situation because Yitbarek's problem never gives pace for the parents.

C) Attitudes on the inclusive education of Yitbarek

Yitbarek is not included in the school

The mother of Yitbarek had not try to put yitbarek in special school or any other type of training due to her attitude towards Yitbarek that made her believe he can not attend school with other children

Factors

- *The problem of Yitbarek is associated with hyperactivity and easy to have temper tantrum when things are not suited him. His social relation will not be smooth with such behavior he has.*
- *The mother and his aunt are afraid of these problems so they did not allow him to attend the preschool in the neighborhood although the preschool is not strict to include children with different behaviors. If they had put him in this preschool, the school situation and peer group norms might have helped Yitbarek to learn more instead of his behavior aggravate*
- *The mother still believes her son's problem might get medical treatment so she is not settled to think of education for Yitbarek rather than her future hope for special school*

6.The opportunity of Mesfin to be included -The son of P6

a) in his family

Mesfin is the is the forgotten child even he is there as a family member. Once in his earlier life he has a better interaction with his own words and movements. But as they had reported he developed withdrawal behavior from time to time therefore, attitude towards the inclusion of Mesfin has never been thought of by his family.

b) Mesfin's inclusion in the neighborhood.

Mesfin is not included with the neighbors

Mesfin is strictly denied of getting in touch with the neighbors. Long time ago he was used to go out and talk with some groups with his own expressions some laugh at him others say 'it was better to kill him' which he still remembers and other commenting on his physique, others becoming his friends. He was happy as well as angry but it was the rule of life to everyone although the types of treatments and happy events differ from person to person.

Factors for his exclusion

- His parents started to feel about the treats of the people who saw Mesfin for the first time. They did not like his being ridiculed. So they confined him to spend his life inside the gate only. Then Mesfin might not get the reason for his confinement depressed and withdrawn.
- The parents do not have awareness and did not get training on similar programs to fight against the community's attitude that see persons with disabilities as something different and try to make issues that humiliate both the parents and the children.
- The people are not sensitized and do not have the knowledge of the modern way of thought on human rights. The other reason is lack of support from any group although the parents are in a crisis of situation because Yitbarek's problem never gives pace for the parents.

c) Attitudes on the Inclusive education of Mesfin

The Parents of Mesfin are living almost in the countryside, far from the urban activities of AA. The information of schooling and special needs training are not knowledgeable to them therefore they have never thought of schooling for Mesfin before the study time. But after the introduction by the researcher their attitude was changed and discussed about the possibility of getting training in his present situation. i.e. to get a kind of hand work training in his sitting instead of

sending him somewhere unless the training center could provide transportation since he is weak and can't walk at this moment

CHAPTER VI

SUMMARY, CONCLUSION & RECOMMENDATION

Overview

This chapter includes the three parts of the study. 1, the Summary; 2. The Conclusion and 3. The Recommendation. The conclusion is specific to the particular situations of the parents in the study so that it is not for generalizing from a minuscule sample of 6 subjects. However, there are some universal facts found in the previous studies and theories equally seen in the findings of this study that has enabled the researcher to make inferences on the formation of the attitudes of parents and the typical situations of children with mental retardation. But the outcome can not be generalized to the majority of parents. Therefore, the conclusion is particular but with general truths. Similarly the recommendation focuses on issues of the parents in this study however, the particular parents of the study are the reflections of the general situations of the society in terms of believes, social services and economic situations. Therefore, the recommendations are useful to the majority of the people with disabilities, parents of children with disabilities of various types as well as parents of children with mental retardation.

1. Summary

Mental Retardation is a type of disability that has been misconceived for centuries. Persons with mental retardation were cruelly treated and put in custody until the past two centuries when the humanitarian movements enlightened the caregivers for education and better treatment. Recently with the human rights and the concerned associations movements, exclusive programs are changing to be more of inclusive nature in most of the developed and some of the developing countries. Ethiopia with ratification of the rights of the child had included a special needs education program in her Education Policy. These measures have their own impacts for the better development of the child. However, the vast number of children with mental retardation in the urban, & rural communities need to be addressed and the parents who are the primary agents are more influenced by the traditional believes. Due to these believes; the children are not included in the society as a right.

This study focused on the parental attitudes on the inclusion of their children with mental Retardation. The objectives are finding out the attitudes of parents of children with mental retardation to be included in their surroundings. The specific objectives focused on identifying specific attitudes of the parents' the causes of positive or negative attitudes of the parents children's inclusion at home, neighborhood and the community/school, training.

Specific Objective

- To identify the specific attitudes and believes of parents on the inclusion of their children in the interactions of the family, neighborhood and schools.

- If there are negative attitudes on the inclusion of their children, to find out the root causes and reasons and replace them with positive attitudes.

To propose possible and implimentable recommendations in the areas of changing negative attitudes (if there are), support positive attitudes and provisions of services for the inclusion of children with mental retardation.

The research questions were formulated with the basis of the objectives.

1. What are the attitudes of parents that are affecting the child's needs of the normal inclusive interactions in the family from early childhood period?
2. What do parents believe in the inclusion of their children in the neighborhoods with peers?
3. What are the parents attitudes about the inclusive education in the regular schools, vocational training, social interactions and career ?

The method of the study includes assessment facilitators and selection of parents as entry points. Their living areas were: - two parents from the center and one from the peripheral area of Addis Ababa, two parents from the peasant associations located in the south west of the city. The parents involved are: 6 of the mothers 3 of the fathers, a grandmother and the siblings. The method used is a qualitative in-depth study on their backgrounds, attitude of causes, medication and the future of their children. Then attitudes on the inclusion of the children among the family, the neighborhood and the school /training.

The method used for data collection was interview, observation, discussion and story telling. A video camera, taperecorder together with facilitators for each family were used to advance and get in-depth data. The selection of the parents was randomly by the availability of a facilitator. The rural community location was manageable for the researcher with a three-hour walking. The period took to cover the data collection was 6 weeks with 2 weeks in each family with a half day

visit simultaneously. The visit program setting was random in each day with different hours to get different pictures of the family interaction.

The findings of the study showed the 6 parents have different economical and educational background. Their children and the of siblings different, Two parents were single mothers, the rest were couples. From the couples one subject was the mother only since the father was not available. The occupation of the two of the single mothers and one of the couples in the rural community to be unemployed and poor while one couple who live in the center is from the high economical status, one from the rural and the peripheral to have a dairy farm and a better status in economy.

Their background history and the personality formation of each parent has direct relation to their attitude and is different one from the other.

Parent Attitudes	Evil eye	Evil spirit	Gods will	God's punishment	medical reasons
on causes of MR	P2	P1	P3, P5	P4	P3 ,P5

Attitudes to	witch doctor	modern treatment	worship to the spirit	not action taken
to treatment	P1	P3, P5	P2 , P5, P6	
Measures taken	P1	P1, P3, P5	P5	P2, P4

Parents Attitudes to inclusion of their children	In the family		In the Neighbors		In the school/ Training	
	Negative	Positive	Negative	Positive	Positive	Negative
	P2,P3,P4 P6	P1	P1,P2,P3, P4,P6,		P1, P3	P2, P4 P5, P6

Those who support the idea of schooling or training for the future are P2,P5 & P6

The first parent was single (mother) although she is not educated (grade 3) and with the low economy has a well established personality that have impacted on the qualitative development of the child.

This mother believed in traditional medicine and had applied to her daughter who is 7 with down syndrome. She believed in early intervention, inclusion of the child in the family and in the school, But not in the neighborhood due to fear of abuse. The causes of mental retardation as she believes are evil spirits (*YESEMAYU*) that possesses a pregnant woman affecting the child in different parts of the body. Apart from this the mother has practically helped her daughter in all means to develop and be included in the regular school.

For the future of her child the mother has a positive idea and together with the opportunity of the existence of the Christian Children's Fund can be taken care of the school where daughter is already accepted. But work more for the special need of her education.

The second parent was also single brought up in the poor community in Addis Ababa, has reached grade 8. She had left her daughter (now 11) to her mother and try to escape from the problem. Her mother is old and is very poor living by peddling than having time for the care of the child and the child is neglected and abused by the neighbors. She believed the cause is evil eye since the onset was after birth of her daughter. The medication is worshipping to the spirits or be under the protection of God, But as she is engaged in commercial sex work, she has guilty feeling to be accepted by God, by the neighbors and by her brother. She does not believe in the inclusion of her daughter in all of the three levels since she thinks all things her daughters doing is wrong by the possession of the evil. For her future she has conflicts in her mind whether to live together and support her daughter or leave her as she is. For the future, the mother has an idea of starting small business and be back to her daughter for a better care. But needs support in finding

a school for her daughter that serves as a day care while she will engaged in income generating activities. Then the application of training to her daughter could help more.

The third parents were married, both were interviewed. They are educated with a high standard of living. They had done their best in the child hood period of their son. They believe the cause is God's will, the treatment is conditional but modern medical support is helpful & trying the holly water also could help. About the inclusion of their child in the family and neighborhood they have negative attitudes, mostly the mother and the elder sister are restricting their son although he is 25 now. But concerning schooling they prefer special school and he was in a special school up to his age 18. For the future, the parents are willing to cooperate for the vocational training at home level or in a center .So they are convinced to start the possibilities. Concerning his inclusion at home level the mother and the elder sister need to get awareness raising programs.

The fourth parents, married **were** involving in the study. The mother is a rejecting type. Her daughter is in a moderate level of retardation with microcephally. Her mother took her as a punishment of God. Due to this her child as she grow up (now 23) became disobedient and against her, The mother increases her negative attitude and the conflict continuos. The siblings ignore their sister except the father who has less impact on her acceptance because of his absence from home most of the day. However, after the discussion the mother seemed to accept partially the idea of training for her futurity. The mother needs a counseling program and follow up for the acceptance of her daughter as having capabilities and reduce their friction in day today interactions. The girl has already shown her interest in handicraft and the mother was astonished to the idea Therefore the attitude seems have possibilities to change if the necessary work is applied.

The fifth parents are married but the mother was available during the data collection. Their education is they have been in elementary level. Her 7 years old child has multiple disability happened after the first 18 months. Therefore, He has hyperactivity, speech problems and aggressiveness as a counter act when he is restricted from things. Therefore, P5 and the young aunt are engaged in his support for the whole day. The causes as she believes is a disease.

The mother is planning to take her son to special education center but has suspected his medical need is still there although the doctors said there is no much to do and wait for his grow. She also hopes for the traditional medicines. As a recommendation, the boy can be enrolled in the near by preschool if they accept him. This needs some discussions with the school heads.

Both of the **sixth parents** were involved in the study with large family. The mother is illiterate and the father has an elementary education. Their son with sever level of mental retardation (age 27) has macrocephally and physical deformity with speech problem. He moves from his room to the toilet then spends the whole day sitting at the back corner of their house. The family is a hardworking group and do not give enough attention to their child. Their attitudes of the causes and treatment to be under the will of God. Concerning the inclusion of the boy, He is forgotten in the family. He is alone and has shut himself for more than 5 years after he was forbidden to go out. This was because of the fear of other persons comment to his physical feature. He was interviewed and with his own way expressed his past life when he was conversing with people, what they have said to him is fixed in his mind but remembers it as a pleasant experience although it was a negative comment. The parents or siblings are willing to cooperate for any type of intervention for him.

2. CONCLUSION

Based on the General and Specific objectives of the study and the research questions the finding of the study has come to the conclusions.

The findings of the parents' attitudes in six family set up has shown to have the following conclusions: -

- ⇒ The parents believe the cause of mental retardation to be:-
Evil eye, Evil spirit, God's punishment, God's will. The educated parent suspects that cause could be for medical reasons.
- ⇒ The treatment according to the five of them is traditional healers, God's mercy, while partially two parents hope for cure from modern medical treatment in addition to the traditional practice.
- ⇒ Four of the parents did not see other children with similar problems either did not have informations about schools whether inclusive or special.
- ⇒ Having the child with mental retardation has different meanings according to their level of acceptance of the children. As this was expressed by many of them, the general feeling is to be inferior from the general community manifested in their strong refusal to mix their children in the neighborhood.
- ⇒ On the children's performances five of them are underestimated, since they have lost their hope earlier when the child was not performing as his or her age mates.
- ⇒ On the behavior of the children two parents have serious problems. These problems are

the aggressive behavior of the brain damaged child and the fight between the grown up girl with microcephally. Those parents who didn't complain are those who have children who keeps quiet, sit as they are ordered. These children as observed have less experiences and less self reliant as well as lacking social interactions.

⇒ The interaction of the children with the siblings showed many of the female siblings are involved like the mothers concerning their siblings with mental retardation. This have negatively affected their educational performances and other social activities.

The fathers with the positive interactions with their children in this study could have made in their children's development, However, non-of them gave time to spend with the children and so far they have no much impact on the development of the child.

⇒ The neighbors as reported by the parents and siblings are mistreating to children with impairments. Usually they make fun of the children and have negative impact unless the proper education is provided.

⇒ The children with mental retardation have capabilities of their own. These capabilities. Are hidden unless revealed by the closest person (the mother) interacts with encouraging words and positive attitudes.

Conclusions on the factors Negative or Positive attitudes of the parents

There are differences from parent to parent in respect to the research questions. These differences arise from the following major constitutions of each family.

- ◆ The level of the parents' exposure to the general knowledge of mental retardation before or during the occurrence of the problem to their own children.

◆ Each parent's choice of mechanisms in coping with the psychological process in accepting the child with his or her problem due to the make up of each parent's personality to have negative or positive outlook on having a child with mental retardation.

◆ The differences and degree of having positive outlooks, tolerance, intuitiveness and practical behavior of each parent in finding solutions to problems so as to accept the child (as the case of parent) and provide his or her own method for the better development of the child.

◆ The availability of information on handling of children with mental retardation.

◆ The availability of social support and financial support for the expenses (Food, medical treatment) at the time of critical period (The support of CCF for parent 1 and the economical capability of parent 3 has helped for early intervention)

◆ Socio cultural background together with the personality make up of each parent.

◆ The education and economical level of the parents to have positive outlooks for early proper

◆ The educational and financial accessibility of medication although the neighborhood awareness level is an important factor. (the case of parent 3).

◆ The level of awareness of the community members, siblings (in the school neighborhood)

neighbors and community elders who could make a difference in the acceptance of the child in his/her environment.

◆ The availability of educational opportunities and vocational training for children with disabilities in the surrounding.

These and other points affect the child's inclusion in the family, neighborhood and school/ training in each of the subjects in the study.

3. RECOMMENDATION

SPECIFIC RECOMMENDATION TO THE CASES IN THE STUDY

All of the children in study need the intervention programs that includes functional training and vocational training together with awareness raising of the parents.

3. All of the parents in this study have negative attitudes about the inclusion of their children with the neighborhood. Therefore, sensitizing the neighbors together with their children will make a big difference in the lives of the children with mental retardation.

4. Four of the parents (p2, p4, p5 and p6) did not thought of education for their children due to various reasons. But they are not strongly opposing if the appropriate type of school is available herefore appropriate educational and vocational training are essential

5. Concerning the cause and the treatments of mental retardation all of them connect it with the supernatural power. Awareness raising programs through the community need to be provided.

As a recommendation in general the main barrier of the children's interaction is the attitude of the parents and the neighbors. These attitudes are again the reflections of the general society.

- *Awareness raising and education to the grassroot level and the general community.*
- *Early interventions for the children and the parents can bring changes in the lives of children with mental retardation.*
- *Guided by the rights of child of the UN, and Provisions of Educational / vocational /, social and economical opportunities to the children with mental retardation is one of the fore front measures that has to be focused.*

Specific Recommendation To the children with Mental Retardation in general

In order to build self-reliance and interact in the society with equal rights, the children with Mental retardation need to be included in the programs of the society. This programs are mainly: -

- Early Child Hood Intervention with medical treatment, counseling to the parents and sensitizing the community around.
- Community Based Rehabilitation programs for awareness raising and the focus on the follow-up and training of the parents or siblings to take early measures for the development of the child with mental retardation.
- Family counseling for the parents and the family members.
- Awareness raising programs for the community members (neighbors, local associations, schools, kebeles, etc)
- Child to Child programs for children in the family neighborhood and regular schools.
- Provisions of inclusive preschooler and elementary education opportunities with special supports for the children with mental retardation.

Prevocational and vocational training for the grownup persons with mental retardation.

These measures are the basis of actions to be taken by systemic approach from macro level to microlevel and the counseling part is more of helping the parents to cope with problem and accept both the child and the problem. Psychodynamic approach is more applicable for the individual work therefore, both approaches are essential to alleviate the problems of the children.

Short Term

1. Recognition of the UN Convention on the Rights of Children With Disabilities and UN Standard Rules on the Equalization of opportunities for persons with disabilities

The existing NGO's and the local associations as well as the disabled persons associations can introduce the rights mentioned here. The collaborated efforts of these social groups with the policies of the government can bring the recognition of these rights, which eventually lead to the implementation mentioned in the long-term program.

2.Early Childhood intervention. Many of the children born with mental retardation are not identified and provided with early intervention program in our country. Due to that they are made to increase the level of retardation. .

There is a possibility of early intervention in some of the urban areas even in the present situation start. There are pediatric centers and clinics in the capital city, there are psychologists, sociologists, educationists, NGOS and Community based Rehabilitation centers. But the majority of the problem is aggravated from lack of these services. Therefore, first the conviction and positivity is very essential on behave of the mentioned professionals .The second step can be organizing a coordinating body in the area of field. The third step can be the involvement of the community with the panning of the strategy. The fourth step can be coordinating volunteer workers and researchers to work with the team that involves the family.

3.Expansion of Community Based Rehabilitation (CBR) programs for awareness raising and the focus on the follow-up and training of the parents or siblings to take early measures for the development of the child with mental retardation. The existing NGO's

working in limited areas of AA even can focus with their programs to include peripheral and remote areas of the city.

The local associations can take the role if awareness and training is provided both by the government and humanitarian organizations.

4. Formation of family counseling centers. This centers are very essential that needs to be included in NGO's and government programs as a part of a hospital social service or as a component of kebele administration. This is implimentable with assigning trained use workers that require a minimum cost. Professionals can involve in the training and follow-up of the services

5. Awareness raising programs for the community members (neighbors, local associations, schools, kebeles, etc). All of the parents ware not willing to let their children with mental retardation to interact with the neighbors. This trend is common with most of the parents. The reason behind as the finding show, the people are not aware of the rights of a child with disability, not to be discriminated or abused. They are also in similar believes that such children are the punishments of God. Therefore, the remedy is educating the neighbors in particular and the other members through participatory methods to gain true changes rather than pushing them to change of attitudes that may not stay long.

6. Child to Child programs for children in the family neighborhood and regular schools. The attitudes of children are easier to change than adults and they are more cooperatives to actions. This was observed in previous experiences where children with mental retardation were included in regular classrooms. The 5th grade students were given a chide to child training before

the integration. The outcome was observable that they were friendly and accepting. In return the children with mental retardation were more preferring the integration classes than the exclusive special education classes (Observed by the researcher during a paper work in Kokebe Tsebah School). Similar changes are reported by CBR agents that a child to child approach is effective in bringing changes of attitudes among peers and their parents as well as neighbors.

7.Provisions of inclusive preschool and elementary education opportunities with special supports for the children with mental retardation. Inclusive and integrative education for this children are possible. This is in line with the policy of MOE and the opportunities of the decentralization policy. The zonal and woreda educational administrations had shown their cooperativeness to involve special needs educations in the regular schools with specially trained teachers. It needs the parents' initiatives for the practicality of the existing positive grounds. Preschoolers are essential for these children and together with the education burex the public preschools can be sensitized to accept limited number of children and start exercising inclusive programs.

8.Provisions of Prevocational and vocational training for the grownup persons with mental retardation. Vocational and prevocational training are very essential for these children. The vocational training need not to be sophisticated but simple that will be functional with the assistances of their family members.

For the long-term intervention program the points raised in the above short-term programs need to be developed to the higher level

Appendix 1
REFERENCE

- Advisory Committee. (1982). *Profile of the child in India*. New Dethi. India.
- Affleck, G. & Tennen, H. & Rowe. (1991). *Infants in cirsis* R.R Donnelly and sons. USA.
- African Journal of Special need Enducalison-(1998). *UNICE special Education* Kampala,Uganda.
- .Allexandra, Ellen. (1999). *Hope is what we have got*. University of Oslo thesis (PHD)
- American Psychologists Association. (1989). *Developmental Psychology* vol 25 Nos 3-5.
- .ANPPCAN. (July 1994). *A survey on the Situation of Child Rights In Ethiopi*. Addis Ababa.
- B. Miles, Mathew & Huberman., A. Michael. (1994). *Qualitative Data Analysis*.
- Banister Peter, Burman Erica, Parker Ian, Tailar Maye & Tindal Corol *Qualitative methods in Psychology. A research guide*. Open University Press. philadelphia. U.S.A.
- Beirne, M., Smith & Patton, R. James (1994). *Mental Retardation* (fourth edition) Prentce Hall Inc.USA
- Beryman, Alan. (1989). *Research Methods and Organization* Unwin Hyman Ltd. London
- Best J. & X, Kohn J. (1981). *Research in education* (4th ed). New Delhi, Prentice- Hall India. private Limited.
- Best J. & X Kohn J. (1999). *Research In Education Seventh Edition*. Prentice- Hall of India private Limited.
- Carlosn, W. & Ginglend, R. (1964). *Play Activities for the Retarded Child*. New York Abingdon Press.
- Castle J. Deborah: (1993). *The Visioning Process as it is Known and Utilised by Human Resource Development consultants*. Thesis for a degree of Doctor.
- Chazan, M, (1982). *The Early years*. (Childrien with special needs) Open University Press, USA.
- Cloninger,C.Susan. (1993). *Theories of Personality Understanding Persons Prentice hall Inc, New Jersey*.
- Convergence. (1990). *Focus on Participatory Research Volume XX1*. International Council of Adult Education Ontario, Canada.

- Cooper, P., E smith, Cox upion G. (1994). *Emotion and Behaviour Diffeculties*..Biddles Ltd. London.
- CSA & RA , (1996) *Report of Socio Economic Survey of Disabled Population*. Amhahara (5 Woredas). CSA, Addis Ababa
- CSA & RA , (1996) *Report of Socio Economic Survey of Disabled Population*. Oromia (4 Woredas. CSA,Addis Ababa
- CSA & RA , (1996) *Report of Socio Economic Survey of Disabled Population*. Sothern Nations, Nationalities and peoples Region.(5 Woredas) CSA,Addis Ababa
- CSA & RA , (1995). *The 1994 Population And Housing Census of Ethiopia, Results for Addia Ababa, Volume 1 Statistical Report*. CSA, AA
- CSA & RA , (1995) *The 1994 Population And Housing Census of Ethiopia Results at Country Level*. CSA, AA
- D. Hibbs. E., (1988) *Children and Families*. Library of congress USA.
- Darge Wole, Dr.(1997) *Childhood Expriences in parental Care and Later Competency The case of Sikegna high school students* A.A
- Denzin Norman K., & Lincoln Yvonna S.(1994). *Handbook of Qualitative Research*, _ sage publications, Inc, London.
- DICAG. (1998). International Seminar- *unveiling Article 23 of the UN convention on the rights of the chil.* cape town, South Africa.
- Drew, H., Logan, R. & Herdoman. L. (1984) *Mental Reterdation, A. Life Cycle Approach*. Ohio: Menin publishing co.England.
- Dolce, Laura. (1994). *Mental Retardation (The Encyclopedia of Health)*. Chelsea House publisher.
- Edward, Allen L.(1957). *Techniques of Attitude Scale construction*, Library of congress, U.S.A.
- Electronic Journals of the U.S. Information Ageny. *U.S. Society & values Toward Inclusion* January 1999 (Internet)
- Erikson, E. (1980). *Identity and the life cycle* Geogрге Mc. Leod Limited, Toronto
- Erikson, E . (1963). *Child hood and Society*. Richard clay Ltd. London.
- .Frankel,G., Max, Happ., & Smith, P.(1967) *Functional Teaching of the Mentally Retarded*. Springfield: Charles C. Thomas publisher.

- Goble, A. & Warren, F. (1993) Strategies for Teaching Students with Mild To Severe Mental Retardation. Jessica Kingsley Publishers London:
- Hegarty, S., Pocklington & Lucas, D. (1981). Educing pupils with special Needs in the Ordinary school. The Neer Nelsson publishing company. U.K
- Hersen Michael & M. Eister & Miller M Peter (editors) (1980). Journal of Counselling Psychology vol 10. American psychologists association
- Holland, James G. & Skinner, B.F. (1961). The Analysis of Behaviour. McGraw-Hill Book Company, Inc., USA.
- Hutt, L. & Gibby, G. (1967). The Mentally Retarded Child Development, Education. And Treatment. Boston: Allyn and Bacon. Inc USA
- ILO, (1989). Expressins and Refelexions on New Concepts of Services Provision for disabled people. Geneva Switherland.
- "Inclusion". (May 1998), News from Inclusion International League of Societies for Persons with Mental Handicap- ILSMH. (on 20). Brussels. Belgium
- Mc Guigan, J. (1993). Experimental Psychology, Methods of Research (6th Ed) Englewood Cliffs: Prentive Hall. U.S.A
- J.Gunarlick, M. (1987) The Effectivieness of Early intevention for At-Risk and handilepped Children. Acadamic press. Inc united kingdom.
- Janzen, Curtis & Havris Olwer (1989) Family Treatment in Social work Practice P.E Peacock Publishers. U.S.A.
- Journal of child Psychology and Psyclnatry. Volum 16 January 1975 program Press lited, NewYork.
- Journal of Educational Psychology Volume 82 No 3 Sept 1990 Americ Psychological Association Inc.
- Kaplan H.B. (1986). Social Psychology of self Referent Behaviour. Prenium Press, NewYork
- .Krech, David, Crutchfield Richard, S. & Livson, Norman (1969). Elements of psychology Alfred A.Knopf, Inc. New York.
- Landreth, C. (1967) Early child hood. Rondon house of Canada limited,
- Levin, A.Robert. (1974). Culture and Personality, Contemporary Readings. Aldeine de greater publsher, New York

- Mc Guigan, J. (1993) Experimental Psychology, Methods of Research (6th Ed)
Englewood Cliffs: Prentive Hall. U.S.A
- Mekdes, G.T. (1993). The status of Disabled Women in Selected Areas of Addis Ababa.
MOLSA, A.A
- Mitten, pitter and Browllet. Ron. (1993) World Year Book of Education Special Need
Education USA
- MOE (1998). Federal democratic Republic of Ethiopia. Education Sector Development Program
Action Plan Addis Ababa.
- Montessori, M. (1954). The Discovery of the child U.S.A
- O. Spurgeon English and weiss Edward,.(1957). Psychosomatic Medicine - A clinical study of
physiologic Reaclions. W.B. Sounders company, Philadelphia London.
- Olf, M. & Godarb, G. & Ursion , H. (1991). Quantification of Human Defence Mechanism.
Druckhous Beltz, Brussels Luxumberg.
- Orford, Jim. (1992). Community Psychology Theory and Practice. John wiley & Sons
Ltd.England.
- PDRE and Unicef. Country Programme & co-operation.1988-1992- Mid - Term Review
Workshop Report Dec. 1990.
- R, Cecil, Reynolds & Mann Lester.(1987) Encyclopedia Of Special Education Volume 1 John
Willy & Sons, New York.
- R, Cecil, Reynolds & Mann Lester.(1987) Encyclopedia Of Special Education Volume 2 John
Willy & Sons, New York.
- Rehabilitation international & U.N. The economic of Disability International Perspective
1990.
- Rutter Michael (1975). Helping Troubled Children .Cox and Wyman Ltd. London.
- Scruggse,T. & Worng, Bye (1990). International Research in Learning Disabilities
Springley vertage NewYork Inc.
- Shaw, Elain, (1993) Children's stress and coping: A family Perspective, Division of
Guilford Publications, inc, NewYork.
- Smith Susan, Willms Dennis, Johnson Nancy. (1997). Nurtured by Knowledge. Learning to
do participatory Action Research International Development Research center, Ottawa. Canada.
- SOOM . Proceeding of Awareness Education Workshop on mental Retardation.

(3 reports). By . Non Government Organization July. November. December 1996

- SOOM. Assessment on the Situations of Mental Retardation in Addis Ababa,
March 1999 A.A.
- SOOM. The situation of Children with mental Retardation in Addis Ababa, July 1999 A.A..
- Stace, Sheila. (1986). Vocational Rehabilitation For Women with Disabilities. ILO,
Geneva 22. Switzerland
- Swanson, L.& Wetson. L (1982) Educational and Psychological Assessment of
Exceptional Children- theories. Strategies and applications. St. Louis: The C.V.
Mosby company, USA.
- Tekle, C., (1999). Parental Attitudes towards children with mental Retardation: MA
Thesis, University of OSLO, Norway.
- Tirussew, T..(1998). Persons with Disabilities of High achievement Profile and Resilience in
Ethiopia. (Radda Barnen save the Children sweden)
- Tirussew, T.. (1997). Psychosocial and Learning aspects of Disability and Intervention
Strategies. Volume 2, AAU, Addis Ababa.
- Tirussew, T.(1997). Psychosocial and Learning aspects of Disability and Intervention
Strategies. Volume 2, AAU, Addis Ababa.
- Tirussew, T., Savolainen, H., Agdew, R., and Daniel, D. (1995). Base line Survey On Disabilities in
Ethiopia. IER, AAU, Addis Ababa.
- Tuckman, W. Bruce. (1978). Conducting Educational research. Harcourt Brace Jovanovich, Inc.
USA
- UNICEF. (1992). Children's Rights: Giving them Legal meaning. (World Summit for
Children), Jeneva
- UNICE. .(1990). Annual Report Jeneva.
- UNICEF: (1993) The State of the World's Children. Oxford university Press, UK
- UNICEF: (1996) The State of the World's Children. Oxford university Press, UK
- Verlag, Springer. (1992). Mental Retardation in the Year 2000. New York...
- Werner, D. (1987). Disabled Village Children. Hesperain. Foundation, USA
- WHO. (1989). Training package for a family member of who has difficulty of learning, moving,
etc.... No1-24. Geneva.
- Williams, Mark. Walts, Frazer. Malkeod, colon. mathew Andrews; Cognitive Psychology
and emotional Disorders (second edition), John wiley and Sons Ltd. England.

Appendix II

Observation checklist

1. Name of the parents
-Mother -----, ----- -Father -----
2. Name sibling : sister ----- Brother-----
3. Other/Explain-----
4. Address-----
5. Name of the child -----Sex----- age-----
6. Date of observation----- Time: from-----to -----
7. The type and level of retardation-----

A. Behavior of the child

Social/adoptive behavior	Observed frequency
Verbal /gesture greetings, smiling to new comers-----	----- times
Obedying and cooperative behavior -----	----- times
Helping mother or others in house chores -----	----- times
Indifferent to outsiders -----	----- times
Playing with siblings at home-----	----- times
Taking care of his/her self-----	----- times
Expressing needs-----	----- times
Not, taken care by others-----	----- times
Feeding self-, taken care by others -----	----- -times
Not, taken care by others -----	----- times
Putting clothes on/ off, taken care by others -----	----- times
Not, taken care by others-----	----- - times
Going to the toilet-----	----- - times
Not, taken care by others -----	----- - times
Washing Face/hands-----	----- times
Not, taken care by others -----	----- times
Taking care of animals or garden -----	----- times
Sing songs -----	----- times
Dances -----	----- times
Performs role play- -----	----- - times
Others explain-----	----- times
Others explain-----	----- times
Has other problems	
Fatigue-----	----- times
irritability-----	----- times
restlessness-----	----- times
crying-----	----- times
beating others-----	----- times
others explain-----	----- times

Date of observation----- Time: from-----to -----
 The type and level of retardation-----

B. Interaction

with mother

situations----- times
 explain-----times
 situations-----times

With father

situations-----
 explain----- times
 situations-----
 times

With siblings, explain-----

situations-----
 explain----- times

With other family members explain

situations-----
 explain----- times

with the neighborhood explain

situations-----
 explain----- times

Expressions verbal/gesture about the child

Positive----- by the mother----- times

Negative----- by the mother----- times

Negative----- by the father----- times

Positive----- by the father -----times

Sibling

Negative, explain ----- times

Positive, explain----- times

DECLARATION

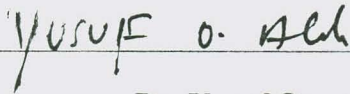
This thesis is my original work and has not been presented for a degree in any other University



Mekdes Gebretensay

Date - June 19, 2000

This Thesis has been submitted for Examination with my approval as the university advisor



Dr. Yusuf Omar Abdi

