

**COPING STRATEGIES AND CARING STYLES OF
PARENTS OF CHILDREN WITH MENTAL
RETARDATION
(THE CASE OF FOUR PARENTS)**

**BY
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**ADDIS ABABA UNIVERSITY
SCHOOL OF GRADUATE STUDIES**

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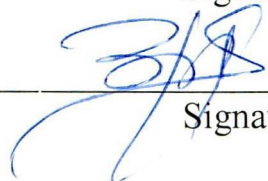
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TABLE OF CONTENTS

Preliminaries.

Title Page
Signed Approval letter
Acknowledgements
Table of Contents
List of Tables
Acronyms&
Abstract

CHAPTER ONE: INTRODUCTION

	Page(s)
1.1. Background.....	1
1.2. Statement of the problem	2
1.3. Objective of the study.....	4
1.4. The scope and limitation of the study.....	5
1.5. Significance of the study.....	6-7
1.6. Definition and concepts of terms.....	8

CHAPTER TWO: REVIEW OF RELATED LITERATURE.....11

2.1.1. Developmentally disabled children.....	11
2.1.2. Concepts of parental coping strategies.....	12
2.1.3. Basic coping strategies of the parent.....	13
2.1.4. Factors of parental acceptance of or coping with disability.....	14
2.1.5. Impact of mental retardation.....	14
2.1.6. Mediating Factors of family stress.....	16
A. The challenge of exhaustive home care.....	16
B. Unable to get social support.....	16
C. The four components of family system frame works.....	17
1. Family interaction system.....	17
2. Family resources.....	18
3. Family function.....	18
4. Family life cycle.....	19
2.1.7 Mental retardation is not a chronic stressor.....	19
2.2.1 The theoretical aspects of parenting style.....	22
2.2.2 Factors of parenting style.....	23
2.2.3 Caring a child in teaching style.....	25
2.2.4 Keep the right of disabled children.....	25
2.2.5 Child rearing practice from the Ethiopian context.....	27
2.2.6 Principles of parenting.....	29
- Home care for the retarded.....	30
- Institutional care for the retarded.....	31
2.2.7 The role of the family of a child with MR in early intervention....	32

2.2.8. The diagnosis of a child with MR.....	34
- Behavioral problems of child with MR.....	34
- The CONSULTED MODEL.....	36
2.2.9. Professional support for family of a child withMR.....	39
- The needs of family of a child with MR (Training and Counseling).....	39
- The Milwaukee project.....	41
CHAPTER THREE: RESEARCH METHDOLOGY.....	44
3.1. Subjects.....	44
3.2. Variables.....	46/7
3.3. Instruments.....	46
A. Parent interview.....	47
B. Home - observation.....	48
3.4. Procedures of data collection and analysis.....	49
CHAPTER FOUR: PRESENTATION AND ANALYSIS OF THE FINDING.....	52
Background of the presentation.....	52
A.1. Presentation of the findings about coping strategies of the parents.....	53
Case 1.....	53
Case 2.....	55
Case 3.....	57
Case 4.....	60
INTERVIEW REPORT FROM A PROFESSIONAL.....	62
A.2. Analysis's of the findings about parental coping strategies.....	64
1. From attitudinal perspectives.....	64
2. From the family system perspective.....	65
3. Life experience perspective.....	67
B.1. Presentation of the finding about caring styles of the parents.....	70
B.2. Analysis of the findings about parental caring styles.....	75
CHAPTER FIVE: SUMMARY, CONCLUSION AND RECOMENDATIONS.....	81
<i>References.....</i>	<i>91</i>
<i>Appendix.....</i>	<i>i</i>

List of tables

9

Table 1.1--- A child with MR has the following IQ levels and types of behaviours	12
Table 2.1--- Major difficulties encountered by the children with mental retardations and Coping styles used by parents to overcome the difficulties	21
Table 2.2.--- Comparison of factors from Henderson et. al (1977), Caldwell, et al.(1975), and Silverstein et al. (1982).	25
Table 4. 1---: background information about the parents.	53
Table 4.2.--- Shows the distinguished behavior problem of the child with MR. and coping strategies used by his parents.	59
Table 4.3.--- Parental Emotional Affection And their Reinforcement Level for their disabled child	70
Table 4.4.--- How Parents arrange play opportunities/activities for their Disabled Child.	71
Table 4.5.--- Direct Involvement of The parents In Teaching Their Child	72
Table 4.6. ---Educational Status of The Family and Their Attitude Toward the education (Inclusive) of their Child	73
Table 4.7.--- Parental caring styles to teach their child With MR out of home	74

List of Acronyms

DD-Developmental Disabilities

MR -Mental Retardation

SOOM -Support organization of mentally Handicapped children

HELPS-The Henderson Environmental learning process scales

ABSTRACT

The purpose of this study was generally to identify the conditions of parental coping strategy and caring styles toward their children with MR. Specifically, it tries to identify and describe parental coping strategies and caring styles toward the disabling condition of their child with MR and parenting that child with the objective of developing the cognitive quality of their retarded children, respectively. Information/ data about the four cases of the parents and their coping and caring condition is collected mainly from mothers of the children with MR. through interview and informal home observation methods. Two of the four cases of the parents (Case 1&4) had been out of Addis Ababa and were not getting educational services for their children with MR during the past years though currently they are in the verge of getting educational service at Kokebe Tsebah primary School, Addis Ababa, like the other two cases-1&3. A qualitative research design and analysis was applied to respond for the statement of the problem, or the major research question of this study. SO, the findings of this study is presented and analyzed accordingly. ***Parental coping resources types*** (e.g. personality type or self esteem of the parents and other characteristics of the parents, their disabled child and his/her disability) and ***other family factors*** (e.g. their interaction & functional system and their attitude toward MR) and ***life experience of the parents with professionals are a mediating factor of coping strategies toward disability and caring the children with MR.*** For example, interview report in this study revealed that only one mother of a female child with mild level of MR is currently more able to cope up positively with the disability and behaviour problems of her child than ever before by consulting professionals regarding the problems of her disabled child. So, this mother is not always practicing physical punishment against her disabled child as in the past though she practices it now rarely. The other child with moderate MR is still punished by her sister so that the child's mother is always complaining about such a wrong action of the child's sister that made the child's mother unable to cope up with it. Even though all parents try to teach their children with MR at home, they are not as expected as to teach frequently their own retarded child at home and to create a favorable environment to satisfy the educational needs of their retarded child at home. The degree of direct involvement of the parents and other family members in teaching their disabled children seems to vary according to the educational status of each cases of the parents and the existence of sisters or brothers of a disabled child who can take the

responsibility of teaching and caring their disabled child at home. In addition to this, all parents of the children with MR are not using enough teaching and play materials and are practicing the teaching process at home informally without receiving professional services or supervision during the involvement of the parents in caring and teaching their retarded children at home. Physical punishment, not reinforcement, for the behavior problems and wrong acts of the children with MR in the process of caring and teaching the child is more usually practiced against the female children with MR than against the male children with MR.. Parents of male children with MR have also wish to send their children for institutional care-which is the reflection of maladaptive coping strategy and being unable to care those children at home, properly. Since these physically abused children with MR are not perfect to receive all the instructions told by their caretakers or their family members, it was reported that mother of the female child with mild MR and sister of the female child with moderate level of MR. had practiced physical punishment against those female disabled children at least once in a week in the past. Therefore, all parents of the children with MR (except Case 1) are not able to cope up positively with the disabling conditions of their children and to care their children with MR properly and in teaching style.

CHAPTER ONE

INTRODUCTION

1.1BACKGROUND

The responsibility of taking a care for a child with good treatment starts from the family level, So parents and all members of the family have to keep the rights and needs of their children economically, emotionally, physically, cognitively and socially. Particularly, parents of the disabled children must ask themselves the question of “What did I do for my disabled child?” rather than rejecting and doing any psychological and physical harm against their disabled child. Peoples’ unrealistic perception about the causes and nature of MR and their inaccurate decision about the degree of severity of MR contributes for the non-existence of adequate data about the prevalence and causes of MR in our country. Therefore, children of the disadvantaged or with out stimulated home environment are also more likely to be affected by mild or moderate levels of MR than children of highly stimulated home environment. Taking this fact into consideration, it is very crucial to assess the home environment of the children with mild or moderate level of MR. It is also clear that parents of a child can play a great role in developing the cognitive skills of their young child. More over, assessing the coping strategies used by the parents and their caring styles should or can be practiced with the aim of assessing the home environment situation or variables that are relevant to the cognitive development and psychological well being of a disabled child. This is because assessing parental coping strategies and their parenting styles toward their young disabled child can give important clues about the effect or impact of

parental coping responses toward their children with MR and their caring practices at home for the development of the cognitive quality of their children.

1.2 STATEMENT OF THE PROBLEM.

Based on the common sense approach, higher percentage of the children with mild and moderate levels of MR are expected to be observed in the less stimulated environment than in the more stimulated one. This is true by the fact that children with mild level of MR are usually more susceptible to be reared in the less stimulated or disadvantaged home environment. There are so many complicated factors of MR. However, mild level of MR is usually associated with the socio-cultural or familial factors; where as the profound type of MR is usually caused by the genetic or pathological factors (Beirne-Smith, *et. al*: 1994). Therefore, it is possible to say that mild and moderate levels of MRs are more the concerns of parents of children from the disadvantaged environment (and even, of the environmentalists) than parents of the children from a history of stimulated environment. Therefore, this study is conducted to investigate how parents of children with MR cope up with the disabling condition of their children with MR and

how they are caring their children with MR. It is true that if a disabled child is not supported well by his family, it is possible to say that he is harmed either psychologically or physically or in both conditions. The last consequence is that the child would become handicapped. The mentally retarded groups are a case in point, who must get attention and proper care and societal service by their care takers, adults,

and mainly by their family members (Llewellyn, Gwnnyth, 1996). It is not unusual to hear in the media and observe the situation of children in Ethiopia who are truly maltreated by their parents or guardians. When we come to the condition of children with mental retardation, they are usually rejected by their parents, family and society, for they are perceived as satanic by their nature (Abereham, H. :1998). They are also perceived as they cannot show any change or development in their schooling and daily life activities (Cherinet, 1999). As far as parental and societal responsibility to keep their child's right is concerned, Hogget (1993) indicated that parents are responsible for looking after their children with the objective of satisfying both the educational and psychological needs of their disabled children. However, child abuse, neglect or rejection by their parents is still going on all over the world. Children with mental retardation seem to be abused more (Kirk and et al, 1993). Regarding the prevalence of mental retardation in Ethiopia, it accounts 6.5% in the year 1980/ 84 (Tirusew, *et al.*: 1984). The year 1999/ 2000 G.C survey report by SOOM has revealed that there are 565 children with MR in the selected 13 woredas of Addis Ababa. Among these, higher number of male children with MR (N=361) were identified than the female ones (N=204). Moreover, majority of the children with MR (68.3%) had never attended any kind of formal education. Only about 11% of them are attending some kind of special education at present, and about 16% had also attended some kind of schooling in the past, but only 4% and 0.9% of them are able to write or read and complete their primary education, respectively. Previous study by Gilenesh, et al. (1999) revealed that parents of the children with MR have a positive reactions toward inclusion, but the policies and practices for educating the disabled in Ethiopia is not meeting the

educational needs of the parents and their disabled child. For example, Adugna Ayana (1991) indicated that parents of children with MR have the need to get any trainings and professional services with regard to their children with MR.

Generally, the results of this study will answer the following as the basic research problems or questions.

- A. What are the coping strategies of parents of the children with mental retardation?
- B. Are children with mental retardation getting the necessary parental/ family care?
How they do care about them?

Specifically, the results of this study will answer the following questions as the details of the research problem

How parents of the children with mental retardation react and cope up with their child's disability and behaviour problems? What are the themes of coping strategies and caring styles?

Do parents care their child with MR. in teaching style to develop their child's cognitive and social skills, or are their children with MR rejected by their parents without getting the necessary parent support and home stimulation for their cognitive development?

Do parents of those children receive professional, institutional and parent support group services so as to make them able to cope up with their child's disability because of mental retardation. If not why? If they get institutional service or people's Support, What kind of benefit they are getting? Do they benefit?

1.3 OBJECTIVE OF THE STUDY

The objective of this study is generally to identify the coping strategies and caring styles of parents of the children with mental Retardation. And Specifically,

- This study is conducted to answer the questions “how parents of the children with MR cope their child’s disability and other associated behavioural problems and how they care their disabled child with the objective of developing the cognitive level and adaptive behaviour of the child?”.

-It will investigate whether the mentally retarded children are treated well or neglected by their parents with the objective of developing the Socio-Cognitive skills of their children with cognitive disability.

-Bearing this in mind, the current research has something to cite, discuss or conclude and recommend about the impact of parental coping strategies and their caring styles on the socio- cognitive skills and styles of their children.

- The results of the study will answer the above mentioned research questions as the details of the research problem

1.4 The scope and Limitation of the Study

The scope of the Study. This study is delimited to four parents of the children with mental retardation and from whom all of their children with MR are attending their education at the special unit centre, Kokebe Tsebah S.S School, Addis Ababa. . Therefore, The families of the children with the mild and moderate level of mental retardation were considered and taken as the cases of this study.

• **Limitation of the Study**

As the scope of this study is limited to four parents with MR, the interviews were mainly done with four mothers, except in one case with a father-who was also interviewed minimally for his low level of experience during parenting his retarded child. Since only their own single mother is parenting three of the families or the children, it was impossible to get three fathers from the rest of the four families. Moreover, women in Ethiopia are more likely to be involved directly in the process of child rearing practice than fathers do. According to Handleman & Harris (1986), fathers are not usually sharing the responsibility of parenting stress because of their disabled child as equally as mothers- who are; therefore, to be interviewed about their coping strategies toward disability and caring styles for their child with MR. Other siblings (like, sisters and brothers, grand parents) had to be interviewed, however, observational checklist is becoming more important than interviewing them to identify or recognize about the caring styles of other family members of a child with MR..

1.5 SIGNIFICANCE OF THE STUDY

This study is conducted upon the family of a child with mental retardation and has the following importance:

It benefits for the family of a child with mental retardation by making them to be alert and aware about the responsibility of caring their disabled children in teaching style by creating an environmental opportunities to develop the cognitive and adaptive behaviour of their child with mental retardation. Taking this fact into consideration, this

study will forward some of the techniques of family intervention through parent/family-child interaction system, and enhancing parent-professional contact and parent-support/group services.

Broadly speaking, the result of this study is thought to help special and social workers to recognise such a single parental reactions, their coping strategies, and caring styles. That will lead to show how this and other similar parents might be helped by professionals or other people, like members of the family. Moreover, it is possible to guess the impact of parental coping strategies and caring styles upon their children with mental retardation..

The problem of children with mental retardation can be aggravated if they are not getting the proper parental care in teaching styles and if their parents are not able to cope up with their child's disability because of mental retardation. The kind of parental coping strategies and caring styles can be affected by the perception (or attitude) of the parents towards mental retardation and other backgrounds of the family, the personality, socio-economic status; child rearing practice and, etc., of the family (Drew, 1984, and Kirk, 1993; and others). For early intervention, the consideration of family factor is an important step (Guralnick, 1993). This is because:

1. A child's rights and his basic and educational needs are to be kept and satisfied, respectively by his/her members of the family who are to be devoted in the development of their child's cognitive and social skills. But, children with mental

retardation are not usually getting appropriate parental care and are neglected by their parents or family, who perceive and accept their child's disability, unrealistically (Kirk, 1993; Rowitz, 1992, and Drew, 1984).

2. Knowledge about the how of family treatment toward their child with mental retardation and getting the possible solutions about the question of effective treatment will help to minimise the reciprocal impact of children upon each family member. Consequently, it is possible to minimise social disorder. Hence, child neglect by his parents is the reflection of the disorder of a child's home and social environment (Bowlby, 1965).

1.6 DEFINITION AND CONCEPTS OF KEY TERMS

Care: - It can be simply defined as meeting the physical, educational, psychological and social needs of the individuals (D. Wilkin: 1981, 85)

Coping: - It may refer to positive stress, which is related to promise and opportunity as well as to the distress, which results from threat or loss. It involves adaptive tasks in which the outcome is uncertain and the limits of the person's adaptive skills are approached (Roberston and Brown: 1992. P. 155.)

a Child: any person under the age of 18 years old level (Obdigo: 1999)

Child Abuse: the non-accidental injury of children by their parents or guardian. (Concise Encyclopaedia of psychology 2nd ed., 1996: p. 133)

Child Neglect: It is a failure to meet a child's basic physical or psychological Needs (Ibid., p. 134)

Developmental Disabilities (DD): a handicapping condition originating in the developmental period (before age 18) that is attributed to mental retardation, epilepsy, cerebral palsy, or autism (Handleman, et al, 1986).

The family. It is the basic unit of society, or a group of people of various ages who are usually related by birth, marriage or adoption (Minett, p.m 1989).

Family Therapy (or counselling)- It has attempted to provide support and direction that families have needed as a result of the stresses and additional pressures that have occurred within the family to care a child. Usually the child is the cause of admission into therapy for the whole family (- Horne, 1982; 3-4)

Parental Reaction - ...psychological response to the handicapped child can be referred as parental reaction, which is characterised by coping to the stressful situation and developing a defence mechanism against the strong emotion (-Encyclopaedia of special education, 1987, vol. 2, 652)

Mental Retardation (MR)- It refers to significant sub- average general intellectual functioning of existing concurrently with defects in adaptive behaviour, and manifested during the developmental period (Sattler, 1992: 647)

Mental Retardation (MR) is a Prolonged and severe deficits in thinking and reasoning condition, as well as deficits in meeting the needs of daily living skills (adaptive behaviour). It is not a disease, but a syndrome that cannot be treated medically. The following table shows the four levels of mental retardation with different syndromes (McGarrity: 1993).

CHAPTER TWO

2.1.REVIEW OF RELATED LITERATURE

2.1.1.Developmentally Disabled Children

Developmentally disabled child need both the psychological, educational, medical, social (community) and home services rendered by different professionals working together with parents or families of a disabled children. This is true because of the child's severe or chronic and multifactor disabilities which results in his/her dysfunction in three or more of the following major life activities:-

- A. Self care B. Receptive and expressive language C. Learning
D. Mobility E. Self direction F. capacity for independent living and

G. Economic sufficiency (Beirne- smith, et. al: 1994). For example, children with mental retardation or Autism do usually exhibit communication, social and cognitive deficits with other additional physical or mental problems that remains difficult to dictate their exact causes (organic or environmental) and age of onset. (Brain 1981). Such children, generally, exhibit deficits in the four diagnostic criteria for developmental disorders (Handle man et al. 1986):

1. Communication disorders
2. Problems of interpersonal responsiveness and social development
3. Information processing difficulties and disorder
4. Developmental delays and associated cognitive disorder like children with mental retardation (MR).

Table 1.1 A child with MR has the following IQ levels and types of behaviours.

Level of MR	Types	In Adaptive Behaviour, they face	IQ levels
1. Mild	Educable	Significant difficulties	55 - 69
2. Moderate	Trainable	more significant deficits	40 - 54
3. Severe	Trainable, but dependant	most significant difficulties	25 - 39
4. Profound	Custodial type	they need special care	< 25

(McGarrity: 1993).

2.1.2. Concepts of parental coping Strategies

Toward their Child with Mental Retardation.

Parents of the mentally retarded children show different coping strategies when they come to recognise that their child is diagnosed as cognitively disabled. At the first time of the diagnosis, they usually react negatively toward the birth of their mentally retarded child by showing a sudden shocking behaviour filled with a distorted feelings, like being caught by surprise, a sort of disbelief - which is not really a true disbelief goes through their mind. After passing through different coping strategies - projection, denial, grief, guilt, and other similar emotionally based defence mechanisms, parents started to accept

realistically their child's disability because of mental retardation (SR Laylock: 1952).

Parents are asking different questions starting from the first level of coping strategy right up to accepting their child's disability (Anderson and Brown 1973). Questions of the 'Why', 'How', 'Where' to go and the 'whom' to consult the professionals and other similar questions are running under the minds of the family. Thus, professionals must support these families to react positively and accept their child's disability realistically and quickly with true emotion. Information about the causes and nature of mental retardation must be told carefully not only by a single professional person, but with the second professional person's opinion; or other professionals who could diagnosis accurately the exact level of their child's mental retardation or development. Thus, parents are able to cope up with their child's disability quickly and realistically. Otherwise, because of inappropriate parental coping strategies, their child will in turn harmed both psychologically and physically (hence, the child's parents are less likely to care about their child's life).As a result of unrealistic family's perception/reaction or attitude and coping strategies, their child with mental retardation is usually maltreated, secluded and neglected by their family. These children are also kept away from being attending their schooling and in participating in stimulating environment to be socialised. This is true if parents have also a negative attitude towards their children. That negative attitude of parents towards their child with mental retardation is arising from the personality of the family and different family or social factors (McGarrity, 1993 and Drew, 1994).

2.1.3. Basic coping strategies used by parents of the children with disability

1. Seeking information about the diagnosis and source of support or service available to know the nature, causes and the treatment of their child's disability.
(Appraisal focused coping)
2. Facilitating the development of their child with disability (Problem focused coping)

3. Seeking emotional support for their stress because of disability (Emotion-focused coping)
4. Meeting other members of exceptional families, parent groups to cope up with their stress
5. Rehabilitation counselling (Roberston: 1992)

It is true that parent's reaction to their retarded child may vary from complete acceptance to complete denial of his inadequacy. Accepting their child's disability by parents is usually accomplished through five stages:- 1st Awareness , 2nd recognition, 3rd search for a cause, 4th search for a solution and 5th Acceptance of their child's disability(Erikson:1965).

2.1.4. There are factors of parental acceptance of and coping with their child's disability. These are:

1. **Attitude of the society toward disability.** In a society where disability is considered as a stigma, parents of a child with MR are likely to neglect their child because of his/ her disability.
2. **Nature of the environment:-** the existence of social support services for the family in their community is an important resources for parents to cope quickly with their child's disability(Sarason and Sarason:1982).
3. The unique behavioural characteristics of their child and his/ her disability with its degree of the severely.
4. **The personality, make up, cognitive level, SES of the parents.** The problem of MR is considered less severe for the financially able, emotionally and intellectually matured parents than to the less capable (Erikson: 1965).

2.1.5.Impact of mental Retardation on families

Having children changes the lives of the parents in many ways. Impact of a disabled, especially a child with MR upon the parents, was intensively discussed by Handleman,

et al (1986). In this discussion, it was indicated that mothers do exhibit more feelings of guilt, physical fatiguing demand of physical care; pain or mental tension; more feeling of depression, or doubts about their ability to care their disabled child, effectively than do fathers. This is because, fathers typically play a less central or demanded role and physical tie with their disabled child and in direct child care than do mothers. Consequently, they may have fewer opportunities to feel that they are doing something of immediate value. However, men or fathers are also subjected to a great extent of stress or worry about their wives' pain and stress from the burden of caring her child with MR. Moreover, fathers feel more stressed than mothers in meeting some special needs of their disabled child, such as in meeting the financial burdens and expending extra resources and time in rearing their handicapped child, continuously or through the different family life cycles, especially during parental retirement. In this situation, without practicing professional dominance over the needs of parents of a disabled child, or without convulsion, teachers, school psychologists, or social workers' helpful, sympathetic and cooperative effort together with parents of a disabled child, could carry out smoothly some sorts of effective home programs for family of child with disability, or mental retardation. Thus home programs could be teaching or counselling or training parents to cope up with the problem or the demands of parenting/caring their child with MR (Adams: 1960; Tizard: 1964; and Handleman et. al: 1986). For example, Handle man et al (1986) described that although the effects of disability on marital adjustment is still on its own issue, disability is not a real cause of marital dissatisfaction. Rather, there are other mediating factors which could play their own additive factors of parental stress because of disability or the birth of a child with MR. The existence of unequal share of parenting responsibility by couples in rearing their child with MR appears to be more correlated with their marital dissatisfaction and the situation of the life cycle of the family than their child's disability.

Family's life cycle, according to Marsh (1992) is likely to be disrupted at the different familial life span. He said:

“Younger parents may have little energy to nurture their marriage; middle-aged parents may long for an empty nest that may never arrive; and aging parents may be deflected from concerns about personal mortality”.

To tackle such above mentioned kind of obstacles for normal family and social life cycle because of disability, Mitchell and Brown (1991) pointed out that professionals are expected first to understand and assess the family situation (their needs and the situation of the components of the family system frame work). For example, assessing their needs or problems with each family life cycle is an important ground to determine the function of the parents to care their child with MR and their resources to cope up with their child's disability. Moreover, it is even important to have in mind that changes in one of the component of family system has also changes on each components of the family system, cyclically.

2.1.6. Mediating factors of family stress because of MR.

As mentioned by Handleman, et al. (1986), there are other mediating factors of stress facing the family of a child with MR. These are as follows:

- A. **Facing the challenge of prolonged and exhaustive home care and parenting responsibility** for a child with MR only by one member of the family, especially by a mother, by older sister and younger brother of a disabled child. This brings about family's dysfunction to care effectively their child with MR.
- B. **Unable to get social support or help from others** (from professionals, extended family members, or grand mothers/fathers and siblings). This is to mean also unable to get social services, counselling and family training services concerning the how of caring/parenting a child with MR and of coping with his/her disability or stress of parenting the child. Though professionals are

willing to help parents of child with MR, some parents are not willing to participate in professionals' programs, like in parent training and counselling programs. This can be happened if professionals are practicing their professional dominance over parents through convulsion without considering the real problems and needs of parents of a child with MR. Otherwise, parents of a child with MR may not have either the skill of creating good interpersonal relationship for problem solving or a belief in creating professional contact as a means to cope up with the disabling condition of their child with MR. Quality of good inter personal relationship skill can be the function of personality of the parents. For example, personality research findings by (McCrae andCosta:1986) has indicated that extrovert individuals do have good interpersonal relationship skill. So that they are more likely to cope with their stressful situations, effectively, than individuals with introvert type of personality.

- C. Moreover, many writers have indicated that **the four components of family system framework** as the mediating factors of family stress and coping strategies (Marsh: 1992; Rowitz: 1992; Kirk et al: 1993; Brine –smith: 1994, etc).

Although there are so many interrelated factors of stress and coping mechanisms that used by family of a disabled child, the general family system theory, as indicated by Marsh (1992), is becoming the best approach by suggesting the four components of family system frame work as the factors of family stress and coping process toward disability. These four components of family system framework are the family interaction; the family resources; the family function; and the family life cycle (Mitchell, et. al: 199).

1.Family Interaction and /or their interpersonal relationship skill for help:

The existence of poor interpersonal patterns in the family; for example, between a husband and a wife; between parents and their disabled child; and between a normal child and a disabled child, is to face the challenge of exhaustive home care for the retarded child only by one member of the family. Therefore,

empowering parents/family of a child with MR to develop the quality or level of their interaction skill among the family members is also empowering them to help each other and cope up with their stress because of MR (Henderson: 1998). Parents of a child with MR create contact with professionals to cope up with the disabling condition of their child (Tirusew: 1998). Henderson (1998) stated that parenting stress is causally related to poor parenting. This brings about the problem of adjustment by the child. Therefore, assessing the family situation; for example, by understanding early the maladaptive parent-child interaction is very crucial. Hence, poor parent-child interactions, without physical or body contact for play activities or positive emotional affection for cognitive development of child, are good indicators of poor parenting style that results about having a mentally handicapped and unresponsive motor intact child.

2.Family resources or distinctive characteristics of the family and the child:-

For example,. SES, cultural value, personality, cognitive appraisal or beliefs of the parents and the disabling situation or the characteristics of their disabled child are also determining the coping recourses of the parents. Parents who care a child with severe type of MR or with difficult behavioral problem are more likely to feel stressed toward their child's disability than parents of a child with mild characteristics of disability or behavioral problem. Religions parents are more likely to have high coping resources towards the disabling condition of their child than the non-religious ones (Drew: 1984).

3.Family function: If the family of child with MR is not able to meet the educational and the different needs of their own child, they are dysfunctional to care their child in teaching styles. And they are likely to feel guilty of their parenting styles, which deteriorates the cognitive development of their child during the critical brain development stage (Deter-Deckard: 1998 and Zuk: 1962). Family's dysfunction brings about additional problem of a child with any

kind of problems (Gold farb, 1978), and the disturbance or disruptive behaviour of a child in turn disrupt family living. That is why the need for professional support or family therapy is important for each members of the family (Horne, 1982). Professionals can approach attention deficits of a disabled child through psychological (psychoanalytic) and family interaction theories (Scully, 1996). For example, the psychologists and special teacher can practice a psychological test upon a child and his family to understand the condition of coping strategies (reactions) and caring styles of a family toward their child with or without disabilities (Siegel, 1989).

4.Family life cycle: Adaptation to the stress of having a child with MR is cyclical. The family may not reach quickly to the stages of accepting their child's disability during the initial diagnosis of their child's condition. They have to face or cope with the new demands of parenting their child with MR during the different life cycle of the family and the child- i.e. during the birth of a child with MR; during his/her schooling process; adulthood; and during parental retirement or the death of parents of a child with MR. Therefore, parents of a child with MR have to prepare themselves to face the challenges of parenting and teaching their child with MR to cope up with the new issues of parenting during the different family life cycle or with the new issues of parenting during the different family life cycle or developmental stages of their child. For example, younger parents are less likely to face or cope with the birth of their child with disability than the older ones or the experienced parents. Younger couples are not advised to create a family before they are matured enough to care their child and take the responsibility of parenting their disabled child in teaching style (Hoddap, et al.: 1995 and Rowitz: 1992).

2.1.7.Mental Retardation is not a chronic stressor.

Mental Retardation, as noted by Drew, et al (1994), is not a real family crisis if it is not considered or interpreted as a stigma by family of a disabled child. It is usually and highly considered as a crisis by parents who are not able to use adaptive coping

strategies. Drew *et al* (1984) also indicated that mental retardation could be a crisis by parents who had poor happy marriage or poor marital satisfaction and who are displaying role tension and poor personality of anger or irritability, towards the birth of child with MR or any stressful situations. However, mental retardation is not a chronic stressor like death, rather, it is an obstacle to the existence of normal social life of one's family member (Rowitz: 1992). Major difficulties encountered by children with MR. and coping strategies used by parents to overcome the problems also indicated by Tirrusew (1998). He indicated that the processes of growth and development and accompanying motivational stresses are a normal part of life. The changes that occur may produce a crisis in the life of a family. Whether the stress that maturation generates becomes a crisis for a family depends on the resources available to the family as a group and an individual. Stress can be exhibited with in the family if they get ineffective transmission of messages and lack of role clarity in the family to identify their roles and positions within the family structures. It must be remembered that stress does not automatically lead to crisis. It is only when the family coping mechanisms are inadequate and if they have dysfunctional inter personal relationship structures a crisis occurs (Tirrusew, 1995).

Table 2.1. Major difficulties encountered by the children with mental retardation and Coping strategies used by parents to overcome the difficulties

Major difficulties encountered by the children with mental retardations	Coping styles used by parents to overcome the difficulties
<ul style="list-style-type: none"> - Physical and /or organic problems (such as injury, illness, epilepsy or convulsions & problems of hearing, sight, motor, etc) - Language & communication difficulties. - Psychological problems (aggression, anxiety, etc) - Unable to pursue formal education - Difficulties regarding interpersonal relationships -Problems regarding self-help. 	<ul style="list-style-type: none"> - Getting enough rest. - Seeking medical attention. - Wearing hearing aid, eyeglasses or lenses. - Looking for help and training from others. - Speaking slowly to make others understand the idea. - Shifting the child to special school. - Getting help and advice from school, professional and other family members, (Pp.63-64.)

Source: (Tirrusew, 1995).

Therefore, if parents/family of a child with MR do have (1) a positive coping strategies or emotional response for the behavioural problem of and the question of the how of rearing their disabled child; (2) the chance of getting high level of family support from the respite care centres and from other community services; (3) and if they have an adjusted marital life and family life cycle, they are more likely to place or care their child with MR at home than to seek out- of-home placement. Moreover, not to seek

out- of home placement is also the usual phenomena to be exhibited by parents of the children with mild type of MR than parents of the children with severe type of MR.(Fotheringhahm:1971).The ecological theory by Bronferberner (1986) Suggested that the problem of an individual child arises not only from the individual himself (*at the micro level*) but it is beyond the micro levels such as from the kind of interaction or contact he/she made with his/her family (*Meso system*). The child's problem is also beyond the family situation (family system theory), i.e. it is from the kind of health, school and social services given to the child with mental retardation and to his/her family from different institutions (*Exeo system*); and from the kind of policies of the government and its political ideology together with societal attitude with regard to MR. (*Macro level*).

2.2.1.The theoretical aspects of Parenting Style /child caring practice

Some Ideas about Family Caring Styles

The way of parents in supporting their exceptional child is evaluated economically, educationally and vocationally; and it is characterised by helping him/her to develop a sense of self identity and socialisation skills, and providing health care opportunities and showing real affection (Boss; 1966; J.R. Brim, 1965; 1968; and Kirk, 1993).

Family care is the dominant residential arrangement for persons with mental retardation; however, it is uncommon for those persons to lead their life out of home, or they are at risk of being homeless as their age is increasing and their parents are no longer able to provide care (Rowitz, 1992). The family system and the interrelationship among the different environments have roles in fostering or delaying the development of a child (Hoddapp et al, 1995). Family is one of the sources of social support for a child with mental retardation to enhance the child's social integration successfully. The focus area of family support can be enhancing child's growth, development and life satisfaction (AAMR; 1992). Supporting this idea, Hibbs (1988) has indicated that parents and home are the most influential factors in child's life. They can influence simultaneously even the education given for the child by the day care centre if they can integrate the education given at home with the education given at the day-care centre

homogeneously. Parental relationship with the day care centre will benefit parents, especially those who are unmarried mothers usually living in their poverty, can be supported by special and social workers in caring their child (Bowlby: 1965; Boss: 1966 and Kirk, 1993).

2.2.2. Factors that influence the effectiveness of the various parenting styles

Moreover, there are factors that influence the effectiveness of the various parenting styles (Tackett and Hunsberger: 1981). These factors are

1. The temperament or basic personality of the parents and their child
2. Age level of the parents and developmental stage of their child
3. The Socio-cultural values and interests of the parents in child rearing practices.

For example lower class, middle class and upper class parents use power-oriented (e.g. physical punishment like the authoritarian parents) democratic and permissive parenting styles, respectively. Lower class parents value the physical competency of their child, where as middle and upper class families value the intellectual and emotional competency of their children. The, home environment of a disabled child should be conducive for the development of all aspects of the child. That could be achieved through practicing a balanced or democratic parenting style and by accepting and expecting, realistically all of the bad and good qualities of their disabled child's temperament/nature and levels of competency (Corsini and painter: 1975).

Usually, the causes of mild level of MR are socio-cultural-familial factors; where as the profound and severe type of MR are caused by the genetic and medical problems of the child (Brine-smith, et al.: 1994). Socio-cultural- familial factors of MR can be poor parenting styles characterized by rejection of a child emotionally, or facing nutritional deficiency and being reared in an environment, which is not appropriate for the cognitive development of the child. All aspect of care must be taken for a child to combat MR through early intervention program for the restoration and maintenance of the emotional, intellectual and social competencies of the child. For example, exposing the child with all senses of stimulation (Auditory, visual and tactile, stimulations) to

maintain the intellectual competency of child with MR, is one aspect of good parenting style (Tackett and Hunsberger: 1981). Some explanations concerning the above mentioned types of senses of stimulation are given in the following manner.

1. **Auditory stimulation:** provide records, radio, television, music, story telling. Be available personally. Speak directly to the child. Ask him questions that can be answered with a "yes" or "no". If he is non-verbal, observe his eyes for response.
2. **Visual stimulation:** provide colourful play objects, pictures, etc
3. **Tactile stimulation:** Provide a variety of play activities involving textures.
4. **Explaining all procedures in simple terms.** Repeat each time how the procedure is done (p.115).

According to Minett (1989), parents can play a role as teacher of their child by:-

1. Looking at books together with the child
2. Reading and Listening to children's stories
3. Providing their child to get a variety of books
4. Encouraging their child in play activities like discovery play (of texture, size, colour of things), physical play (as in physical exercise), creative play (to express the self ideas/ feelings in the form of picture drawing (for younger children) and writing (for more skilled or older children). Imaginative play, like imitation role, manipulator play (use of hands, brick buildings or bricks play) which takes place when children play together to learn the feeling of cooperation, to share and to be honest. (Carlson, et. al: 1961)
5. Love, cradle, keep clean your child and Talk to the child so that she/he can develop the feeling of security and wanted. Play and be with your baby and child. Reward, do not over protect and spend all your time and energy with your child to avoid the burden of caring the child and feeling of over dependency by the child. The task of parenting is the art of balancing child rearing practice (Calm and Franchi: 1987)

2.2.3. Parenting or caring a child in teaching style

Caring a child in teaching style is an important aspect of appropriate parenting style (Henderson, et al.: 1972; Caldwell, et al.: 1975; Tackett and Hunsberger: 1981; and wolfendale: 1992). For example, Henderson, et al. (1997) suggested the importance of the six home variables for the cognitive development of a child. These variables involve parental caring practices in teaching style for the cognitive development or achievement of their child. These variables can be presented in table form.

Table 2.2. Comparison of factors from Henderson et. al (1977), Caldwell, et al. (1975), and silverstein et al. (1982).

Henderson et al. (1997)	Caldwell, et al. (1975)	Silverstein et al. (1982)
<ol style="list-style-type: none"> 1. Parental reinforcement of education 2. Parental outside activities for their child with MR or (external interests and community involvement) 3. Their direct teaching of their child with MR or (Intellectual guidance) 4. Their level of Education and providing a supportive environment for school learning 5. Their practices in encouraging their child with MR in play activities 6. Their attitude about education (or their attention) 	<ul style="list-style-type: none"> - Emotional and Verbal responsibility of the parents - Avoidance of restriction and punishment - Opportunities for variety in daily stimulation activities for the child - Maternal involvement with the child - Organization of the physical and temporal environment. - Provision of appropriate play materials 	Parental : <ol style="list-style-type: none"> 1. Involvement 2. Reinforcement 3. Intellectual guidance 4. Literacy 5. Role-playing 6. Expectations

(From Henderson et. al, 1997)

2.2.4.Keep The Rights of Disabled Children, Not To Abuse Them.

The health and educational policy of Ethiopia allows the disabled children to get medical, psychological treatments and educational opportunities. Moreover, the economical and social services should also enable them to develop their capacities to the maximum and fasten their social integration without the limitation imposed upon them. This is true by the fact that Ethiopia accepts the rights of the disabled persons

proclaimed by the UN in 1995. Therefore, the disabled persons, their families and communities shall fully be informed by all appropriate means about the rights of disabled persons, mainly of the children with disability (Gilenesh, et al.: 1999).

Much of the responsibility of taking care about the rights of those children is laid upon and starts from the family level. Confirming this idea, Hogget (1993) indicated that parents are more responsible for looking after their children either personally or by creating the learning environment opportunities to develop the cognitive or educational/occupational and social skills of their children. However, child abuse, neglect or rejection by their parents is not unusual news to hear in the media and observe in the community (Levitt, 1968, Cown, 1970; Cleland, 1978; Haymovich, 1980 and Obdigo, 1999). Even the study of child abuse on other normal children without mental retardation in the four Woredas(3,5,6 and12) of Addis Ababa revealed that child beating, bodily injury, theft and other harmful actions are performed on those children(desalegn:1998).The Handicapped Children, particularly, children with mental retardation are also under the abandonment condition, whom took the road to develop emotional problems (Bowlby, 1965; Rowitz, 1992; Kirk and et al, 1993). These handicapped groups are living with their irresponsible society, painfully without getting special family support and services. It had been mentioned and confirmed by many research that parental rejection and abuse of their children with mental retardation has a negative impact upon the psychological and emotional behaviour of those rejected children who are really receiving the greatest punishment in the world (Abraham: 1998). Hodaap, et al (1995) pointed that the family has an important role in the development of adaptive skill of a child with mental retardation. All members of a child's family are expected to keep the child's right and fulfil his/her needs economically and educationally, too (Beirne-Smith et al, 1994). This is because; parents and home are the most influential factors in child's life.

It is a logical fact that the mentally retarded are intellectually disabled group. Their parents may either over expect or under estimate their child's school progress. This is wrong. Corsini and Painter (1975) have recommended more formally about it.

One of the most serious and common errors by parents is interference in their children's schooling. Parents should try to motivate them indirectly by creating an intellectual atmosphere in the home rather than directly lecturing, criticising and by punishing, etc... (P.71).

Thus, a school is and should be the child's business. It does not help if the school does not fit with the needs of the retarded group. Parents should not be surprised about the cognitive disability of their children. Do not criticise the child if the school does not depend on the child's natural desire and ability to improve himself. And think that higher education is not always a must for everyone. And therefore, one way in bringing up the child with mental retardation (Wilks and John, 1974) is by taking part in parent support /group conferences with other older parents of children with similar situation. Because, they can give information and share their experience about mental retardation and the how of child rearing practices for other younger or more stressed parents who are fade up with the care of their children with mental retardation.

2.2.5. Child Rearing Practice From The Ethiopian Context.

Though there is cross-cultural variability in child- rearing practice (Guthrie, et al: 1966), currently in Ethiopia authoritative (not authoritarian as in the past) parenting style is the common pattern of child rearing practice (Seleshi; 1998). Authoritative parenting style is characterized by restrictive parenting with love and care. Findings by one researcher (Cherinet:1999) has revealed that parents of the children with MR are not necessarily rejecting their children. But they are doing that ignorantly without facilitating opportunities to their children to participate in some home or play activities and are restricting their children not to participate in the social (or play) environment or with other people or children thinking that their disabled child can not interact well with others or others may harm their disabled child. Therefore, they are restricting their children not to play outside or interact with others and to stay in their homestead for a longer period of time without sending them to school. This wrong child rearing practice is the result of lack of knowledge by the parents in the how of creating interactive environment for their children and of rearing/handling their children with MR.

However, parents of the children with MR need to get information through education or counseling services and other social services, like special educational services for their children with MR (John and Wilkins: 1974). The study by Gilenesh, et al. (1999) revealed that parents of the children with MR have a positive reactions toward inclusion, but the policies and practices for educating the disabled in Ethiopia is not meeting the educational needs of the parents and their disabled child. For example, through parental education/training service, parents of a child with MR can be made to aware of the factors which can help them to make a happy home environment for their children in which their children can grow up without practicing wrong parenting style. Minnet(1989) jotted down some of the factors of making a happy home environment in the following manner:

1. Parents who love and respect each other and their children's security.
2. Parents who consider that children are more important than the housework.
3. Parents who realize they are not perfect.
4. Parents who realize that no child is perfect. All children go through the phases of good and bad behavior.
5. Parents who do not expect too much of their children. Children enjoy life more when they are praised and lived for what they can do, rather criticized for what they are unable to do.(P.20)

Therefore, according to Seleshi(1998) variation in parental behavior (e.g. in coping behaviors and parenting style) tend to show differences in children's behavior.

The adequacy of children to be socially responsible and independent largely depends on how families bring up their children. Defective child rearing practices are, for example, among the major causes of the development of various deviant behaviors in individuals. (P.2)

According to the results of the case study by Cheirnet (1999) on families of children in Ethiopia, parents seem to show limited interaction to communicate ideally and share their true emotions with their children with mental retardation. They do have also false perception about the cause and nature of their child's disability. Even, past studies on

other countries' normal children with regard to parental reaction towards their child has revealed the same results like Ethiopian case. For example, many parents usually show a disturbed behaviour about the presence of their child and his/her participating during the conversation time with the presence of other adults (Menninger, 1948). This and other activities, like hiding the child from the society are an example of wrong parental caring style for a child with mental retardation that must be stopped since it leads to poor adjustment of a child, socially and cognitively. There are four styles of parenting (over protective, permissive, authoritarian and authoritative) that could have connections with one aspect of children's behaviour, such as with a child's academic achievement level (Seleshi: 1998). Particular style of parenting; parents' socio economic status and their attitudes toward parenting, or their quality of competence in child rearing practice have been identified and proofed as the contributing factors of child's academic achievement and his/her normal adjustment within the society. Moreover, home environment of a child with mental retardation should be adjusted in a way, which is favourable for the cognitive development of the child. There is no universally accepted or valued principles of parenting style as far as each styles of parenting has its own advantages or disadvantages for one individual to another individual (Wolfendale: 1992; Tackett and Hunsberger: 1981, Calm and Franchil, 1987; and Curtis and Singh: 1987).

2.2.6.Principles of parenting

According to Tackett and Hunsberger (1981), each principles of parenting style has its own advantages and disadvantages. Moreover, the preferences of a given parenting style vary from one parent (the father/ husband's) to another parent (the mother/wife's); from parents of a given family to another ones; and from the parenting preference of a child to the preference of his/ her parents parenting style. Parenting style preference also vary from parents of a given society (from different cultures, values/ interests, SES, and classes, etc) to parents of another society. However, there are some guide lines of parenthood. These are as follows:

- I. keep the dignity of being parenthood by Presenting a united front regarding rules and the disciplinary measuring taken to enforce them

Avoid arguing with the child

Avoiding threats, promises, bribes and sarcasm

Talking less and listen more to the child.

- II. Use firm but fair loving discipline

- III. Let the child see that you as a parents mean what you say.

- IV. Show the child the right way to maturity and faith.

- V. Teach the child to be self-dependent, honest, creative and ambitious

- VI. Avoid extremes of being over permissiveness and authoritarianism and of taking revenge, as such conditions may produce unhealthy response by the child.

Democratic or balanced parenting style is, therefore, a useful temperament to be practiced by parents of a child without the practice of permissive and authoritarianism parenting. He has also mentioned that usually the lower class, not upper class parents are usually practicing punishment with no reward to control the behaviours problem of their child. The SES, socio cultural values or interests of the parents and their personality could be the factors of practicing a given parenting style. A child is also another factors of a given parenting style. For example, if cognitively disabled child is aggressive, reciprocally, his/her parents will exhibit reflect the temperament of their aggressive child so that their parenting style can be characterized by authoritarian parenting style by using punishment rather than reward to control the behaviour problem of their child with MR. The consequence of such parenting style is that to rear a child with low self esteem. Caring a child with cognitive disability in teaching style is an important aspects of parenting a child with MR. Since caring a child in teaching style is a means of developing the cognitive quality of the child (Sileshi:1998& Cherinet:1999).

Home care for the retarded

It was mentioned that if families of a child with MR are not able to care their child, they are dysfunctional to rear their child by meeting the different needs of the child. For

example, developmentally disabled and the impaired are still considered as cursed or demon possessed, so they still have no special home care opportunities for further development through appropriate caring styles. Therefore, Families should include their children with MR in as many family activities as early possible and exposed them with all senses of home stimulation to develop the cognitive skills and maintain the intellectual competency of their children with MR (Minett 1989, calm and Franchi: 1987). The main point here is that the problem of choosing which parenting/ caring style should be practiced?

Institutional Care For Children with MR.

According to Tizard (1964) institutional care is recommended for a child only if the child is deprived of normal home life. This is because taking a child away from home or from his relatives, especially from his mother is extremely a serious case. Every effort must be made to enable children from the institution to contact with their families and return them back to their homes as quickly as possible. Moreover, extending the day care services adds the number of relief for parents of the disabled children so that those parents are willing to accept their children and rear them at home. Where institutional or public residential care is unavoidable, children of the institutional care should be 4-7 groups to live in a single dormitory. And those children are to be reared/ cared by a particular and permanent member of the institutional staff who trained as a sympathetic and substitute mothers and fathers. They are expected to give a continuous care by assuring both the physical and the psychological needs of the children through out the developmental life of the children with MR at the residential care. The educational and vocational needs of those children have to be considered by the institution since those children have the right to get staff guidance and counseling services to met their vocational and educational needs.

Institutional care for children with MR must substitute the family home by supplying the children with: (Handleman and Harris: 1986)

1. affection and understanding their interest, capacity, defects and regarding their personality.

2. the feeling of stability to remain with the caretaker till their independence.
3. opportunity for making their best of ability and aptitudes as developed as in the normal home environment
4. opportunity to share the common life with a small group of people.
5. the sense of identity and belongings to people in the community and to children of the ordinary people, who live with their families at home. In this situation, these children are to be encouraged to contact with parents of other children outside institution and with responsible adult people in the community to develop their friendly associations with other families acting as parents of the institutionally reared children with MR. (Handleman and Harris: 1986)

2.2.7. THE ROLE OF THE FAMILY OF A CHILD WITH MR. IN EARLY INTERVENTION

It is witnessed that parents have a great influence on their children's learning and adjustment. The importance of parent-child interaction is becoming one of the hot issues for the overall and cognitive development of a child (Henderson, 1981). For effective intervention or the prevention of MR, parental involvement through home-based learning model is becoming a highly significant component. In the light of this, after the summary of past early intervention studies for children with MR, Gurrallnic (1987) described this:

For infant and toddler programs, in particular parents were either trained to be the primary service provider, or to provide additional programs at home, often reinforcing, supplementing, and generalizing lesson activities. Overall, the instructional burden for younger children was placed clearly on parents ... (P. 14).

Moreover, parents have great role to play in the pre-schooling program of their disabled child as a partner of schoolteacher to design the curriculum (Erickson: 1965). Even though parents have a significant role in early intervention program, they need professionals' advice, information and social support to make them ready in coping up with the birth, parenting and teaching of their child with MR. (Batshaw 1992). And to achieve these goals, the family resources, such as socio-cultural and economic aspects

and even characteristics of the family and their child's disability are playing a vital role. Gallagher (1993) suggests that family resources or parental perceptions and attitudes towards themselves, their disabled child and parent intervention program (e.g. Training about parenting skills) seem to be important factors for the effectiveness of early intervention. Without the willingness of parents toward early intervention program, professionals and social support have nothing to contribute for the successful achievement of early intervention program. Thus, professionals should know the needs of parents or families of children with disabilities before starting their own different kinds of professional services.

In the preventive nature of pre-school program or curriculum for mentally retarded children, the following is suggested by Erikson (1965) as a means of early intervention program to be considered by professionals of a child with MR or any kind of disabilities.

- A. Assessing the Child's potential in relation to his total adjustment through observation.
- B. Specific training to alleviate learning disabilities and its factors, such as poor motor skills, visual, proactive and Auditory discrimination.
- C. Provision of an environment that stimulates intellectual and social growth.
- D. Parent-education to improve child-rearing practices and understanding of the child's behaviour.

Parent education is, therefore; one of the needs of the parents to participate in the program of early intervention against their child's MR. Parent-education must be given for parents of the children at risk and from the disadvantaged home environment. Why? Because research witnessed that children from impoverished backgrounds or disadvantaged home environment and with moderate level of MR (40-54IQ) if they attend pre-school program (Home based learning approach) by parents or if they get early stimulation by their parents, they are less likely to have been retained in grade or to have been assigned to a special education. Therefore, they are also less likely to be classified as mentally handicapped, or they are capable of higher level of functioning

than formerly thought (Hallahan, et. al.,: 1996) .Regarding the advantage of pre-school program for the mentally retarded, Kirk, et. al., (1951) also suggested this:

“ ... It is possible that many children who are unable to adjust to our society, would have been able to make adequate adjustment following an intensive program of pre-school education. The cost of education at this level may be insignificant compared to the cost of support and care at later age (153)”.

To achieve effective early intervention for MR, Professionals are; therefore, expected to identify and satisfy both the psychological and educational needs (which are the central needs) of families of the children with MR. (Heward, et al, 1988). Marsh (1992) had also suggested the need to have scientific knowledge about the how of caring the family members and coping up with mental retardation effectively.

2.2.8 The diagnosis of a child with MR.

In the diagnosis of a child with MR during the pre-school program, different professionals, such as psychologists, speech therapist physiotherapist together with parents should assess or diagnosis early the disabling condition of their pre-school child. This leads them to the right way how to discuss and then create their common goal among them for their disabled child and to facilitate early intervention program. Early detection and correction of the child's disability by professionals at the elementary levels also reduce the handicapping influences and allow the child to make better use of his abilities. Even though a kindergarten child is diagnosed as cognitively disabled, parents of the child can be advised by professionals to allow their child to remain in the elementary levels, which is advantageous for the personal and social development of their child who is usually with behavioural problems (D.Wilkin: 1981).

- Behavioural and emotional problems of a child with mental Retardation.
- Behavioural and emotional problems are common among children with mental retardation. Such problems are mainly the results of being the child reared in the disadvantaged home environment situation. *“The most potent causes in school children's behaviour problem are factors at home situations. So that it is important to remember that behaviour at home as important as behaviour in school”* (Haigh, 1977,

5152). Therefore, the best answer for the behavioural problem of children with mental retardation is to assess or measure the home environment that enables their care takers or teachers and to recognize which of those children may require special help and to devise some sort of strategy which will help especially the school teacher to cope up with the aggressive and withdrawal behaviour of those children with mental retardation. Consequently, it is possible to identify the current disability of a child and his/her additional problems- Behavioural/ Emotional problems. The following are some of the suggested techniques (by Tirussew, 1991) to be practiced by parents or school teachers of the children with (mild level of) mental retardation in the prevention and minimization of further behavioural and cognitive deficits of those children.

1. Accept the children realistically with true emotion though they do have aggressive behaviour, which is mainly related to their unfavourable home situation (e.g. rejecting the child), which is aggravating their disability to adjust or cope with the tasks demanded in the school.
2. Continuous reinforcement and follow-up for their study habit.
3. Encouraging them to develop their expected personal/social communication, adaptive, self-help and/or confidence skills through additional training.
4. Allow them to use all their senses.

Here, we come to recognize the importance of parental involvement in the project of early intervention program for their mentally retarded children. Individuals with moderate (trainable) level of MR can also be the benefited group of the pre-school program during their first three years of life. However, the diagnosis of the level of mental retardation of an infant is difficult unless there are qualified and multi types of professionals working together with parents collaboratively (not authoritatively) in the process of the diagnosis of the level of a child's disability and of early stimulation of the psycho-motor, cognitive and affective domains of infants and the children at risk. However, there must be accurate means to identify those individuals with cognitive disabilities from their time of infancy till the pre-school or a few times after their school age. Assessment of a child's problem must be identified before the passage of

the first five years of the child. Hence, it is possible to arrange at this time early intervention that can be effective so as to stop or alleviate the child's additional problems because of his/her disability to think strategically and adjust or interact positively with the outside environment

The CONSULTED Model

The first and most important variable to facilitate early intervention program effectively and in working with families of people with disabilities is establishing a positive, facilitative and working relationship atmosphere with high levels of interpersonal communication and the practices of basic counselling skills, like the CONSULTED model of counselling steps for Intervention (Handleman and Harries: 1986)

1. **Confer** (creating a conference) with the family concerning what professionals/parents see as the problem and its factor and their need to be met
2. **Observe** the problem behaviour with its factors and consequence of the possible treatment. Well-trained parents can conduct much of the observation.
3. **Name problems** or define it from the explicit definition to a more refined definition.
4. **Set priorities** of the first top target behaviour and the most important needs of the parents from a number of different target behaviours
5. **Utilize the appropriate resources** from each family member, the community/ environmental and the school resources
6. **Label obstacles** to success or solutions i.e. Note obstacles explicitly for the parents for future reference as possible basis for referral to other professionals if there are issues/ questions that should be considered during each steps of the **CONSULTED** model. Example, there might be the question of parental cultural conflicts with regard to the suggested solutions by professionals.
7. **Try interventions** by the family after the teacher consultant lays the ground model work.
8. **Evaluate** outcomes frequently (once in a week) and the least significant needs of the parents.

9. **Determine the next steps** of performance 'what to do next? If the treatment ends with success, shift to the next items on the list of priority problems. If not, modify the intervention program.

Moreover, professionals are expected to make alert parents to ways they can actively manipulate the physical environment to create a need for speech from their disabled child. Regarding this, Handleman and Harris (198) also described that the expansion of training for parents of developmentally disabled children is:

To help parents to cope up with a number of problem behaviors, including rituals, whining, and non compliance, and to teach non verbal and verbal imitation skills to their developmentally disabled children. Several early studies looked specifically at the parent's role in facilitating speech and language (p. 113)

For example, the findings by Courts and Lings (1987) revealed that parental viewing of the language and school related behaviour of their child is highly predictive of academic performance of their child. The two fruitful areas of home-based intervention program is also teaching a disabled child about the daily life skill activities (such as toileting, griming, dressing, cleaning, cooking, gardening, hygiene and setting table) and prevocational activities (such as matching, sorting, patterning, assembling, packing, filing and block printing).

According to Gurrallnick (1987), the role of parental involvement in early intervention is significant. Comprehensively, Parental involvement should be extended to family systems that emphasize the mutually interacting network of forces influencing all members of the family/parents, brother, sister and other siblings of the children with any kind of disability. (Brossard: 1953 and Cowan: 1993). Thus, early intervention to minimize the child's additional handicapped ness because of her/his/ being disabled can be approached through family intervention that concerns all members of the family.

A professional as a researcher has to identify variables that can mitigate the effects of another parental/family stress because of their child's disability since parental stress can be minimized by the promotion of parental coping strategies. Regarding early

intervention to minimize family stress through the promotion of family coping strategies, Guralnick, et al (1987) expressed the following:

The promotion of coping strategies and the role of family resources including social support networks add important dimensions to early intervention programs. Within this framework the family truly becomes a more prominent and direct focus of the early intervention program. In the simplest sense it is recognized that sound family functioning is essential for the child with special needs ...crucial question in the future will be concerned with how to translate and integrate family interaction models into early intervention programs, how to develop useful instruments to assess the factors of interest, and how to establish the network of services and identify professionals capable of assisting the families to develop effective coping and adaptive strategies (pp.367-368).

We come to understand that the extension of parental involvement into the family system level is for the practice of extensive early intervention program - which is mainly aiming at the development of cognitive domains of a child. However, recent theories and research results support the importance of the establishment of adaptive parent-child relationships characterized by warm (in natural manner), reciprocal and supportive relationships that are becoming the primary goals of family-child interactions (Guralnick, 1987 and work, 1965). Within this approach; therefore, parents can receive technical information and skills training from professionals regarding their child's disability and other associated problems, as they are the key solvers of their child's problems and so, they are to be encouraged to build a positive relationship and attachment with their children by accepting their child's disability. Moreover, all these perspectives lead to the inevitable conclusion that individualized approach to parents and to each family will be required and that can only be accomplished through the understanding of contemporary approaches to family functioning.

Many parents are willing to serve as therapist (Guralnick, 1987) and would play an active part in educating their children (Hegarty et al, 1988), effectively if they are encouraged that they can do it and are given the meaningful, feasible and comfortable roles - as both a teacher and a therapist. Families of the children with mental retardation can be helped by professionals if they are interested and accept their

child disability and develop their children's cognitive style or basic adaptive skills by acting as a skill therapist and teacher, respectively. The study by Adugna (1999) revealed that parents of children with mental retardation have the needs for information exchange and for emotional supports, social networks and training. However, they must get sufficient information and settlement prior to training them to develop rational coping strategies and parental care. To accomplish this, professional support is needed (Laycock, 1952; Erikson, 1965; and John & Wilks, 1974).

2.2.9. Professional Support for Family of a Child with Mental Retardation.

Professionals can explain fully about the nature and causes and intervention mechanisms of mental retardation. However, they have to be careful in telling (informing) and counselling parents who are less matured, uneducated, young and who have low level of socio-economic status; because they are usually showing a feeling of shock to hear about their child's disability. Blechman (1990) also warned that people have to be conscious to choose a particular and acceptable coping strategy during the stressful situation, like the existence or the birth of a child with mental retardation at home. How the family of a child with disabilities copes with the stress depend on the nature of the stress, the family's available resource to afford for the rehabilitation of their disabled child; and the way the family interprets the situation as normal or abnormal to happen (Kirk, 1993). Through professionals, parents are helped to change their false perception about the causes and nature of mental retardation. In addition to this, family therapy must be approached to have effective family intervention program by which all members of the family of a disabled child are helped to minimise their stress (because of the presence of a child with mental retardation) and are encouraged to care about or help their child to show the expected cognitive and the socially accepted behaviours.

The Needs of Family of a child with MR.

The Psychological and educational needs of each family of pre-school child with MR must be satisfied by the psychologists and school professionals' or social workers'

supportive attitude and advice until parents accept their child's disability realistically with true emotion (Hegarty, et. al., 1988). Consequently, parents as partners of professionals can arrange Individualized Family service Plans (IFPs) for early intervention program by creating the program or advocacy through parental network before the 6 months of their child's disability (Mitchell, et. al., : 1991). Professionals can also observe that quality of parent- child interaction and model (Batshaw: 1992) or give training for parents (Gurrallnic, et. al.,: 1987) about the techniques of child rearing practices, which are likely to yield developmental benefits for their disabled children. However, to achieve such the above-mentioned goals of professionals' services, identifying the needs of families of child with MR is very crucial. Marsh (1992) put the central needs of the family in the following manner:

As a consequence of the mental retardation of family member, families have a number of central needs: (a) for a comprehensive system of care for their relatives; (b) for information about the disability, about intervention, about services and resources; (c) for skills to cope with the mental retardation and its sequel for the family; (d) for support; (e) for meaningful involvement in intervention; (f) for managing the process of individual and familial adaptation; (g) for contact with other families; and (h) for assistance in handling problems in the large society. (P. 16)"

According to Handdeman and Harris (1986) professionals can meet the needs of parents of a disabled child through the provision of training programs like **parent-teacher and Didactic training for parents.**

Parent- teacher Training:- parents can learn to be the teacher or behaviour modifiers of their children with cognitive impairment as those children often need a very structured context in which to learn new skills and decrease behavioural problems. This could be achieved effectively through home programs that should be performed with the involvement of parents of a child with MR. parents can teach their children to get dressed in the morning or to play simple games with her/his older sister.

Didactic training for parents:- moreover, didactic training is an integral component of any effective family intervention program to develop skills(for problem solving or

adaptive coping strategies) through direct contact or a person-to person counselling between parents and teachers. This is because counselling is, probably more valuable to develop positive coping strategy by parents of a child with MR than the numerous email IEP conferences, newsletters, or note writing. Off course, some parents may be so indifferent, intellectually handicapped or emotionally distressed that they cannot or will not master the necessary coping skills with their child's cognitive behaviour problems and with the how of the burden of caring or rearing their child for a prolonged period of time. Consequently, such parents may seek to place their child out of home care for institution care for their being unable to cope up with the behavioural problems of the young child with disability who are usually below 21 years old level. If their child with disability is above 21 years old level, the most important reason for family's decision to seek out of home placement of their older disabled individual is the disruption of family life or relationship, family retirement, and the burden of intensive, exhaustive, prolonged and special care, like the medical care given for the severely disabled child.

The Milwaukee project: The best example of environmental Intervention program for MR

Many scholars mentioned about the Milwaukee project (1975/77-82) when they raised their issue on the how of intervention program for high-risk children or socio-cultural-familial disadvantaged children; and for children with cognitive disability (Henderson: 1981 & cooper: 1981). The Milwaukee project is one of the most example of environmental research for an intervention program which was conducted by Garber and Heber (1975/77) from 6-9 years to evaluate the effectiveness of early intervention program (cooper: 1981). The result of this project, as described by Corbett (1981), has shown that children with mild level of MR ($IQ \leq 80$) were highly concentrated among the disadvantaged mothers, whom have usually low level of SES and $IQ \leq 75$ on the WAISC- which was used as the criterion for intervention program of the Milwaukee project. Socio- culturally disadvantaged children were, therefore, included in that intervention program from their age 3 months up to their 6-9 years of age by receiving a highly structured program of developmental stimulation at home and compensatory

stimulation at a special day care centre. At the same time, home-based learning program (or parent training) was given for mothers with low level of SES and IQ<75 in the form of vocational and educational program together with job training. This kind of professional support or parent training, especially for mothers of a child with disability, was one of the means by which parents can be empowered to teach their children and /or to cope up with the exhaustive care of their disabled children (Wolfendale: 1992). Such Home-based learning curriculum approach for parents of a child with MR was also a means to achieve the educational needs of families of developmentally disabled children (Handleman: 1986). Finally, the majority of experimental children, in the Milwaukee project, have shown improvement in their IQ level of 121 that of the control group 87 though there are individual variations among those children and their families included in the project (Corbett: 1981). Therefore, helping parents of a child with MR to cope up with the demands of parenting and teaching their child with cognitive disability through parent training and counselling programs is the reciprocal means of developing the cognitive quality of their disabled child.

From the experience of the Milwaukee project, Corbett (1981) also concluded the following six early intervention programs for children with mild MR and for the prevention of mild level of MR.

1. There is need for better indicators for intervention if it is to be used economically and effectively with the families in greatest need. These indicators should include better criteria for identifying family risk factors, as well as earlier and more reliable methods for measuring developmental delays. These techniques should be capable of application on epidemiological basis.
2. It is of vital importance to involve parents in the intervention programs.
3. That intervention programmer must be flexible, so as to meet appropriately the needs of each individual and their families.
4. There must be emphasis on particular aspects of skill development. For example, in language competence Intervention should be based

on a clear developmental framework, although not necessarily bound to a particular developmental theory.

5. Intervention programmes need to be maintained over long periods if early gains are to be dissipated (pp. 243-244).

Thus, beyond the educational and community services for cognitively disabled children, meeting the needs of their families at home (home needs) by training and counselling parents to teach and care their disabled child by coping up with the burden of caring their disabled child, effectively and respectively. Enhancing parent advocacy and offering social support services for family of a disabled child is also very crucial for effective coping. Consequently, the normal functioning of the disabled child and family stress buffering effect because of their child's disability can be achieved, effectively. For example, a short term residential care (as in the practices of the Milwaukee project) for the mentally handicapped children is a form of relief and support for their parents (Tizard: 1964 and D. Wilk: 1981).

CHAPTER THREE

RESEARCH METHODOLOGY

This research was done through the case study of the four parents of the children with mild and moderate level of mental retardation (MR). First, Children of the family were selected equally from both groups of sexes (male and female) with the specified level of mental retardation. And then, family of the selected groups of children was taken as the subject of the study. The Psychological and Family interaction theories; and the ecological models about the parents and their disabled child are consulted in different reference materials to design the ecological approaches of this study. To gather the data on the variables, Interview with Mothers of each cases and home environment Observational Guide was used and that data was analysed qualitatively.

1.1.Subjects

A case study was conducted on four (4) parents of the children with mild and moderate levels of MR. Two parents' children (Cases 2&3) has been getting a day care service and educational service at the center for the retarded in governmental school (at Kokebe Tsebah Primary School) for more than two years. The other parents had been out of Addis so that their children were not getting educational service at the specified school before a year. These four parents were selected purposefully according to the sex differences and degree of cognitive defects of their children. Two-fourth of subjects of the study were parents of two children (a male and a female) with mild level of MR. Another

two-fourth were also parents of two children (a male and a female) with moderate level of MR.

It should be understood that the selection of families of the children to be taken as the subjects of the study was determined after the selection of children with the mild and moderate level of MR from both sexes. The families of the female and the male children with that level of MR are taken after the selection of the names of those children. Thus, it was possible to say that the selection of the four families of children with MR was done based on the characteristics of the disabling conditions and sex categories of their children . Two families of the male children and the same number of families of the female children with mild level of MRs were selected. The same selection was done for parents of the children with moderate MR. Therefore, the total number of families of both sexes of children with MR were four ($N = 4$) and selected purposefully.

According to the criteria of the school, children with MR if they are capable to learn reading and writing skills(they are educable) and have less significant problems in adaptive behaviour, they were identified and selected for this study as mildly retarded children. Children with MR if they are not capable to learn reading and writing skills(they are not educable, but trainable) and have more significant problems in adaptive behaviour, they were identified and selected for this study as moderately retarded children. Therefore, for the selection of the subject of the study, the names of the family of the child or the child

(him/herself) were taken from the list of the child's institution where he/she is attending.

3.2 Variables

The *sexes* and *levels of mental retardation* of the children are considered as an important variable for the selection process of the parents of each child.

Therefore, the only differences is existed on the variables of the *family factors* so that it is possible to investigate different family factors and their contributions in *influencing the parent's coping strategies and caring styles* toward their child with MR. For example, families of the male and female children with MR were interviewed about their coping strategies and caring styles (which are the two main variables to be considered in this study) towards those children. Most interview items and observational checklists were; however, taken from the most recent version, the **Henderson Environmental Learning Process Scale HELPS**- It measures the following six-factors/ variables in family homes.

1. parental reinforcement of education and:
2. their outside activities for their child with MR.
3. their attitude about education.
4. their direct teaching of their child with MR
5. their level of education
6. their practices in encouraging their child with MR or their young disabled child in play activities (curtis and singh: 1997, 286-9).

Home observation check-lists was also adopted from the (following) six categories of Caldwell's home factors and it was used by Integrating with the above variables.

1. Emotional and verbal responsibility of mother
2. Avoidance of restriction and punishment
3. Organization of physical and temporal environment
4. Provision of appropriate play materials.

5. Maternal involvement with child
6. Opportunities for variety in daily stimulation (from Tackett and Hunsberger: 1981,1366).

3.3. Instruments:-

A. Parental interview was used as an instrument to get data about parental coping styles toward their child with MR and the burden of caring their disabled child. It was designed by the researcher by adopting other models of coping strategies used by adult people during a stressful situation- which was adopted from Hurwitz, et al. (1971); Hamilton and Warburton (1981); and McCrae and Costa (1986). Moreover, there are also additional interview instruments designed by the researcher to have clues about the coping resources of parents of a child with MR, as such parental variables are playing their mediating roles in determining parental coping styles toward the burden of caring their own disabled child. To obtain data about parental caring styles toward their child with MR, another interview instruments was also designed by adopting the **Henderson, et al. (1972) Environmental Learning Process Scales (HELPS)**. The scales were translated in to Amharic and modified into the "yes/no" type of responses by parents to assess parental practices (parenting styles) in the home environment for the cognitive development of their disabled child. The Henderson (1972) Environmental Learning Process Scales is taken from "Journal of the educational and psychological measurement" Vol.57, No 2, PP. 286-288. Therefore, Interview Guide with parents of a child with mental retardation was used as the main instrument of data gathering to assess the situation of parental coping strategies and caring styles toward their child with mental retardation; and to

get and assess the past and present history of their child. Incidentally or informally a teacher or social worker of the children with MR was interviewed to have a holistic approach on the casework. During interview, tape recorder was used as the main research device to record parental coping strategies. For example, parents were interviewed to tell a series of stories orally that reveals their opinion about the causes and nature of their child's disability because of mental retardation. And they were asked what they had felt from the stress of parenting their child with MR and what measure they had taken and wish to take because of that. In this situation, family's reaction or choice of their coping strategies can be detected and analysed from the recorded story so as to identify the exact nature of parents' response or behavioural reactions towards their child

B. Moreover, **home-observation check - list** was used by the researcher to have a good enough and reliable data about parental caring styles in teaching or developing the cognitive skills of their young disabled child. Therefore, Caldwell's Home observation scale was used after doing a little modification of its design and it was also adopted from and used by integrating with the **HELPS**. Observations are often made over an extended period of time starting from the pilot study up to the final accomplishment of the case study. The first observation on the adaptive behaviour of a child with MR is also practised to identify children with mild level of MR. Hence, observational checklist on the adaptive behaviour of a child is the main criteria of the identification of level of MR. Family's child interaction system and caring styles are observed through unobtrusive method. There fore, observational checklist was prepared based on Caldwell's *Home observation scale format*.

3.4. Procedures of data collection and analysis.

Information about the *coping strategies and caring styles* of parents/family of a disabled child was obtained through intensive interview with parents or caregivers of each child. That interview session was determined mainly by the preference of parents of the children with MR so that it was going on in the home of parents of the disabled children for a month (from March 12, 2001 up to April 20, 2001). During the interview days and session, there was no time limitation imposed upon the parents by the researcher, rather time limitation was decided by the parental preference. Such interview questions and informal observation process were also administered and going on respectively for a week by the researcher for about 4-5 days for each cases of the parents per that week to know about:-

- parental *coping strategies and caring styles* of the parents/family

- the background, personality and stressful events of the parents; and about their family situation (eg SES) and about the characteristics of their own disabled child or about the nature of their child's MR; his/her behavioral problems; and amount of care needed by their disabled child.

- the practices of the parents/family at home to develop the cognitive skills of their children.

Another important things that should not be forgotten is that each of the six variables can be categorized specifically and were translated into Amharic language, so interview

instruments were administered by Amharic language. Moreover, interview sessions was conducted based on the preference of parents of a child with MR or according to the favourable time and place arrangement suggested by each parents. This was done purposefully so as to make parents to feel at ease during the interview sessions so that they could not give hasty responses during the interview session.

The result of this study was confirmed by gathering empirical evidences and using the above mentioned instruments and different theoretical approaches. People's opinion or eye witness, and analysing important events described by other people, like by special, social or rehabilitation service workers, were taken as an additional ways to confirm facts from the data, successfully. Research work can also be effective when it is done co-operatively with the other professionals who do have and share more experience about some of the important events for the study. Thus, a social worker that knows the behaviour of the children and their family situation or backgrounds was interviewed about parents of those children. As the Henderson (1972) environmental learning process scales, Caldwell's Home-observation checklists are summarized into six (6) categories of *home variables*. Such home variables were informally observed by the researcher for a month, so each variables were checked by the mark " ✓ " after the researcher had assured whether there exists conducive or simulative home environment or not for the cognitive development of a child with MR. If the caring styles or child rearing practices of family or parents of a child with MR was characterized by teaching styles, they were given a mark " ✓ " or "one score" for they had been caring their child in teaching styles.

Finally, in the analysis part of this study, it is possible to compare and analyse the condition of each cases of the parents about their coping strategies and caring styles in relation to the sexes and condition of their child's disability and other family factors. This is to mean that the collected data/ variables about each cases of the family is analysed qualitatively (case by case). However, during the analyses, some descriptive statistics were used to have quantitative characteristics of the research.

CHAPTER FOUR

PRESENTATION AND

ANALYSIS OF THE FINDINGS

Background of the presentation and analysis.

The purpose of this study was to identify and describe families' parental coping strategy and caring styles toward the disabling condition of their child and the child with MR, respectively. Information/ data about the four families is collected mainly from mothers of the children with MR. Two of the four cases of the families were selected from the place out of Addis Ababa and were not getting educational services for their children with MR during the past years though they are in the verge of getting educational service at Kokebe Tsebah, Primary School, Addis Ababa.

As mentioned in chapter one, a qualitative research design or analysis was applied to respond for the statement of the problem, or the major research question of the study. In this chapter, the findings of the study will be presented and analysed accordingly.

Presentation of the interview report as given by the parents is concerning: -

- A. their coping strategies toward the disabling condition of their child and behaviour problems of their child with MR.
- B. their caring styles, especially in the process of teaching their child with MR for the development of the cognitive quality of their child with MR.

A short summary of the findings about each cases of the family are presented in the form of tables.

General analysis of the major findings or factors are compared and selected by their commonalities and differences; separated (as facts) from opinion/reviews and errors and biases of the past and present studies.

Presentation of the findings:

The following data are about *parental coping strategies and their caring practice in developing the cognitive skill of their retarded children-which* was collected and organized in the form of tables followed by statements of the findings.

Table 4. 1:BACKGROUND INFORMATION ABOUT THE PARENTS

Name of the parents	Age	Education level	Family size	Economic level	Religion	Child's level of MR
Mother of Winta (w/o Azalech)	40	2 nd grade	5	Low	Orthodox	Moderate
Mother of Tewodrose W/o Leteberihan	32	12 complete	4	Low	Orthodox	Moderate
Mother of Tariku W/o Alemitu	27	Literate	4	Low	Orthodox	Mild
	35	7 Grade				
Mother of Tizita w/o Yesihareg	34	12 complete	3	Medium	Orthodox	Mild

A.1. Presentation of the findings from the interview about each parents' coping strategies.

Case1: Family of a female child with mild level of MR.(14 years old girl)

The child's mother is teaching at elementary level. Only her mother with out getting paternal treatment reared the child, as her father is dead when she was in early childhood period. The child had spent much of her early childhood period with her

grand parents' home environment (at Zewai) where she had been maltreated (eg. poor breast feeding experience) and abused sexually by others at her late 10th. The disabling condition of the child was caused by pre-birth factor. Her mother used to practice physical exercise during her pregnancy which is reported to be the causes of the birth of her child with moderate level of MR with minor muscular disability-which is identified after the child was two years old level. At this time she was not able to stand and walk properly. She was not able to read and write up to her 8 years of age. Because of her child's problem, her mother tried to consult medical doctors concerning the causes and treatment of her child's disability. A doctor, unknowingly, prescribed tablets for her disabled child so, tablets had been taken by the child for fours years (from 6-10 years of the child's age). Such tablet rather aggravated the child's disability and makes her to show sluggish and sometimes aggressive behaviours so that the prescribed tablets had no use and was thrown away by the child's mother. The child's mother reported that she had recently been practicing physical punishment against her child for her wrong behavioural activities. For example, closing a door to make her mother stay outside is the usual activities of this disabled child when her mother is seen out or sit with an adult individual of the opposite sex. Because of this situation, the child's mother does not want to re-establish new marriage with a new partner. However, after the stoppage of using the prescribed tablets, the disabled child started to show quick progress in developing the normal socio-cognitive behaviours. Even, she could learn, properly, figure drawing, language expressive and vocational skills. Moreover, her mother started to contact other paraprofessionals working for MR who are; therefore, helping the child's mother to cope up with the disabling condition and

its associated behavioural problem of her child by explaining to the child's mother about the how of treating her disabled child, and about the nature or causes of her child's disability and behavioural problems. Creating contact with paraprofessionals and special unit centre teachers, as reported by the child's mother, had helped her to stop practicing frequent physical punishment against her disabled child. Regarding the contribution of professionals and her feelings, the child's mother expressed this:

After I had created contact with paraprofessionals, I got good counseling service on the how of handling and coping up with the behaviour problem of my disabled child without practicing physical punishment against her. Now, I feel ashamed and guilt of my past action against her. Even, I feel panic when I thought about my disabled child's future, as there is no one can give one's own effort to care, handle and teach my disabled child properly more than my help. Considering my child's educational opportunity, I planned to shift my previous (Ziwai) environment to Addis where I get special school or unit center for my child with MR.

Case 2: Family of a female child with moderate level of MR.

The case of this child (8yrs old) with moderate level of MR is presented according the report given by her mother (40 yrs old). The child's father is alive, but he is not living with this family and is not taking the responsibility of caring his disabled child, except her poor mother. The child's mother reported that during her pregnancy, she had a serious asthmatic health complains and tensions. To alleviate her illness, she had unknowingly been taking tables during her pregnancy so that she was affecting her foetus and finally she gave birth for a premature baby. As the child grows, her mother realized that her three years old child as cognitively disabled child. This is because she

had observed her disabled child as too slow to show the expected socio-cognitive behaviours characterized by MR and other behavioural problem. It was also reported by the mother that her child has the feeling of restless and makes a disturbance when she sits with other people other than with her mother for a long hours of a day. So, she could not let her child with MR with people of the neighbour hoods, whom are usually rejecting and making a quarrel with her disabled child. She is, therefore, unable to cope up with other people's reaction toward her disabled child. Moreover, the child's mother is a daily labourer so that she has to leave home for working out by letting her disabled child with her elder sister. However, the child's sister is always practicing harsh physical punishment for the wrong acts of her younger disabled sister with MR- who has the habit of tearing her clothes and the things that she gets at home. Moreover, the habit of playing with and eating mud or dirty particles is also another boring situation for her older sister- whom has to clean the dirty body and clothes of her younger disabled child. But the disabled child's sister could not resist with such conditions by her disabled sister that she used continually harsh physical punishment to control the bad habits of her younger disabled sister. To avoid such a physical punishment against this cognitively disabled child by her elder sister, her mother is being forced not to leave home by letting the two sisters together at home or by letting the disabled child with her elder sister who is practicing authoritarian type of behavioural control, which is also aggravating the restless behaviour of the child with MR. To avoid the physical punishment against the disable child, her mother is also always going out for work by taking her disabled child to the working area. Now, the child's mother seems to take no other means to solve the behaviour problem of her

disabled child and so does the wrong action of her elder sister. Further more, the child's mother expressed the following regarding the how of handling and coping up with her child's disabling conditions:

I tried holy water to my disabled child; but it lasts with no solution. I'd been consulting medical doctors for so many times, but they did nothing except telling me about the two suspected causes of my child's being with MR, pre birth defects by medication or defects on one parts of the brain because of accidental bumping faced on my child's head. I come to believe that I'm the only person who can treat and cope up with my disabled child's problem. However, I'm still searching for the real causes of my child's disability to learn even the basic academic skills. Sometimes I've seen her when she shows some unexpected behaviors from her, which is exhibited by a non-disabled adult people. For example, she is not forgetful to memorize the things you don't expect that she can memorize it fully. When she meets with new adult persons, she can memorize and greets them very well during her second meets with them. Therefore, I've a hope that my child could be improved, but I don't expect that she can achieve or complete her elementary level education and live her self-dependent life without my care. Who is going to feed and care my disabled child for the future? Currently, there is no satisfactory residential care center for such disabled children. Recently, I've visited one of the residential care centers for MR established by NGOs. I don't want to send my child at there since life at that center seems to be miserable for my child with moderate level of MR. This is because, the disabling condition of institutionally reared children is more sever than my child's disability so that I don't want to send her at there and to make her to interact with those institutional children as she would gain nothing at there and from those children.

Case 3 :Family of a male child (11 years old boy in Addis)with mild level of MR.

Only his poor mother reared the child until his 5 years of age. After awhile, the child was becoming reared by two of his parents, a husband (35 years old man) and his wife (27 years old woman). These parents have also another child, the younger sister of the child with MR, who was sometimes for gotten to be cared properly by her mother for

the sake of treating her elder disabled brother, Tariku (10 years old boy with MR). The child's father was a militiaman of the old regime who lost his right armpit at war situation. Now, the child's parents are daily labourers who are leading their life from hand to mouth, so economically they are too weak to fulfil the basic needs of their children. However, they seem to be strong enough to accept their child's cognitive defects though they are not able to cope up with the daily change of the mood of their retarded child. He is usually exhibiting behavioural problems when he senses noisy situations and feels headache, angry and Hungry, too, For example, the child cannot accept smoothly any commands from his parents when the child is in bad mood because of the above-mentioned situations. Their child has a problem of establishing a positive relationship with other children. Even, he has sometimes, depression with no language expression, especially when he feels hungry. Because of the child's poor social interaction skills with other children, his parents feel stressed. Therefore, they do not allow him to go out and play with other normal child without disability of his own. The child usually goes to school and back home without his own close friend and the guidance of others. Educationally, the child can read, but do not have proper writing skills, as he could not handle properly his writing materials for he had been injured because of car accident on his right part of his body so that his right hand and right leg are not normal. Therefore, beyond the child's disability to handle paper and pencil properly, he has the problem of walking in straight-fore ward looking position and handling any objects by his right hand fingers. Moreover, the child's mother expressed the following regarding the situation of her child with MR.

My child is both cognitively and physically so weak that might be happened mainly because of his poor experience of breast feeding from the time of his birth. Because of this, I feel guilty of hurting my child during his baby hood so that I have always been working hard to fulfill mainly the basic needs of my disabled child that of my non-disabled daughter's needs.

Finally, the child's parents expressed their wish to send their child with MR to the residential institution if they get support organization for the retarded. They said that sending their child to residential care centre could make free of their child from living in a plastic covered house, which is situated at the roadside of Addis Ababa, at "Jan meda". That could also alleviate the worsening life situation of their disabled child. The non-existence of residential care by the government, as reported by the child's parents, had diminished their power of coping strategies to be used and their caring styles to be practiced by them. What other behavioural problems are usually exhibited by and what kind of abuses have faced by the child with MR? And what measures have been taken by the child's parents/ family to cope up with the identified behaviour problem of their child with MR? Answers for such questions can be presented in the following table.

Table 4.2. Shows the distinguished behaviour problem of the child with MR and coping strategies used by his parents.

behaviour problems of the child	Coping strategies used by parents
<ul style="list-style-type: none"> - Unable to accept any commands from parents during his bad feelings - Currently, the child started to show aggressive behaviour at home - Previously, the child was always making quarrels with other children. - The child is always asking his parents by crying to buy him playing materials that could not be afforded by them - Sometimes, the child show epileptic behaviour if he senses a disturbing sounds and experiences social hysterical or disorder or mob around his environment. 	<ul style="list-style-type: none"> - We said or do noting except we discussed about it - We always intended to consult our child's teacher at the school to know the causes of that emotions .we are still confused about it - We were not allowing him to join those children or play with them. Rather, we made him to stay or play at home. - They prepared manually the requested play materials and give for their child with MR to play with it. - They tried to calm down their child, but they are still confused about the how of getting treatment for their child's epileptic behaviour. - physical punishment is not practiced

Case 4: Family of a child with moderate levels of MR (Tewodrose, 10 years old by with MR)

This child is with moderate level of MR who lives with his parents much of the burden of care is not laid up on the child's father, but on his mother, 32 years old woman educated up to grade 12. Family size of the child is four (there are two sons and their parents) and their economic status is very low. The most distinguished behaviour problem of the child beyond his cognitive disability and language disorder is that he always urinates during sleep situation. Therefore, such behavioural problem is becoming one of the unbearable situations especially to the child's mother, who always complain about it and wants to know the source of this problem. She is still searching answer for her questions about the causes of her child's unconscious urination on the bed day-by-day. Off course, she has a little perception about the causes of her child's disability and problems which happed after her child had experienced a car accident and injured on his spinal cored. The Childs' LD is believed to be improved in the future so that his mother is trying to teach her child about the basic academic skill of reading and writing. However, though she is teaching her child, she does not have any hope whether her disabled child can master those skills or not. She does not have also a hope whether her child would be able to read and write and lead his self-dependent life or not though the child is very enthusiastic to acquire those cognitive and adaptive skills or the socio-cognitive skills. Sometimes, the child is not allowed by his mother to participate in the social activities of other child since his mother has seen those

children while treating badly her disabled child. The child's mother gives further explanation about it.

I don't allow my disabled child to play out with other children as he is facing a conflicting situation from them during play activities. Those children considered my child's cognitive disability and speech disorder as the sign of mental illness or foolishness so that they are kicking or joking upon my disabled child. I feel sorry and couldn't cope up with it. Finally, I decided to change my previous environment (Wonji area) and move to Addis, the place where I can rear and teach my child properly. Now, I wish to send my child to residential care center, if possible.

As the child's family resource indicates, his family has such a low level of socio-economic status that may contribute to the burden of caring the child only by his mother, whom couldn't cope up with her child's disability and other children's negative reaction to ward her disabled child. Or she could not resist with other children's response toward her child's disability - which is considered by those children as insanity with foolish character so that the child's disability hinders him not to participate normally in the play activities of other normal children. Moreover, the child's mother is not allowing her child to make play interaction with other children. The consequence of this phenomenon is that language development of the child would be impaired unless he has got an opportunity to interact with his age mates. The only means of rearing properly that disabled child, according to the child's mother, was changing the previous environment (wonji area) to another area where she can rear and teach properly her disabled child. This also proved to show that the impact of MR on the family as causing the family to move to another environment. They had not been cope up to live in their previous environment, which is not favourable to rear their disabled child before.

Interview report from a professional working at SOOM has revealed the following regarding parental practices for their children with MR and services they get.

Majority of parents of a child with MR are caring or treating their disabled child, traditionally. After they get social service from support organizations for the mentally retarded ones and their families; For example, many parents of the children with MR feel guilt of their past practice against their child with MR. They had the problem of accepting their child's disability and its associated behaviour problems, realistically. Parents do not feel guilty of their past action against their retarded child until they are informed that they are neglecting their child. Skill training is given for their child with MR so that the level of MR and behaviour problems of their child are being improved. The situation of the children with MR had been considered by parents of the child as an illness rather than the states of being retarded in cognitive development that can be improved through time and skill training. The sense- training and muscle training are being given for children with MR for the development of sensory discrimination and motor control of the children, respectively. Though parents of a child with MR have been trying their best of caring their disabled child, many of them do not have a full hope on the changes of their child's disability unless they get counselling. They have great role in teaching their disabled child together with professionals. Some of the educated families help their child with MR by teaching reading and writing skills. But uneducated parents had nothing to do after they cognised that their child is cognitively disabled. This is because uneducated families might have lower hope on the changes of

the disabling condition of their child with MR by learning and their involvement than the more educated ones. If educated parents are too busy to teach their child, they assigned private teachers for their children at home. Even physiotherapists and speech therapists are assigned for some of the children from high level of SES. Beyond parental counselling and training to teach their child, some parents are getting social services from some support organizations like from SOOM-support organization of the mentally handicapped individuals. For example, social services are given by our organization, SOOM in the form of facilitating:

Parent advocacy and discussion program

Physiotherapy and speech training for their children with MR.

Parent counseling and financial support for poor mother of a child with MR to make them able to cope up with their child's disability and the burden of caring their disabled child.

It was also reported by the social worker that Parents' interaction with their children with MR is not necessarily rejection, but it can be a result of their lack of knowledge about how to communicate, how to interact and, generally, how to handle a child with MR . Each parents of the children; however think over about the safety of their child and felt that their own child will fall down on their way to school and will face any accident or she/he will disappear since she/he doesn't know the way to school or home. If there is no one guiding their child they will stop sending their child to school thinking that it is better to take prolonged care of the child at home. Confiding children at home for fear of accident on their away to school is also the kind of over protection

by parents of the children. This can affect the development of children's cognitive development and of facing the problem of developing their self-dependence skill. Parents are also under stress In relation to the futurity of their children with MR..

A.2. Analysis of the findings about Parental Coping Strategies.

This part of the analysis is presented based on the different perspectives of the findings. Therefore, it involves the analysis from the perspective of parental or societal attitude toward MR, from the perspective of family situations or factors (like parental resources to cope) and from the perspective of life experience of the parents to cope with MR.

1. Analysis from the perspective of parental and societal attitude towards MR

According to the findings of this study, parents of the children with MR are not, fully or effectively, able to cope up with their child's behaviour problems and other peoples' reaction against their disabled child. For example, it was found that all parents of the children with MR are complaining about other peoples' and children's' reaction against their disabled children. Such a reaction by the children can be happened as a result of children's' negative attitude toward MR that modelled from their own society's attitude toward MR so do have the children of that society toward mental Retardation. Why? In the society where mentally retarded individuals are considered as a cursed creatures, the same attitude can be developed by children of that society (even by the parents) toward MR or toward their own children with MR so that parents can not cope up with

the disabling condition of their own children (Erikson : 1965). In this findings, parents of the female child with mild level of MR(Case 1) and of the male child with moderate level of MR are, for example, forced to leave their previous home environment for they are not able to cope up with the negative reactions of the children of that environment toward their disabled children and the unfavourable condition of that previous environment for the education of the disabled children.

2. From the family factors or family system perspective:- This is analysis of the finding from the personality perspective of the parents or their resources to cope up with MR and their functional and interaction system. Moreover, ability to cope with a stressful situation can be determined by the personality type of the parents. For example, the study by (McCrae and Costa:1986) indicated that people with extrovert personality are usually exhibiting a positive coping strategy toward a stressful situation, were as maladaptive coping strategy was mainly the characteristic of people with introvert personality dimension. Therefore, the personality of parents of a disabled child can be a mediating factor of their stress because of their child's disability. However, Is mental retardation a real family crisis? Drew (1984) expressed that MR is not a real family crisis. But it can be considered as a crisis for family or parents of a disabled child who have poor coping resources and have a disrupted family life and relationship, such as the phenomena of divorce or the death of parents of a disabled child. Beyond the personality of the parents, there are other factors of either adaptive or maladaptive coping strategies toward MR. These factors are family resources to cope with the disabling conditions of their child and parenting or teaching him/her up to the

expected level of developments. It is, therefore, necessary to understand the level of stress because of disability that varies from the parents of a disabled child to another one. For example, in this study it was reported that parents of male children with MR are not able to cope up with parenting their disabled children for they consider themselves as if they are not able to care and teach properly their disabled child at home situation so that they wish to send their male children with MR to institutional care. Parents of the female children with MR have also the same stress, but they do not want to send their female children to institutional care for they consider themselves as having more power to care their female children with MR than the institutional care. For example, parents of the children (of case 1&2) reported that sending their female children with MR is making them to be abused by others so that they do not want to send their female children to the institutional care centre which is considered as unfavourable to their own female children with MR. Family's or parental resources to cope up with their children's behaviour problems are the major factors to determine the levels of stress faced by the parents of a disabled child because of MR (D.Zuk: 1962 and Deter-Deck and 1998). Such parental resources like, the low level of socio economic status of the parents and their poor coping strategies or cognitive appraisal of their self esteem to care their disabled child are some of the causes of poor coping strategies used by the parents to minimize their stress of parenting their children with their own behaviour problems. Interview report (with Cases 3&4) of this study also revealed that it is not the degree of children's disability, rather the low level of parental resources to cope with their children's behaviour problem and to care or teach properly

their male disabled children with MR, seem to be the main causes of parental wish to send their male disabled children for institutional care (Tizard 1964).

If parents/families of all children with MR do have a positive coping strategies toward the behaviour problems of their disabled children and get training from professionals regarding the how of rearing and teaching their disabled children, or if they get family support from respite care centres/ community service, and if they have normal family life and interactions, they are not likely to seek out-of-home placement for their children. (Fotheringham, et al: 1971). The disrupted family interaction, like the non existence of a husband at home in all family of a disabled children, except in the family of a male child with mild MR, is also contributing for the cause of poor parenting style as all the disabled children are parented only by their poor mothers so that mother could develop poor coping strategy in the burden of caring their disabled children. Moreover, they could have been dysfunctional to satisfy the daily needs of their disabled child.

3. Analysis from the life Experience of the parents

Professionals are expected to assess the needs of parents of disabled children and be patient of parental unconscious responses or reactions characterized by guilt, anger or projection, etc (Adams: 1960 and Mitchel & Brown: 1991). For example, some parents of the children with MR (as in the case of parent of a male child with moderate MR) are poor at creating interpersonal relationship skills with others or professionals to solve their problems with regard to their child's disability. They may not have the belief that creating good interpersonal relationship skill with professionals as a means of minimizing their stress because of disability. Rather they intend to cope with their

child's disability without receiving professional advice and support regarding the how of coping with the problem behaviour of their disabled child and of rearing that child effectively. If parents of a child have good relationship skills with professionals as a means of coping with their stress because of MR, they can cope up quickly with their stress because of the disabling condition of their child (Kirk, et. al. 1986). The main question of the professional can be how to identify parents of the children with MR whether they do have good interpersonal relationship skills or not. Is good interpersonal relationship skill the function of the personality type of an individual? Or is it a learned behaviour which is determined only by the existence of favourable home environment that invites for the development of good interpersonal relationship skills as a means of coping with the stress faced by the individual who brought up in that interactive environment? If creating good interpersonal relationship skill is the function of personality, are parents of the children with MR expected to change their poor personality of interpersonal relationship skill through learning with the objective of creating good interpersonal relationship skill so that they can get social support from others and cope up positively with the stress of parenting their disabled child and controlling his/her behaviour problem effectively? It is definitely true that those professional can help parents of the children with MR if parents create a positive relationship with those professionals who give service for the mentally retarded. For example, parents of cognitively disabled child in Ethiopia(as Mother of Case 1) try to cope up with their child's disability by consulting others regarding the problem behaviour of their retarded child because of disability (Tirrusew: 1998). So, creating good interpersonal relationship skill with others is an example of a positive coping

strategy used by parents of a disabled child. However, the personal life experience of the parents with unresponsive and passive professionals may led the parents to learn and give low credit to the value of creating interpersonal relationship as a means of getting support from others and minimizing the stress from parenting their own disabled children with MR. In this finding it was also reported that all parents of the children with MR are in need of special support from professionals or social workers working for MR with regard to the problem behaviour of their child. But no solution is found for each parents of the child with MR, except for one parent of a female child with mild level of MR (Case 1).

Thus, professionals are expected to know the central needs of each parents, their coping resources (e.g. their interpersonal relationship skill); their reactions or attitude towards disability and professional service; and their components of each family systems so as to met individually their own different needs and create a positive relationship skill with each parents of the children with MR.

B.1. Presentation of the findings about caring styles of the parents.

Table 4.3 Parental Emotional Affection And their Reinforcement Level for their disabled child

Parental Emotional Affection And their Reinforcement Level for their disabled child	Scores given for Family Caring Styles by the Family of each Cases				
	C	A	S	E	S
	1	2	3	4	Total
1. Giving emotional affection and understanding their child's emotion.	0	0	1	1	2
2. Reinforcement for their child's Education /performance	1	½	1	½	3
3. Encouraging the child to develop his/her self-confidence	1	½	1	1	3.5
4. Not Practicing physical punishment against the child at least once a week.	0	0	½	1	1.5
8. Encouraging the child to read and listen	1	½	1	1	3.5
TOTAL	3	1.5	4.5	4.5	=13.5 20

Parents of a child with MR are good at giving emotional affection and reinforcing their child with MR. However, most of them (except family of case 4) are practicing physical punishment (for the wrong doings) against their children with MR.. This is because, parents of the disabled children practice physical punishment for the wrong doings of their children during that informal teaching-which is going on without getting professional guidance and using standardized teaching materials.

Table 4.4. How Parents arrange play opportunities/activities for their Disabled Child

How Parents arrange play opportunities/activities for their Disabled Child.	Scores given for Family Caring Styles by the Family of each Cases				
	C	A	S	E	S
	1	2	3	4	Total
14. Giving play opportunities for the child at home,	1	1	1	1	4
or giving play opportunities for the child out of home.	0	0	0	0	0
16.1 Existence of play materials (e.g. Toys) for the child at home	½	½	½	½	2
21. The child usually practices some play or sport activities at home with parents .	0	0	0	0	0
TOTAL	1.5	1.5	1.5	1.5	<u>6</u> 16

More over, parents of the children with MR are not giving much emphasis to buy children books, play materials and to arrange play activities for their disabled child as a means of teaching their children with MR at home. It was also observed informally that Parents of these disabled children are not usually practicing playing with their disabled child as the best mechanism of teaching their retarded child. They do not even allow their child with MR to play out with other children.

Table 4.5. Direct Involvement of The parents In Teaching Their Child

Direct Involvement of The parents In Teaching Their Child	Scores given for Family Caring Styles by the Family of each Cases				
	C	A	S	E	S
	1	2	3	4	Total
4. Exchanging ideas/information with the child	1	1	0	1	4
7. Direct involvement of the parents in teaching the child or	½	0	0	½	1
17.1 Direct involvement of the siblings in teaching the child or	1	0	0	1	2
9. Teaching the child to read letters/alphabets or count numbers before schooling	1	1	1	1	4
10. Management of the child's behavior through plan	1	1	1	1	4
11. Follow- up ing the child's schooling or school performance daily.	1	1	1	1	4
12. Giving feedback for the child's school performance	1	½	½	1	3
13. Telling new ideas/information (from the media) for the child	1	1	0	1	3
20. Parents are asked about something by their child	1	1	1	1	4
TOTAL	8.5	6.5	4.5	8.5	= 28 36

Based on the above data, Parents teach their children with MR at home. However, the degree of direct involvement of the Parents in teaching their disabled children varies according to the educational status of each members of the family and the existence of sisters or brothers of the disabled child to take the responsibility of teaching and caring their disabled child at home. (For reference see the next table).

Table 4.6. Educational Status of The Family, Their Attitude and their Practices toward the education (Inclusive) of their Child

Educational Status of The Family and Their Attitude Toward the education (Inclusive) of their Child	Scores given for Family Caring Styles by the Family of each Cases					Total
	C	A	S	E	S	
	1	2	3	4		
15. Educational level of the parents of each cases is (grade 12,2,7 &12 respectively)	1	½	½	1		3
17. Educational level of other person caring/teaching the child other than the parents (e.g. siblings, sisters or brother of the child with MR is Grade 5,7, 0 & 1, respectively.)	1	1	0	1		3
19. Parents have a positive attitude towards inclusive education	1	½	1	1		3.5
16.2 Existence of educational/reading materials for the child with MR at home (e.g. children's book)	½	0	½	½		1.5
TOTAL	3.5	2	2	3.5		<u>11</u> 16

For example, more of the educated parents (as in the cases of the parent of a female child with mild level of MR and of a male child with moderate level of MR) are helping their disabled children by providing educational materials and reading children stories together with or for their disabled children and by giving feed back to their children's good performance. Though these parents have direct involvement in teaching their disabled children, during the interview they reported that they were not hopeful whether their children can or can not accomplish their educational tasks up to the end of their elementary level. The same is true for the conditions of other parents' hope regarding the educational achievement of their disabled children. Especially, parents of the children with moderate level of MR are not hopeful whether their children can or can not live their own self- dependent life of the future. Since some of these parents (especially parents of the children with moderate MR) considered that the activities of their children with MR are governed by the unconscious behaviour, they think that their children cannot properly perform, learn any home activities and to lead their own

independent life in the future. And parents/families of the children prevent their own children from participating in any relevant home activities adapted to the children potentials and needs which makes the condition more worse.

It was also observed informally that siblings (or sisters and brothers) of the disabled children do play greater roles than their parents in teaching their disabled brother/ sister about the basic academic skills of reading and writing together with the daily life at home. This is because most parents of the child with MR are not spending much of their daytime at home with their disabled children. Rather, they spend much of their time at working area or situation. Therefore, sisters or brothers of a disabled child, if they are capable, they are given the task of caring their disabled brother/ sister at home so that they are more likely to be involved in teaching their disabled child at home than their parents do. For example, it was observed that children of the case 1,2 and 4 (except case 3) are being helped by their sisters or brother at home during play and their own home or school tasks or activities.

Table 4.7 Parental caring styles to teach their child
With MR out of home

Home Variables, or Parental Factors	Parental caring styles to teach their child with MR out of home.	Scores given for Family Caring Styles by the Family of each Cases				
		C	A	S	E	S
		1	2	3	4	Total

Family's Level of Involvement In The community With Their Child.

- 6. Taking out the child with MR to market, shopping and visit
- 18. Making the child to aware about his/her surrounding environment

1	1	1	1	4
1	1	1	1	4
				= 8
				8

If parents of a child with MR are to spend their time in and out of home with their disabled child, usually, mothers were observed, not other family members of the children with MR, when they are more likely to care at home and teach their disabled children about the outside world by walking out of home with their disabled children during recreation, marketing and visiting friends or relatives than other family members, respectively.

B.2. Analysis of the Findings about parental caring style.

The research finding of this study has revealed that parents of the female children with MR seem to show poor parenting style for they are practicing physical punishment for the wrong doings against their own disabled children while they are teaching them informally about life skills. According to Tackett and Hunsberger (1981), there are factor of such poor parenting styles. These factors can be the temperament or basic personality of the parents and their socio-cultural values, interests or other background of the parents that could play a role in their child rearing practice. The characteristics the disabled child and the condition of his disability can also be the causes of poor parenting styles practiced by family of those children with MR. Through the practices of reinforcements rather than punishment (as in the authoritarian parenting style) parents of the children with MR can improve the cognitive skills of their child and

avoid the deteriorated development of social learning skills of their disabled children. For example, the finding of this study revealed that that only female children with MR that of the male ones have received harsh physical punishment either from their parents or siblings. In addition to this, interview report by the parents has revealed that one of the female children with MR who has the mild level of MR once had been sexually abused at her own home. This shows that female children with MR are receiving harsh physical punishments and are more abused either physically or sexually by their family members than male children with MR.

Regarding the level of parental involvement in teaching their disabled children with MR at home, they are not as such they are expected to perform teaching their children at home as they are not spending much of their day time with their disabled child. Rather, they spend much of their time at the work situation; therefore, the tasks of caring and teaching a disabled child with MR at home is usually given for younger brother and older sister of a disabled child (Handleman, et al.; 1986). For example, in this study, it has been found and reported that a child with moderate level of MR is being helped to learn and do some educational tasks by his younger brother. In spite of the low level of parental involvement in teaching their disabled child at home, parents of these children with MR have been identified as playing the greater role in teaching their disabled child about the realities of the outside world than other members of the family-sisters or brothers of disabled child. Parents of these children teach their children about shopping or marketing by going out with their disabled child and are explaining something new during their visits to friends and relatives. Therefore, one has

to consider that parents of the children with MR can play a role as teachers of their disabled children (Minett: 1989). However, if parents of the disabled children are to spend their time at home, they are likely involved in caring their disabled children at home and making their disabled children to aware about the realities of the outside world or their environment. In other words, if parents of a child with MR are to spend their time in and out of home with their disabled child, usually; mothers, not other family members, of the children with MR are more likely to care at home and teach their disabled children about the outside world by walking out of home with their disabled children during recreation, marketing and visiting friends or relatives than other family members, respectively. As far as the findings of this study is concerned, there is no clear evidence about the reason why other family members of the disabled children, except their mother, are not willing or involved well in acquainting their disabled child about his environment or the realities about the outside world.

Moreover, parents or family of a child with MR are expected to encourage play activities and to arrange play opportunities for their disabled children with in and out of home play situations. (Caldwell, et al: 1975 and Henderson, et al: 1977). This is true by the fact that encouraging play opportunities are one of the means of teaching children with cognitive disability. Carison, et al. (1961) mentioned that children with MR could be educated best at play situation. The kind of play can be either individual or social play type. During social play, children are playing together so that they can learn the feeling of cooperation and to be honest and to share ideas together. However, the finding of this study seems to reveal the reverse facts about the level of parental practices in encouraging play opportunities out of the homestead with other children,

which is very low. Parents of the children with MR are not willing to send out and see their children while they are playing with other normal children for fear that conflicts may be raised between their own disabled child and other children. The consequence of that children with MR are being restricted to get the chance of language or social interaction with other children so that those children with MR would face a deteriorated process of social and language developmental skills in their latter life. Deteriorated forms of language development could affect the academic competency of a child with mild level of MR during their early education program, or they are less likely to show a change from early intervention program (Hallahan et al:1996). Thus, parents of the children with MR are expected to value the language development of their children with MR. Curtis and Singh (1987) also found that parental valuing of the language behaviour of their child is highly predictor of academic performance of their child. The practice of early intervention for MR can be effective if parents of the children are participated equally as professionals in the program of early childhood education (early intervention) for MR (Gurrallnic: 1984). With such educational intervention program, the language aspects of the children with MR must be emphasized and considered so as to develop the cognitive and social interaction of a child with MR (Corbett: 1981, and Handleman & Harris: 1986).

The practices of good parenting style can be improved through parent training program about the practice of effective child rearing style that has to be aimed at the development of the cognitive quality of a child with MR at home by exposing their children with MR with all senses of home stimulation, such as by providing different

teaching materials or children books, toys, television and radio at home. Such child rearing practice by the parents can help to develop the cognitive skills and maintain the intellectual competency of their children with MR. These can be achieved if parents of the children with MR do have a positive attitude toward educating or the education of their children with cognitive disability which can be improved through the practices of effective child rearing practice in teaching styles. Therefore, if parents of the children have a positive attitude or hope toward the educational achievement of their children, they are more likely eager to consider the home environment as the learning environment and equip the child's home with the teaching and play materials so as to create a simulative home environment for their child with MR. Even though parents of the children with MR, according to the result of this study, have a positive attitude toward the education of their children with MR, they are not good enough to equip their child's home environment with the standardized teaching and play materials for their disabled children. Previous findings of the study by Cherinet(1999) revealed that four parents among the five ones do not believe that children with MR have ability to perform any home activities and can learn from that activities.

It was also mentioned that sisters or brothers of a disabled child if they are capable they are given the task of caring or teaching their disabled brother/sister at home so that they are more likely to be involved in teaching their disabled child at home than their parents do.

According to the results of the case study on the four parents of the children with mental retardation, they have limited interactions with their child. Each parents have

also false perception about their child's disability, its causes and nature so that they were not in the position to take early intervention action so as to alleviate their child's disability and stop any other additional problems associated with that disability. Thus, children with mental retardation are not getting appropriate parent care in Ethiopia. So, they will develop the psychological, educational and sociological adjustment problems if their parents' coping strategies and caring style were in the wrong way and traditional type, respectively.

CHAPTER FIVE

Summary, conclusion and Recommendations of the major findings.

I. Summary of the study

Summary of the findings from interview about parental coping strategies.

Case 1. Mother of a female child with mild level of MR. is a concerned parent about the problem behaviour of her child so that she has been consulting Medical doctors and Para professionals and frequent practice of physical punishment against her disabled child is minimized now. She was anxious and worried about the previous environment of the child and it was not appropriate for the education and social interaction of her child so that she moved away of her previous environment for the educational opportunity and normal interaction of her child with other children. She had the feeling of guilty conscious for her past action against her disabled child.

Case 2. Mother of a female child with mild MR. is practicing overprotection, except the child's sister, which has forced the mother not to leave home her disabled child with other individuals, so her retarded child is always around her mother for security. She is deeply stressed with regard to the future care of her disabled child-Who is usually punished by her elder sister for the wrong doings so that mother of this child could not cope up with the wrong action of the child's sister and other individuals against this child with MR..

Case 3. Parents of a male child with mild MR. are somewhat stressed with regard to the behaviour problem of their child and they are still thinking of the future care of their child. They have a wish to send their child for institutional care. This wish is a form of maladaptive coping strategy. More over, his mother had the feeling of guilty conscious of her past action against her disabled child

Case 4. She is still in search of the solutions for the unconscious urination of the child on his bed daily, so she is still confused about it. Because of that she has even the wish to send her child for institutional care. She was as anxious and worried parent about the previous environment of the child that was not appropriate for the education and social interaction of her child so that she moved away of her previous environment for the education opportunity and normal interaction of her child with other children.

Summary of the findings from home observation about parental care.

- I. According to the data of the first table (see also in the ***analysis*** part), family of the two female children with mild and moderate MR (case1 and 2) are not easily understanding or accepting the emotion or wrong acts of their disabled children so that they were practicing at least once a week in the past harsh physical punishment (for the wrong doings) against their female disabled children.
- II. Almost all parents of the children with MR are doing some activities to teach their disabled children; however, they are not involved in the direct

teaching activity at home. Sisters or brothers of the children usually practice home teaching with MR, except by the family of a male child with mild level of MR (case 3).

- III. Parental involvement in the community with their disabled child (by taking their disabled child to the market area, shopping, or to other places to visit friends or relatives) seems to be very high.
- IV. Almost all parents of the children with MR are not willing to send out or to see their disabled children with other normal children, rather, they forced their disabled child to stay and play at the homestead. However, children of the case 1,2 and 4 (except case 3) are being helped by their sisters or brother at home during play and their own home or school tasks or activities.
- V. Educational status of parents of the children with MR seems to be above elementary level, except for parents of the female child with moderate level of MR (case 2). Regarding the educational attitude of the parents toward the inclusive education of their disabled children, it is positive. Even though parents of the children with MR do have positive attitude and appropriate educational status to teach their disabled children at home, they are not good enough to provide educational and play materials as means of educating /teaching their disabled child at the home environment. Concerning parental hope in relation to the education of their child, the social worker reported that the more educated parents have higher level of hope than the less educated ones.

II .Conclusion of the major findings about parental coping strategies and caring styles.

We have understood that Coping strategy is the mechanism by which parents exhibit a sort of emotional reactions and behavioral actions that are taken as a means of solving their tension because of the birth, parenting and the existence of a child with mental retardation at home. It is also the way of reaction/feelings by parents or family of a child with mental retardation to minimize their stress because of their child's disability.

Where as *Caring style* is the over all action of either the true or adopted parents of the children with MR. for the normal development of the whole personality of their child with mental retardation. It is also the way of parents in supporting their exceptional child economically, educationally, socially, emotionally, vocationally, and providing health facilities. Or it is the kind of family support by which the extended form of parental care is given for the child with mental retardation by all members of a family of a child.

Parental coping resources types (e.g. personality type or self esteem of the parents and the characteristics of their disabled child) and *other family factors* (e.g. their interaction & functional system and their attitude toward MR) and *life experience of the parents with professionals are a mediating factor of their stress and coping styles toward caring their children with MR.* For example, one parent of a female child with mild MR were able to cope up positively with her child's behaviour problems by consulting professionals regarding the problems of her child. The other punished the disabled if not possible to cope up with the child's disabling conditions. Empowering parental

source of coping with their children's disabling conditions because of MR and with the burden of caring the child is the reciprocal means of helping their own disabled child - who must get all type of care from his/her parents without practicing maladaptive child rearing style, such as practicing physical punishment for the child's behaviour problems. Empowering the sources of family's coping mechanisms towards the disabling conditions and caring of their child with MR needs an intervention program at the family level. However, the ecological theory by Bronferberner (1986) Suggested that the problem of an individual child arises not only from the individual himself (*at the micro level*) but it is beyond the micro levels such as from the kind of interaction or contact he/she made with his/her family (*Meso system*). The child's problem is also beyond the family situation (family system theory), i.e. it is from the kind of health, school and social services given to the child with mental retardation and to his/her family from different institutions (*Exeo system*); and from the kind of policies of the government and its political ideology together with societal attitude with regard to MR. (*Macro level*).

Though most families do care their children with MR to develop the cognitive and social skills of their children with MR, it is traditional type for they are not using standardized teaching materials and practicing the teaching process at home in a planned manner as they are not getting professional guidance/support and receiving professional supervision. Moreover, physical punishment, for the behaviour problems and wrong acts of the children with MR in the process of the teaching their daily life skills, is more usually practiced against the female children with MR than against the male children with MR. These physically punished children with MR are not perfect to

receive all the instructions told by their caretakers or their family members. For example, physical punishment was usually practiced by mother of the female child with mild MR and by the sister of the female child with moderate level of MR, respectively. Most families do not care their children with MR in teaching style. However, the degree of direct involvement of the family in teaching their disabled children varies according to the educational status of each members of the family and the existence of sisters or brothers of the disable child who can take the responsibility of teaching and caring their disabled child at home. For example, more of the educated parents (as in the cases of the parent of a female child with mild level of MR and of a male child with moderated level of MR) are helping their disabled children by providing educational materials and reading children stories together with or for their children and by giving a feed back to their children's good performance. Though these parents have direct involvement in teaching their disabled children, they are not hopeful whether their children can or cannot accomplish their educational tasks up to the end of their elementary level. The same is true for the conditions of other parents' hope regarding the educational achievement of their disabled children. Especially, parents of the children with moderate level of MR are not hopeful whether their children can or cannot live their own self-dependent life for the future.

Recommendations

Short term recommendation

1. As it is necessary to consider first the notion of the ecological theory by revealing the fact that all parents/families of the children with MR need societal and Governmental or Non Governmental Organisations—GO& NGO supports to minimise their own stress from being hopeless and the burden of caring or teaching their child (since the sources of each parents' stress is beyond their child's disabling condition) so that they can cope up positively with the behaviour problems, parenting, teaching and future care of their children with MR and their behaviour problems. To achieve this, through the ecological model, professionals are expected to know the central needs of each parents, their coping resources (e.g. their interpersonal relationship skill); their reactions or attitude towards disability and professional service; and their components of each family systems so as to met individually their own different needs and create a positive relationship skill with each parents of the children with MR. For example, parents of children with MR have good attitude toward the inclusive education of their retarded children after they have seen a change on the behaviour of their children with MR from the program of inclusion. However, they are still in search of another solution either from the school or GO& NGOs to eradicate totally the cognitive disability of their own children.

2. Therefore, parents of the children should get counselling service to perceive realistically about the nature and causes of their children's disability and whether it can

be improved or not through learning up to the expected level of development. More over, if parents or family of the children with mental retardation are not taking appropriate care and teaching process, or support for their retarded child and are not able to cope up with their children's disability, it is necessary to take appropriate family therapy by professionals as an intervention program through the CONSULTED model of counselling.

3. It is also possible to suggest that parents or family of a child with MR are expected to gratify their child's basic needs optimally for appropriate health and safety. Parents of a disabled child are not only expected to supply their child with basic needs or economically, but also to satisfy the educational and psychological needs of their children with MR. This is because, parents of a child with MR can be good enough to care, treat and educate appropriately and formally their child with MR at home if they get professional guidance, such as parent training service about child rearing and teaching practices. The finding of this study revealed that parents' educational level is above literate so that they can clearly understand and teach the instructions or methodology which they received from professionals for their retarded child. Thus parents are expected to:

-Show a positive affection, attitude and realistic expectation or hope with good verbal response or reinforcement for their child's educational and cognitive achievement.

-Encourage their child's play activities without restriction and punishment.

-Impose as few social restrictions as possible in child's exploration and motor behaviors.

-to have a realistic acceptance of their child's disability and expectation/ hope on his/her capacity and competency. That will promote his/her feeling of trust of self and others

-Organize the physical and temporal environment of the child, such as the provision of appropriate play materials and varied, balanced, and patterned sensory inputs that much with their child's cognitive, social, emotional and motor organizational levels that promotes the overall developments of the child.

-Create chances for the child to be cared by, to contact and interact frequently with few adults who are physically, verbally, and emotionally responsive and who can value and reinforce the child's achievement in education and language/communication skills in an accepted norms, emotions and behaviors. Hence, parental viewing of the language and school related behavior of their child is highly predictive of academic performance of their child.

Long term recommendation

4. However, parents of the children with MR should get teaching training to make them act as teacher of their disabled children starting from the early time of the diagnosis of the disabling condition of their retarded children.

5 The practices of good parenting style can be improved through parent training program about the practice of effective child rearing style that has to be aimed at the development of the language aspects and cognitive quality of a child with MR at home.

6. But this can be achieved if the educational and social policies of the government has given emphasis for the training or educational and psychological needs of each of the disabled parents (or family members of the child) the children with MR..

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Interview Instrument for parents of a child with MR.

Part One

Interview Instrument to recognize coping strategies and caring styles of parents/family of a child with mental retardation.

Instruction: Use tape-recorder during the interview session, if possible

ይህ መጠይቅ ወላጆች የዓዕምሮ ዘገምተኛ ልጆቻቸውን ሁኔታ ከተገነዘቡ በኋላ፣ ልጆቻቸውንም በመንከባከብ ሂደት ለደረሰባቸው ጫና እና በልጆቻቸውም ሆነ በሌሎች ተጓዳኝ በሆኑ ምክንያቶች የደረደባቸውን የሥነ-ልቦና ችግሮች ለመፍታት/ለማቃለል የወሰዱቸውን ስልቶች ለመገዘብ የሚያስችል መጠይቅ ነው።

ሥልዘዉ እንደወላጅነትዎ ይህ ቃለ መጠይቅ እርስዎን የሚያመለክት ጉዳይ በመሆኑ ለቃለ መጠይቁም እንደሚተባበሩኝና ለጥናትና ምርምራ ይረዳኝ ዘንድ ዕውነተኛና አስፈላጊ መረጃ በእርስዎ በኩል እንደሚሰጠኝ እተማመናለሁ።

አመሰግናለሁ።

A. Background information about the family

- 1. የአናት እድሜ _____ የአባት እድሜ _____
- 2. የቤተሰብ ብዛት _____ ወንድሞች _____ እህቶች _____ ሌሎች _____
- 3. የትምህርት ደረጃ _____ የአባት _____ የአናት _____ የልጅ _____
 - ሀ. ማህይም/ማገዘብ መጻፍ የማይችል ለ. ማገዘብ መጻፍ የሚችል ሐ. አንደኛ ደረጃ
 - ትምህርት ያጠናቀቀ መ. ሁለተኛ ደረጃ ትምህርት ያጠናቀቀ እና ከዛም በላይ
- 4. የቤተሰብ የኢኮኖሚ ሁኔታ _____ ሀ. ዝቅተኛ _____ ለ. መካከለኛ _____ ሐ. ከፍተኛ _____
 - ሌላ _____
- 5. ልጅዎ የአእምሮ ዝግመት ሁኔታ እንዳለበት የተረዱት በስንተኛ አመቱ ነው?
 - ሀ. አንደተወለደ ለ. በስድስተኛ ወሩ ሐ. መዋዕለ ህፃናት ወይም እንደኛ
 - ደረጃ ትምህርት እንደጀመረ መ. ሌላ _____
- 6. የልጅዎን ችግር እንዴት ይገልፀዎታል _____ ሀ. መናገር አይችልም
 - ለ. መራመድና መናገር አይችልም ሌላ _____
- 7. ችግሩ ከምን የመጣ ይመስልዎታል?
 - ሀ. ከመውደቅ ለ. ከወለድ ሐ. ከዘር መ. ሌላ _____
- 8. ከዘር የተያያዘ ከሆነ የዚህ ዓይነት ችግር ያላቸው የቤተሰብዎ አባላት ይገለጹ። _____
- 9. ልጁ/ቷ እስከ ስንተኛ ክፍል ሲገባ ወይም ልትገባ ይችላል ብለው ይገምታሉ? _____
- 10. ለወደራቱ እራሱን/እራሱን የሚችል ወይም እራሱን/ሷን የሚያስተዳድር ይመስልዎታል?
 - ሀ. አዎ ለ. አይመስለኝም
- 11. አይመስለኝም ካሉ ለምን? _____

Part Two

A. Parental Coping Strategies toward the stress because of their child's cognitive disability and its consequences.

መልስ

አዎን/አይደለም

1. የዐስምር ዘገምተኛ ልጆቻችን ችግሮች ለመፍታት ምን ማድረግ እንዳለበት ተሎ መወሰን ያስቸግሮታል/ አስቸግረዎት ነበር? አዎን አይደለም

2. አይደለም ካል ምክንያቱን ምንድነው ነው?

3. እስከአሁን ድረስ የልጆቻችን ሁኔታ ሲያስቡ ከፍተኛ የሆነ የሀይቅ/የቁጭት ስሜት ውስጥ ተቀብሎ ይላል? አዎን አይደለም

4. ልጆቻችን ከሌሎች/ጎረቤት ሰዎች ጋር እንዲቆይ ካደረጉና ከቤት ውጭ ወጣ ካል ያስጨንቀኛል ይላል? አዎን አይደለም

5. በእርስዎ በኩል ሊፈቱ ያልቻሉ ብዙ ዓይነት የሆኑ የልጅ ችግሮች አለበት/ባት ይላል? አዎን አይደለም

- | | |
|-----------------------|----------------------------|
| ሊፈቱ ያልቻሉ ችግሮች ካል ይጥቀሱ | የተሞከሩ/የተወሰዱ የመፍትሔ እርምጃ አሉ? |
| 1. | 1. |
| 2. | 2. |
| 3. | 3. |
| 4. | 4. |
| 5. | 5. |

6. ምንም ዓይነት የመፍትሔ እርምጃዎች በእርስዎ በኩል ካልተሞከረ/ካልተወሰደ ወይም ከአቆሙ ለወደፊቱ የልጆቻችን ሁኔታ ለማሻሻል አቁመዎል ማለት ነው? አዎን አይደለም

7. የልጅዎን ሁኔታ በማሰብ ና ብዙ ጊዜ ትኩረት በመስጠት ለልጅዎ መፍትሔ ሞክረዋል/እርምጃ ወስደዋል? አዎ አልወሰድኩም

8. ከዘመናዊ የህክምና እርምጃ ለልጅዎ መፍትሔ ባልማገኘትዎ ሌላ እንደአማራጭ የወሰዱት እርምጃ ነበር? አዎ አይደለም

9. የጎረቤት ወይም የአካባቢ ሰዎችን በልጅዎ ላይ የፈጸሙት ዘዴዎ ወይም ስነምግባራዊ የጎደለው ድርጊት በተደጋጋሚ ፈጽመዋል? ከፈጸሙት ዘዴዎች ይጥቀሱ

- | | |
|----|-----------------------------|
| 1. | በእርስዎ በኩል ምን ዓይነት እርምጃ ወሰዱ? |
| 2. | 1. |
| 3. | 2. |
| 4. | 3. |
| 5. | 4. |
| | 5. |

10. ልጃችሁ ቤት ውስጥ የመረበሽ ወይም የጥፋት ድርጊት ፈጽሞ ያውቃል?

ጥፋቶቹን ይጥቀሱ

በእርስዎ በኩል የወሰዱት እርምጃ አለ?

- 1.
- 2.
- 3.
- 4.
- 5.

- 1.
- 2.
- 3.
- 4.
- 5.

11. የዓዕምር ዘገምተኛ ልጃችሁን ችግር ለመፍታት ያክል በብዙ ጊዜ ሌሎች ሰዎችን አማካሪ (ምክር

እንዲለግስዎት ጠይቀዋል)? አዎ አልጠየኩም

ምክር ያልጠየቁበት ሁኔታ ካለ ምክንያቱ ምንድነው?

ምክር ከጠየቁም እርስዎ ለማን ብዙ ጊዜ ያስመልጧት ያማክራሉ?

ሀ. ለባለሙያ (ጉዳዩ የሚመለከታቸውን) ለምሳሌ፤

ለ. ለባለቤቱና ለቤተሰቦቹ

ሐ. ለጓደኛዬ

መ. ለዘመዴ ለልጆቹ አያቶች

ሠ. ለጎረቤት ሰው

ረ. ሌላ ካለ ይጥቀሱ _____

12. ሀ. ክልጅዎት ጋር አብሮ መወያየትና መጫወትን ያዘወትራሉ? አዎ አላዘወትርም

ለ. ለልጅዎት ጋር አብሮ ሱት መጫደና ዘመድ ወይም ጓደኛ መጠየቅ ያዘወትራሉ

አዎ አላዘወትርም

13.1 ስተራ ቁጥር «12» መልሱ «አዎ ካልሆነ» ምክንያቱ ምንድን?

ምክንያት ሀ. _____

ለ. _____

13.2 እስከአሁን ድረስ የልጅን ችግር ምክንያቱን ለማወቅ ብዙ ጊዜ እጨነቃለሁ ይላሉ?

አዎ አልጨነቅም

አሁን ምን ውሳኔ ላይ ደረሱ? _____

እስከ አሁን ድረስ ችግሩን/ሯን መፍታት አልቻልኩም ይላሉ?

አዎ አይደለም

14 ሀ. ብዙውን ጊዜዬን የጨረሰብኝ ነገር ቢኖር የልጄን ሁኔታ ምክንያቱን ለማወቅ ባደረኩት ጥረት ነው ይላሉ?

አዎ አይደለም

ለ. ብዙውን ጊዜዬን የጨረሰኩት «የልጄን ሁኔታ እንዴት ማሻሻል ይቻላል?» በሚለው ጉዳይ ላይ ነው ይላሉ?

አዎ አይደለም

15. አጠቃላይ የልጄ ሁኔታ ሲታወቅና ሊፈታ የማይችል ችግር ነው ይላሉ?

አዎ አይደለም

16. በአጠቃላይ የልጅዎትን ችግር (የዓዕምር ዘገምተኛውን/ሃን ሁኔታ) ለማቃለል ያክል ምን አስቦ/ፈጸመ?

ሀ. ስለልጄ/ልጅቷ አንድ የሚበጀ ነገር አስቡና ያሰብኩትን ሳልፈጸም ወዲያውኑ ዘለላ ነገር ላይ ትኩረት ውስጥ እገባለሁ

ለ. እስከ አሁን ድረስ ምንም ነገር አልሞከርኩም፤ እጨነቃለሁ፤ ግራ ገብቶኛል፤

- ሐ. እስከአሁን ድረስ መፍትሔ በማፈላለግ ላይ ነኝ (ሌሎችን በማማከር የመሳሰሉት)
- መ. ልጄን ወደ ጊዜአዊ መጠለያ ባባይ እንዲቆይ አድርጌአለሁ ወይም ወደ መንግስት/መከታተያ አዳሪ ቤት ልኬአለሁ።
- ሠ. ልጄን ቤት ውስጥ ለረጅም ጊዜ እንዲቆይ/እንድትቆይ ወስኛለሁ።
- ረ. ሌላ _____ ።
- ሰ. ችግሩን ለማቃለል የገጠሙ እንቅፋቶች ካሉ ይጥቀሱ _____ ።

17. በአጠቃላይ በአሁን ሁኔታ ልጄችሁን በመንከባከብ ሒደት በባም የሚያስጨንቅ (የሚያሳዝን የሚያበሳጭ) ወይም የሚያሰለች ሁኔታ ገጥሞቻታል?

አዎ አልገጠመኝም

አዎ ካሉ ይጥቀሱ

- ሀ. የፀዕምር/የፀዕምር ዘገምተኛው/ዋ ልጄ፣ መጥፎ፣ ፀባይ አለበት/ባት (ለምሳሌ ቤት ውስጥ/በአካባቢ ይረብሻል/ትረብሻለች።
- ለ. ጤናዋ/ው የተጓደለ በመሆኑ ሁልጊዜ ማስታመሙ ለምሳሌ ህመም አለበት።
- ሐ. መሰረታዊ የሆኑ የዕለት ተለት ተግባሮችን በእራስ/ሷ አለማከናወን (ማልበስ፣ መመገብና የመሳሰሉት) ያሳዝናል።
- መ. ለቤት ወደ ት/ቤት ና ከት/ቤት ወደ ቤት መውሰድ ያስለቻል።
- ሠ. አደጋ እንዳይደርስበት/ባት ና እንዳያደርስ መጠበቁ ያስለቻል።
- ረ. መሠረታዊ ፍላጎት ማሟላቱ (ለምሳሌ መመገብና ማልበስ የመሳሰሉት)
- ሰ. አንድ አጥጋቢ የሆነ መፍትሔ በመንግስት በኩል አለመደረግ ያሳዝናል።
- ሸ. የወደፊት ሕይወቱ/ቷን ለማስተካከል ባለመሞከሩ ወይም ባለመቻሉ (ለምሳሌ እኛ ከሌለን) ያስጨንቀኛል።
- ቀ. ከእራሱ ውጭ ሌላ እንክብካቤ ለልጄ ሊያደርግ የሚችል ግለሰብ/ድርጅት ባለመኖሩ ያሳስበኛል።
- በ. ለፀዕምር ዘገምተኛው/ዋ ልጄ በማለት ሌሎች ልጆቹን የእንክብካቤ ትኩረት ባለመስጠቱ
- ተ. ሌላ ካለ ይገፁልኝ _____ ።

Part Three

Parental Caring Styles

B. This is an interview instrument is to assess parental caring styles with the objectives of increasing the cognitive quality of their child with mental retardation by creating stimulating home environment for the cognitive development of the child

(Put a mark "✓" or Yes/No in the space provided for each answers of the interview question)

ለልጅዎች የሚከተሉትን ክንዎች ቢያንስ በሰውነት አንድ ጊዜ ከራጸሙ ለተጠየቁት ጥያቄ አዎ/አልተረጸመም በማለት መልስ ይሰጡኛል።

Yes/No

1. ሥሜቱን/ቷን ለመረዳት ለመቀበል ጥረት ማድረግ (ለምሳሌ ሲቆጣ/ስትቆጣ በትዕግንት ለማግኘት መሞከር)
2. ዘዕለት ተለት የት/ት ሂደትና ጥረት እንዲሁም ለጥሩ ውጤት የማበረታቻ ሽልማት ወይም ምሥጋና መሥጠት
3. ለማንኛውም ዓይነት ክንዎች ልጅ/ቷ በራሱ/ሷ እንድትተማመን እድል ይሰጣል?
4. አንዳንድ ሀሳቦችን በመለዋወጥ ከልጅ ጋር ይወያያል?
5. ሲያልፉ/አቸው ለማይችሉ ጥፋቶቹ/ቷ የዱላ ቅጣት ይሰጣል?
6. አብራችሁ ከልጅዎት ጋር ወደውጭ ወጣ ማለትና አብሮ ገበያ ሸርሸር ይሄዳል?
7. በመማር ማስተማር ሂደት ውስጥ ለልጅ/ቷ ቤት ውስጥ እርዳታ ያደርጋል?
8. ልጅዎት ትምህርታዊ የሆኑ መልዕክቶችንና ቁም ነገሮችን ከራዳዮ፣ ከመዕሀፍትና ቱሌቪዥን የመሳሰሉትን እንዲያደምጥ፣ እንዲያነብና እንዲመለከት ያበረታታል?
9. ት/ቤት ልጅ ከመግባቱ/ቷ በፊት ፊደል እና ቁጥር እንዲማር ያስተምሩት ገበር?
10. አንድ ነገር ከመስራቱ/ቷ በፊት በመጀመሪያ አቅድ እንዲኖረውና ደረጃ በደረጃ በአቅድ በመመራት ነገሮችን ልጅ እንዲያከናውን/እንድታከናውን ያደርጋል?
11. ልጅዎት ት/ቤት ውስጥ ምን እንደተማረ/ች በየዕለቱ ይጠይቃል/ይከታተላል?
12. ይህንም ሁኔታ በመከታተል በየዕለቱ ለልጅዎት አስተያየትና ምክር ይሰጣል?
13. ከቱሌቪዥንና ከራዲዮ ያገኛቸውና አዳዲስ ነገሮች ለልጅዎት እንዲያውቀው ይናገራሉ/ ከልጅዎት ጋር ትወያዩበታላችሁ?
14. ከቤት ውስጥም ሆነ ከቤት ውጭ (በአካባቢው) ልጅ/ቷ እንዲጫወት በተገቢው መልኩ እድል ይሰጣል?
15. የት/ት ወይም የስልጠና ደረጃዎ ምን ያህል ነው? (ማንበብ መጻፍ አይችሉም፣ 1-4ኛ፣ 5-8ኛ፣ 9-12ኛ የተማሩ ወይም 12ኛ በላይ)
16. ምን ያክል የልጆች መጻሕፍትና አሻንጉሊት ቤት ውስጥ አሉ?
17. ከልጅዎት ጋር በይበልጥ ቅርብና ልጅ/ቷን ለማስተማር የመርዳት ሥሜት ያለው ሰው ካለ የት/ት ደረጃው ምን ያህል ነው? ማንበብ መጻፍ የማይችል ወይም 12ኛ በላይ)
18. ልጅዎት ሥላሳ አካባቢው እንዲረዳ/ትረዳ (ሥላሳውጭው አለለ እንድታውቅ) በጎዳና ላይና በሂደታቸው ቦታ ትምህርታዊ ገለጻ ለልጅዎ ያደርጋል?
19. ልጅዎት በማንኛውም ዓይነት ት/ቤት በከታተል ጠቀሜታ ለልጅ አለው ይላል?

20. የሚከተሉትን ነገሮች/ጉዳዮች ልጅዎት ለማወቅ ቢያንስ በሳምንት አንድ ጊዜ እርስዎን ይጠይቃል/ትጠይቃለች?

ሀ. ስለ «የሰው ልጅ መሰረታዊ ፍላጊቶቿ» ይጠይቃለች/ይጠይቃል? (ለምሳሌ አብላጫ፣ አልብሱኝ በማለት ይጠይቃል/ትጠይቃለች)

ለ. ስለ «ሥነ-ምግባር ስለ ሥነ-ተዋልዶ ጉዳዮች ትጠይቃለች/ይጠይቃል? (ለምሳሌ HIV/AIDS ምንድነው?)

ሐ. ስለ ራስ/ሷ ማንነት ተዋልዶ ጉዳዮች ትጠይቃለች/ይጠይቃል? (ለምሳሌ አባቱ፣ እናቱ፣ ወንድሜ፣ እጎቱ ማን ነው እያሉች ትጠይቃለች?)

መ. ስለ «ዘመድና ንጹህ ምን እንዲሆኑ ትጠይቃለች/ይጠይቃል?

ሰ. «ጎረቤት ስዎች» ትጠይቃለች/ይጠይቃል? (ለምሳሌ እነዚህ ስዎች እነማን ናቸው? ምን ይሰራሉ...)

ረ. ስለ ሌላ (ይግለጹ):-

21. ልጅዎት የሚከተሉት ሁኔታዎች ጊዜ ከማን ጋር በአብዛኛው (ቢያንስ በሳምንት) ማከናወን ይወዳል?

ከሚከተሉት ሁኔታዎች ጊዜ ልጅ/ልጅ ከ _____ ጋር _____ ማከናወን ይወዳል

ሀ. በሥራ/ትምህርት ጊዜ » ከ _____ ጋር _____ ማከናወን ይወዳል

ለ. በባህላዊ ክንዎኔዎች (በዘፈን/በዳንስ) ከ _____ ጋር _____ ማከናወን ይወዳል

ሐ. የቤት ውስጥ ሥራዎችን ለመሥራት ከ _____ ጋር _____ ማከናወን ይወዳል

መ. ለማንበብ፣ ለማዳመጥ ሥዕል ለመሰል ከ _____ ጋር _____ ማከናወን ይወዳል

ሠ. በንጹህ ጊዜ ከ _____ ጋር _____ ማከናወን ይወዳል

ረ. ለማውራትና ለማዳመጥ ከ _____ ጋር _____ ማከናወን ይወዳል

ሰ. በምግባር በመኝታ ጊዜ ከ _____ ጋር _____ ማከናወን ይወዳል

ሸ. ወደ ት/ቤት በሚሄድበት ጊዜና በት/ቤት ሲመለስ ከ _____ ጋር _____

ማከናወን ይወዳል።

DECLARATION

This thesis is my original work and has not been presented for a degree in any other university and all sources of material used for this thesis have been duly acknowledged.

Name Aschalew Mesfin Haile

Signature 

Date June 6, 2007

This thesis has been submitted for examination with my approval as a university advisor.

Name _____

Signature _____

Date of Approval _____