

**ATTITUDES OF PARENTS TOWARDS THEIR  
MENTALLY RETARDED CHILDREN: A RURAL  
AREA EXAMINATION**

**BY**

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**Attitudes of parents towards their mentally retarded children: a rural  
area examination**

by

**Nancy Govender**

A dissertation submitted in partial fulfillment of the requirements for the degree of Master of Arts (Clinical Psychology) in the Department of Psychology University of Zululand.

**SUPERVISOR: PROF N.V. MAKUNGA**

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**TABLE OF CONTENTS**

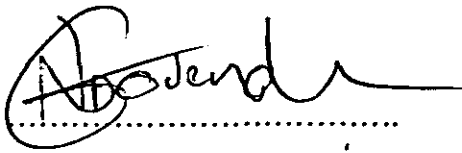
	<b>PAGES</b>
<b>CHAPTER ONE: INTRODUCTION</b>	<b>1</b>
<b>CHAPTER TWO: LITERATURE REVIEW</b>	<b>8</b>
<b>CHAPTER THREE: RESEARCH METHODOLOGY</b>	<b>49</b>
<b>CHAPTER FOUR: PRESENTATION AND ANALYSIS OF DATA</b>	<b>55</b>
<b>CHAPTER FIVE: DISCUSSION AND CONCLUSION</b>	<b>65</b>
<b>REFERENCES</b>	<b>68</b>

## **APPENDICES**

- APPENDIX A - English Questionnaire**
- APPENDIX B - Zulu Questionnaire**
- APPENDIX C - Permission requested from Thuthukani Special School**
- APPENDIX D - Permission granted by Thuthukani Special School**
- APPENDIX E - Attitudes of parents as reflected by themes**

## DECLARATION

I hereby declare that this is my own work and all the sources I have used or quoted have been indicated and acknowledged by means of complete references.

A handwritten signature in cursive script, appearing to read 'Nancy Govender', written over a horizontal dotted line.

**NANCY GOVENDER**

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## **D E D I C A T I O N**

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## ABSTRACT

This study examined attitudes of parents towards their mentally retarded children in rural areas of Zululand. The study sample was obtained from a local hospital, a clinic and a special school for the mentally retarded in the Zululand area.

The findings of this study revealed that parents in rural areas of Zululand have positive attitudes towards their mentally retarded children. There were no differences between the attitudes of mothers and fathers with both parents having more positive attitudes. This study further revealed that parents in rural areas of Zululand loved and accepted their mentally retarded children. However, the majority of parents were found to be disappointed by having a mentally retarded child and expressed feelings of embarrassment.

In the light of these findings further research areas is recommended with the aim of using such information to build appropriate and successful rehabilitation and intervention programs for mentally retarded children and their parents.

## CHAPTER 1

### INTRODUCTION

The 19<sup>th</sup> century saw a “strong awakening of interest in humane treatment of the mentally retarded” (Anastasi, 1982 p.5). However, examining some of the writings of the 20<sup>th</sup> century (Huey, 1912; Fernald 1912 in Anastasi, 1982; Foster, 1990), the attitudes of those purportedly concerned with the mentally retarded seemed anything but humanitarian. Parekh and Jackson (1997) make an important point, that a common perception exists that mentally retarded children are social outcasts, due to the stigmatizing consequences of the process of labeling. Foster (1990) also, agree that the treatment of mentally retarded people has been characterized by neglect and abuse. In support of this notion Gilbride (1993) maintain that despite advances in public policy and legislation, significant barriers towards people with mental handicaps still exist. Attitudes held by both the general public and the key players, especially parents in the person’s life are often cited as an important component of the “handicapping” environment (Hahn, 1982; Yunker, 1988).

An attitude may be defined as the individual’s tendency to react positively or negatively to some person, object, situation, institution or event (Aiken, 1985; Thomas, 1982). This definition concurs with that of Graham and Lilly (1984) who describe an attitude as an opinion about something, reflecting how favourable people are towards groups, people, ideas or issues. Kagan and Havemann (1980) also, refer to an attitude as an organized and enduring set of beliefs and feelings, predisposing us to behave in a certain way. Kagan and Havemann (1980) explain that it is the emotional component

of an attitude that distinguishes it from a belief. In this study the term 'attitude' will be used loosely to cover parent's behaviour, perceptions, reactions, values, feelings, etc.

## **MOTIVATION FOR THE STUDY**

The most important figure in the child's immediate environment is a parent. Increasingly, parents are also involved in caring for their children who are mentally retarded.

A child with such a disability may have anxiety, fear, shame or other negative feelings. These reactions usually reflect how the child has been treated by others especially the family (Thompson & Rudolph, 1996). Literature has shown that parents' attitudes are critical to the successful caring of children with illness. For instance, Atkinson and Coia (1995) point out that the way parents' react to an ill child partly depends on how they perceive the illness and the practical impact the illness has on them. Similarly, parents' reaction to a child with mental retardation will depend on the parents' attitude towards mental retardation. McConachie (1986) agrees that parents' attitudes are an important source of information about their behaviour towards their children. Hence the present study attempts to examine how parents' of mentally retarded children view and cope with the situation.

## **STATEMENT OF THE PROBLEM**

When a child has a disability, family problems (which the child can sense) increase. Demands for energy, time and financial resources add a heavy burden of stress.

Emotionally, the greatest risk to which most mentally retarded children are exposed is the loss or lack of adequate relationship with an adult caregiver. This loss/lack has profound implications (Bowlby, 1988).

Mentally retarded children are particularly vulnerable to a range of negative attributions. The most powerful of these is likely to be the position of “social reject” to which, inevitably, they are subjected. Mentally retarded children are socially marginalized and rejected by almost all sections of the community. Nevid, Rathus and Greene (2000) agree that people who have mental retardation are often demeaned and ridiculed.

However, it should not be assumed that because most people find it stressful to care for a relative with mental retardation that all parents would experience stress. Nevid, Rathus and Greene (2000) argue that there are considerable cultural variations in family members’ reactions towards mental retardation. Since cultural beliefs help determine whether people view behaviour as normal or abnormal, parents from different cultures will judge unusualness from different perspectives.

Almost no research has been conducted on the attitudes of parents in rural areas of KwaZulu–Natal, who have a child with a mental disability and the effect which their attitudes might have on their child. Yet according to McConachie (1986) parents’ attitudes are an important area of inquiry in search for improved services to families of mentally handicapped children and again, parental attitudes play a major role in the treatment and diagnosis of the mentally retarded child.

The present study thus hypothesized that, as with other people, contact with a mentally retarded child alone will not result in positive attitudes. In this study, it is specifically hypothesized that only those parents of children who did not view their child's disability as central, did not view their child as different, incompetent or inferior and did not feel they were unable to cope with the disability would demonstrate positive attitudes towards children with mental disabilities.

### **OBJECTIVE OF THE STUDY**

The main objective of the present study was to assess the attitudes of parents in rural areas of Zululand towards mental retardation.

### **DEFINITION OF OTHER KEY TERMS**

#### **Mental Retardation**

The American Association on mental retardation (AAMR) defines mental retardation as a significantly sub-average general intellectual functioning resulting in or associated with concurrent impairments in adaptive behaviour and manifested during the developmental period, before the age of 18 (Drew, Logan & Hardman, 1992; Kaplan & Sadock, 1998).

The fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) defines mental retardation as a significantly sub-average general intellectual functioning that is accompanied by significant limitations in adaptive functioning in at least two of the following skill areas: communication, self care, home-living, social/inter-personal skills, use of community resources, self-

direction, functional academic skills, work, leisure, health and safety. DSM-IV allows for four grades of severity: mild, moderate, severe and profound mental retardation. (American Psychiatric Association, 1994; Kaplan & Sadock, 1998).

The 10<sup>th</sup> revision of *International Statistical Classification of Diseases and Related Health Problems* (ICD-10) currently in use in some countries around the world refers to mental retardation as a condition resulting from a failure of the mind to develop completely (World Health Organization, 1993 in Kaplan and Sadock, 1998). According to ICD-10 mental retardation is a condition of arrested or incomplete development of the mind characterized by impaired developmental skills that contribute to the overall level of intelligence (Kaplan & Sadock, 1998). ICD-10 suggests that cognitive, language, motor, social and other adaptive behaviour skills are affected and thus should be used to determine the level of intellectual impairments.

For the purpose of this study the definition of mental retardation as provided by DSM-IV will be accepted as DSM-IV is the classification system that is widely used even in South Africa.

## Parents

Authors of English Dictionaries (Brown, 1993; Simpson & Weiner, 1989; Hughes, Michell & Ramson, 1992) provide various definitions for the term parent (plural, parents):

- a person who has fathered or given birth to a child

- a biological father or mother

- a person who has adopted a child
- a person who holds the position or exercises the functions of such a parent, a protector, a guardian

However Mabalot (2000) argues that a 'real' parent is a responsible person who takes an active part in the child's life. For this study a modified definition based on one provided by Mabalot (2000) will be used. A parent thus would be defined as a responsible person who takes an active part in a child's life, irrespective of whether this person is the child's biological mother or father.

## **Children**

Authors of English Dictionaries (Brown, 1993; Simpson & Weiner, 1989; Hughes, Michell & Ramson, 1992) provide various definitions also for a child (plural, children):

- a young human being below the age of puberty
- an unborn or newborn human being, foetus, infant
- one's son or daughter at any age
- A young person of either sex below the age of puberty, a boy or girl.

The United Nations Convention on the rights of a child held at Turkey in 1999 refers to children as persons who have not completed their eighteenth year of age, unless under the law applicable to the child, do not attain legal age (United Nations Convention, 1999). In this study the definition of a child

by the Oxford Dictionary (Brown, 1993; Simpson & Weiner, 1989; Michell & Ramson, 1992) as one's biological, adopted or foster son or daughter at any age is accepted.

### **Rural Areas**

According to Small (2001) 'ruralness' is best thought of as a construct, with meaning provided by the particular context in which it is described. Contexts which provide meanings of rural areas include: demographics (whether there are few people in a given location, or whether the number of people is low given the available space), economics (an area may be defined as rural based on a single dominant economic activity, usually farming), social (the values, behaviours, beliefs and or feelings of individuals living within a particular community), psychological (ruralness can also be thought of as a state of mind. Individuals self identity as being members of a rural community), cultural (city dwellers are perceived to be fast-paced, heterogenous, and easily adjustable to change while rural residents are perceived to be slow-paced, homogenous and reluctant to give up tradition).

The above definition provides a comprehensive understanding of the term 'rural area' as used in this study.

## **CHAPTER 2**

### **LITERATURE REVIEW**

#### **INTRODUCTION**

Mental Retardation is a source of pain and bewilderment to many families. Its history dates back to the beginning of man's time. The idea of mental retardation can be found as far back in history as around 1500 BC in Egypt (Scheerenberger, 1983).

The objectives of this chapter are to provide the reader with an overview of mental retardation, a developmental disability with a long and sometimes controversial history and to examine cultural influences on judgements of children with a disability. Rehabilitation of children with a disability will also be discussed.

#### **A HISTORICAL REVIEW ON MENTAL RETARDATION**

##### **In Western countries**

Words used in earlier times to refer to people labelled mentally retarded included imbecile, feeble-minded, moron and defective (Trent, 1995). As time progressed these terms were replaced by word such as mental defectives, high grade and low-grade imbeciles, and higher functioning mentally retarded. All these words reveal the meaning people attached to mental retardation. These terms were changed even more recently to "persons with developmental disabilities" or "persons specially

challenged” with the intention of reducing the negative stigma associated with mentally retarded individuals (Trent, 1995). The plight of individuals with mental retardation has been dependant on the customs and beliefs of the era and culture or locale.

During medieval times, individuals with disabilities, including children were frequently sold to be used for entertainment or amusement (Scheerenberger, 1983). Many of the unfortunate victims that were hounded and destroyed, during the early seventeenth century, were people of low intelligence (Marais & Marais, 1976).

Trent (1995) indicates that from time immemorial people with mental retardation in America were an expected part of rural and small town life. Mentally retarded individuals with physical disabilities usually received care from extended families. When the family broke down they would usually be placed with neighbours, or in almshouses (indoor relief as it was known) and those who were capable of breaking the law were placed in local jails. It is evident from literature (Trent, 1995) that people with mental retardation might have been teased, pitied, their habits would disgust others, however, unlike criminals they were not feared.

A cornerstone event in the evolution of the care and treatment of the mentally retarded was the work of a physician, Jean-Marc-Gaspard Itard, who in 1800 took charge of a boy named Victor found living in the forest in France. At about age 12, Victor was found to be deaf and mute with little understanding of anything beyond his basic needs. Although the boy was declared to be an idiot by Dr Philippe Pinel, Itard believed that intensive training could transform him into a normal, intelligent being. Itard developed a broad educational programme for Victor to develop his senses, intellect and emotions.

Although after five years Victor continued to have significant difficulties in language and social interaction, he acquired more skill and knowledge than many of Itard's contemporaries believed possible. Itard's educational approach became widely accepted and used in the education of the deaf (Scheerenberger, 1983). Edward Seguin, a pupil of Itard, impressed with Victor's achievements developed interest in the problems of mental retardation and opened the first school for mental defectives in Paris in 1837, using his own invention and some of the principles developed by Itard. The work of Itard and Seguin had influenced people like Dr Maria Montessori, who then opened her own school in Rome in 1896 (Marais & Marais, 1976).

Reports of successful education of disabled children in France and England led to key developments occurring in the United States. Residential training schools were established. During the early part of the 20<sup>th</sup> century, residential training schools proliferated and individuals with mental retardation were enrolled. But when training schools were unable to "cure" mental retardation, they became overcrowded and many of the students were moved back into society, where the focus of education began to change to special education classes in the community (Trent, 1995).

According to Trent (1995), training schools, which were initially more educational in nature, became custodial living centers, hence between 1910 and 1950 institutionalized care for people with mental retardation was popular. After World War II, institutions were housing more and more disabled people with fewer and fewer resources. As a result of the disillusionment with residential treatment, custodial care was no longer acceptable in the 1950's through the 1970's. Hence the Wyatt – Stickney federal court in the 1970's was a landmark class action suit in Alabama establishing the right to treatment of individuals living in residential facilities (Sheerenberger, 1983). Between 1950 and 1970 state

authorities built, refurbished and added more public facilities than in any period in the American history. The community model, which was prominent among mental health supporters was talked about in meetings of the Association for Retarded Citizens. State officials were also concerned about community placement. Between 1880 and 1950, mental retardation had largely been seen as a problem of lower class individuals and this group was regarded as a threat to the social order. However, after the early 1950's, Americans were more and more likely to see retarded people as human beings (Trent, 1995). Today, most states guarantee intervention services to children with disabilities between birth and 21 years of age (Sheerenberger, 1983).

The test of intelligence developed by Binet was translated in 1908 by Henry Goddard and in 1935 Edgar Doll developed the Vineland Social Maturity Scale to assess the daily living skills / adaptive behaviour of individuals suspected of having mental retardation (Sheerenberger, 1983). Psychologists and educators now found it possible to determine who had mental retardation and provide them with appropriate training and residential training schools.

It is clear from literature (Sheerenberger, 1983; Trent, 1995) that presently few mentally retarded people live in large state operated institutions. In communities, many intellectually disabled people are part of innovative learning, occupational and living arrangements. According to Trent (1995), mentally retarded people who have money, supportive relatives and understanding neighbours and employers do well in American communities.

## In South Africa

According to Foster in Lea and Foster (1990), in South Africa mental handicap was treated as a form of insanity throughout the earlier periods. In the days of the Dutch East India Company there was a strong belief among white settlers that lunacy was the result of demoniac possession. There was very little mention of mental disorders as a disease. Individuals with mental disabilities were confined at places such as the first hospital (opened in 1656), the slave lodge or the convict station of Robben Island (Foster, 1990). Later on in 1846 an asylum was formally established on Robben Island under British rule (Minde, 1974 in Foster, 1990). Robben Island was characterised by very poor conditions such as overcrowding, unsatisfactory food, lack of facilities for recreation and games and the only treatment available was of a purely physical nature (Minde, 1974 in Foster, 1990). Robben Island was closed as a lunatic asylum in 1920 after inquiries and numerous complaints on the conditions (Foster in Lea & Foster, 1990). Other asylums established throughout the country during the period from 1876 to 1895 were also characterized by overcrowding and inadequate facilities. Foster (1990) explains that lunatics were only segregated from other patients as a specific class of patients by the turn of the 20<sup>th</sup> century. In the mid 1860's lunatics were classified according to gender and race, that is 'European' and 'coloured' (Moyle, 1987 in Foster, 1990).

Foster in Lea and Foster (1990) indicates that the notion of mentally handicapped or defective persons was barely acknowledged and hardly treated as a separate category in the whole of the 19<sup>th</sup> century. Real concern for the issue of mental defectives dates only from 1913. A committee investigating the treatment of lunatics stressed the shortage of accommodation and noted that the large number of insane and feeble-minded people was a serious danger to future generations (Foster in Lea & Foster, 1990). In

1901 in England there had been a change in terminology, the 'feeble mind' was now being referred to as 'idiot'. Thus in the proposed new Lunacy act for the Union, the committee recommended that offensive terms, used to describe individuals who needed special care and treatment, be avoided. In 1913, the under-secretary for education pleaded for an estimated 2000 mentally defective European children to be educated and cared for by the central authority (Foster in Lea & Foster, 1990). In June 1913 a meeting was held in Cape Town to begin steps for raising funds to develop a scheme for the care, protection and training of the feeble-minded persons (Minde, 1975 in Foster 1990). The *Girls and Mentally Defective Womans Protection Act no.3 of 1916* prohibited unlawful (other than between husband and wife), 'carnal connection with any female idiot or imbecile' with severe penalties for those who attempted to or went against the act. Foster in Lea and Foster (1990) explains that this act was concerned with social control. Subsequent to the legal recognition to the category of 'mental defectives' in the 1916 Act, there was a flurry of activity over the following three decades regarding this problem category (Foster in Lea & Foster, 1990). According to Foster social control, rather than humanitarian care and concern for this newly recognised category of person was the dominant organising motive over this period.

An intense new approach to handicap by the state was only noticed in the 1920's and 1930's. 'The linking of handicap to IQ, the rise of the mental testing movement, the preferential treatment of white persons, the institutionalisation of defectives, the problems associated with administrative spheres of responsibility, the differentiation of types of mental handicap (in particular the start of special education for milder versions), race segregation and the linking of mental handicap to other forms of deviance, were all issues of concern in the 1920s' (Foster in Lea & Foster, 1990).

In 1927, importance and the need for child guidance clinics to conduct initial assessments of handicap as well as provide guidance to 'parents was recognised. A psycho-educational clinic designed to determine the extent of feeble-mindedness was opened in Bloemfontein in 1927. The division of authority for mentally handicapped following the Special Schools Act No. 9 of 1948, indicated that lower grade handicapped fell under the Department of health. The only facilities available were the large 'asylum' type institutions (Alexandra, Umgeni, Witrand) or licensed homes, were the dominant policy was custodial and basic physical care and no education was provided for. Provincial educational authorities were given the responsibility for the 'higher grade' of mentally handicapped children, roughly those in the IQ range 50 to 80. Compulsory and free education was provided for in special classes and schools (Foster in Lea & Foster, 1990).

According to Foster in Lea and Foster (1990) during the period from the mid 1960's to the late 1970's the training for more severely handicapped was recognised. This period, as Foster (1990) further maintains was the beginning of a more outwardly-oriented approach where milder forms of mental handicap began to fall increasingly under educational authorities and gradually extending to more severe forms. Shifts towards community based and day-centre approaches in mental health societies and other voluntary associations occurred, but mainly for whites and on a limited scale when compared to Europe and North America. Discrimination and racial segregation remained firmly entrenched because statutory provision for black persons with mental handicap appeared for the first time only around 1980 (Foster in Lea & Foster, 1990).

In the 19<sup>th</sup> century 'idiots' were classed alongside other outcasts i.e. the insane, lepers, the chronic and poor sick. In the early 20<sup>th</sup> century 'defectives' were associated with delinquency, prostitution,

criminality, the 'poor white' and other social problems. Mental handicap has throughout this period, in legal terms, been associated with insanity. In the 1980's according to Foster in Lea and Foster (1990) mental handicap has been further stigmatized as it has been classed with the disabled, that is, the deaf, blind and the crippled.

The apartheid era (post 1948) has been characterised by the systematic extension of racism in all aspects of mental health. Foster in Lea and Foster (1990) state that prior to 1948, even though racism was evident in practise, no specific reference to 'race' was made in mental health legislation. However, from 1960 onwards laws pertaining to mental handicap specified separately for different 'population groups'. During this period, broad trends of change took place. There was a shift from custody to treatment, from incarceration and segregation to outpatient and community based interventions, and in the case of mental handicap, from little or no intervention to a recognition of the need for education and training. It was only in 1974 that the more severely handicapped became known as 'mentally retarded,' however, this was applicable only to white children. Special education for black mentally handicapped children was only introduced in terms of the Education and Training Act No. 90 of 1979 which provided for both categories, the 'educatable' (or handicapped) and the 'trainable' or 'mentally retarded child' (Foster in Lea & Foster, 1990).

After 1965, apartheid was firmly established and in South Africa black resistance was largely crushed. This period was characterised by a period of 'moral panics', concern about inadequate controls for more widely differentiated sets of social misfits which led to inquiries into areas such as drugs, alcohol, minimal brain dysfunction, mental handicap, mental derangement, the mental health act, sterilization, etc. (Foster in Lea & Foster, 1990).

In the early 1980's in terms of the Manpower Training Act No. 56 of 1981, vocational training centre schemes for mildly retarded people were added to existing sheltered employment facilities. However, these facilities were largely for white persons. In the mid to late 1980's, it was evident that there was a renewed state attention that was concerned with the issue of disability in general and including mental handicap. Foster in Lea and Foster (1990) indicates that for the first time there was open recognition of the massive shortfall in services for black handicapped persons along with calls for improvement and co-ordination of services for all 'race' groups. Even in the last decade of the 20<sup>th</sup> century the apartheid based separate provisions was still in the statute books. It may be only in 1994, when the first democratic elections was held, that people of all race groups were allowed to make use of the available facilities for people with mental retardation.

Considerable changes were evident within the approach to mental health from 1960 onwards in South Africa, but more especially in Western Countries (Foster in Lea & Foster, 1990; Trent, 1995). These shifts were away from segregation to more active treatment, together with movements away from incarceration to voluntary, consent and more community oriented interventions. There were attempts to normalise the experiences and circumstances of the mentally ill and handicapped, and to reduce the move away from the stigmatising effects of categorisation and institutionalisation. From the 1960's to the 1980's facilities in general were increased substantially. However, according to Foster in Lea and Foster (1990), some of these changes were evident in South Africa, but at a slower pace, mainly concerning whites with little exposure to the fierce attacks against professionals or institutionalisation.

Foster in Lea and Foster (1990) states that in South Africa not a great deal has occurred in terms of real change with regards to mentally handicapped people. Foster notes that a change has come about in the

recognition of educational needs, but effectively only for whites. According to Foster, the rhetoric of greater community based policy for mentally handicapped has been present since the Van Wyk report of 1967, but not many of their long list of services have been implemented. Some developments, which were rather slow, have taken place in wider sites of facilities for handicapped persons, such as sheltered and protective workshops, day-centres and social clubs, but they were mainly for white persons. The questions of normalisation, advocacy movements, self-help organisations, community support networks and human rights of persons with mental handicap have hardly been raised in this country, until recently (Foster in Lea & Foster, 1990, p.62).

According to Gqubule (1987) provisions for the black mentally retarded was started by welfare and private organisations such as mental health societies and churches. The government has only recently joined with these bodies to provide for the mentally retarded among blacks. The new constitution gives all persons with mental handicap equal rights with every other citizen in the Republic of South Africa. However, Kathleen (1996) states that given the current social and economic climate in South Africa, it seems unlikely that much will be accomplished in the short term. The above-mentioned author believes that it is unlikely that the government would be prepared to allocate an enormous sum for the re-location of those persons with mental handicap who at present are housed in deplorable conditions in mental institutions.

## **CLASSIFICATION OF MENTAL RETARDATION**

The Diagnostic and Statistical Manual of Mental Disorders presents four categories and dimensions based on intelligence quotients (IQ) to classify mental retardation, that is: mild mental retardation (IQ

level 50-55 to approximately 70), moderate mental retardation (IQ level 35-40 to 50-55), severe mental retardation (IQ level 20-25 to 35-40) and profound mental retardation (IQ level below 20 or 25) (American Psychiatric Association (APA), 1994). Kaplan and Sadock (1998) add that these levels of mental retardation reflect the degree of intellectual impairment.

People with mild mental retardation develop social and communication skills during the preschool years (ages 0-5 years) and they often are not distinguishable from children without mental retardation until a later age. They can acquire academic skills up to approximately the sixth-grade level. As adults they may need supervision, guidance, and assistance. They can usually live successfully in the community, either independently or in a supervised settings (APA, 1994).

Individuals with moderate mental retardation acquire communication skills during early childhood years. They profit from vocational training and with moderate supervision, can attend to their personal care. They are unlikely to progress beyond the second grade level in academic subjects. As adults they are able to perform unskilled and semi-skilled work under supervision in sheltered workshops or the general workforce (APA, 1994).

During their early childhood years individuals with severe mental retardation acquire little or no communicative speech. During the school age period they may learn to talk and can be trained in self-care skills. However, they are limited in terms of instruction in pre-academic subjects, such as learning the alphabet and simple counting. As adults they are able to perform simple tasks in closely supervised settings (APA, 1994).

Most individuals with profound mental retardation have an identified neurological condition that accounts for their mental retardation. They display considerable impairments in sensorimotor functioning during their early childhood years. Motor development and self-care and communication skills may improve if appropriate training is provided. Some can perform simple tasks in closely supervised and sheltered settings (APA, 1994).

### **REACTIONS OF PARENTS TO HAVING A MENTALLY RETARDED CHILD**

Early parental reactions following the diagnosis of a handicap of a child include ambivalence, anger, confusion, denial, self pity, blame, feelings of helplessness, depression, disappointment, grief, guilt, mourning, rejection, shock, impulses to kill the child and suicidal impulses (Mary, 1990; McConachie, 1986; Ntombela, 1991). McConachie (1986) quotes several authors such as Drotar, Baskiewicz, Irvin, Kennell and Klaus (1975); Cunningham and Davis (1985) who described parents reactions in terms of stages. According to these authors a state of shock is experienced at the initial disclosure, i.e. a feeling of not being able to register or understand the news and thus withdrawing. This will be followed by a reaction stage, during which emotions of denial, sadness, anger, etc., may be felt in a rush. Then gradually parents will enter an adaptation stage when they, for example, begin to ask questions about what can be done, and finally a reorganisation stage when they seek help and begin to plan ahead (p.45).

McKeith (1973) states that parents reactions will be influenced by a number of factors such as: whether the handicap is evident at birth or becomes evident later; whether there is a prospect of severe

mental handicap or not; whether the handicap is obvious to other people and by the attitudes of other people such as lay people, teachers, social workers and doctors to handicap and handicapped people.

In her study of the reactions of Black, Hispanic, and White mothers to having a child with handicaps, Mary (1990) found that almost all mothers reported strong feelings for their child immediately after receiving the news of the disabling condition. The most commonly expressed negative emotion was a feeling of grief or sorrow, which had lessened over time. There were also reports of the negative feeling of shock and guilt which had also lessened over time. The mothers that reported considering suicide were mothers of children with severe retardation. The study also revealed that Hispanic mothers reported an attitude of self-sacrifice towards the child and greater spousal denial of the disability more often than did the other mothers. Both Hispanic and White mothers often reported stages of reaction from strong negative feelings to later periods of adjustment. Overall the study revealed a common and universal reaction of love and sorrow across cultures and level of retardation.

Similar reactions of shock, surprise, anxiety, disbelief and disappointment by mothers was found by Kromberg and Zwane (1993) in their study of Down Syndrome in the Black population in the Southern Transvaal. Many of the mothers in this study had been very upset, wept and withdrew. Some had felt physically sick, tired, helpless, numb, faint and cold after learning of their child's diagnosis.

According to Rawlins (1983), a recent development in the literature is the acceptance of the dynamic nature of the interaction between the parents and the handicapped child. Walter and Stinnet (1971) suggests that because both parties (parents and children) are interacting with each other, the attitudes of

rents do change from one of numbing, shock, rejection and depression to one of acceptance and understanding as the child grows older (cited in Rawlins, 1983, p.96).

McConachie (1986) states that strong initial reactions by parents are affected by the manner in which they are informed of their child's disability. Parents who were informed 'well' reported primarily feelings of sadness rather than of anger (Cunningham & Davis, cited in McConachie, 1986). Ntombela (1991) adds that parents are unlikely to accept that their child is extremely mentally handicapped if they are informed late and in an impersonal manner (p.15). According to Hannam (1975) cited in Ntombela (1991) "there is no good way of letting parents know that their child is mentally handicapped, but there must be ways of not making a bad situation worse" (p. 15).

Swinstein, Nadler and Rahav (1991) state that the higher levels of acceptance of a mentally retarded child by their parents are associated with greater coping efforts by relying either on self (i.e. self-help efforts) or others (i.e. help-seeking).

## **ACTORS AFFECTING A MENTALLY RETARDED CHILD**

### **Education**

A study conducted by Govender (1984) revealed that there was a significant difference between the predictions of parents of scholars and parents of non-scholars regarding the future functioning of their respective children. Parents of scholars had a more optimistic attitude regarding the future functioning and independence of their children than parents of non-scholars. This study also found that parents of

non-scholars who were optimistic about their child's future tended to view their children's condition in a less threatening light and described their conditions as slight. This study looked only at parents of physically disabled and chronically ill children. However, mental retardation is a chronic condition, which very often is accompanied by physical disabilities. Thus the findings of the abovementioned study can to an extent be generalised to parents of mentally retarded children.

### **Loss of a significant caregiver**

Pringle (1975) state that there is a wide variety of circumstances that leads to the separation of children from their families. These may include chronic mental or physical illness and desertion or death of parents or significant caregivers. When this happens, substitute care for the mentally retarded child is sought. The child may end up being cared for by another family member, fostered or placed in an institution. According to Pringle (1975) the removal of a child to an unfamiliar environment causes great distress, more especially if the child is young and has a limited understanding of verbal explanations. The child may feel insecure and blame his naughtiness for the loss of his/her loved one. "However adverse a home, the child lives in familiar surroundings and is looked after, however inadequately by familiar people. Being taken from it means the collapse of the world he has accepted and trusted as the only one he knows" (Pringle, 1975, p. 135).

Children with a disability may not be as easily accepted into the homes of others as children without a disability. According to Pringle (1975) adequate physical care is not sufficient to ensure satisfactory emotional, social and intellectual growth. The loss of a significant care-giver for the mentally retarded child implies, in most situations, the loss of the only person who understood and loved him/her.

## The future in terms of employment

As a move towards normalization, a number of programs have been developed in South Africa and abroad to teach vocational skills to individuals with mental retardation. Seyfarth, Hill, Orelove, McMillan and Wehman (1987) state that some of these programs have helped workers with mental retardation to gain employment in which they work beside and perform the same tasks as non-handicapped workers. Seyfarth et. al., (1987) further state that while these vocational training and placement have important benefits to the people involved, such as enhanced feelings of efficacy and self-worth, there are also dangers and disadvantages as well, such as the possibility of physical injury, exploitation, abuse and loss of guaranteed financial aid payments. Success in a given job, according to Seyfarth et. al., (1987) is influenced by many factors other than mental ability and there are threshold requirements in most occupations that close out some persons from entering those fields. For mentally retarded people, even the logistics of daily life, such as telling time or travelling on a public transportation system, are challenges that limit their immediate prospects to gain employment (Seyfarth et. al., 1987).

All parents hold idealized expectations of their child's potential and prospects in the world of work (Venn, Dubose & Merbler 1977; in Seyfarth et. al., 1987), which may be either realistic or unrealistic (Johnson & Capobianco 1957; in Seyfarth et. al., 1987). Seyfarth et. al., (1987) conducted a study in Virginia on the factors that influence parent's vocational aspirations for their children with mental retardation. The sample consisted of mothers or fathers of persons with mental retardation who were 17 years of age or older. Some of the factors that they found to be significant were: parents attitudes towards work as a normal part of life; the child's age and the child's developmental level. Parents

disagreed that work should be a normal part of life for their sons and daughters. Parents of older persons held lower aspirations for their sons and daughters as compared to parents of younger persons. Parents of children with higher developmental functioning held higher vocational aspirations for their children when compared with parents whose children functioned at lower developmental levels. Characteristics such as the child's sex and parents education were found to have little or no impact on the parent's vocational aspirations for their mentally retarded children.

In a study on the factors relating to the employability of persons with intellectual disability, Rimmerman (1998) found that persons with mild rather than those with moderate intellectual disability were preferred for employment.

The government in 1996 released a Green Paper on Employment and Occupational Equality. The aim of this paper is to minimize barriers to people from historically disadvantaged groups and accelerate hiring, training and promotion. According to Kathleen (1996) this proposed equalization plan appears to include disabled persons. However from the changes that have been implemented following this paper, it seems that people with physical disabilities are only included. The likelihood of large industries and company's hiring an individual with a mental disability is minimal. Thus it is highly unlikely that a mentally retarded person would be able to secure unsheltered employment.

## **IMPACT OF SOCIAL/ENVIRONMENTAL AND CULTURAL FACTORS ON A MENTALLY RETARDED CHILD**

### **rural environment**

Health services such as occupational therapy, physiotherapy, speech therapy and psychological services are generally limited or not available in rural areas. Also transport to such services is a limitation. Without these services it becomes almost impossible to assess and treat individuals with disabilities. As a result these individuals may lose out on provisions made by the state to assist them such as the single care grant.

### **Socio-economic factors**

A family's socio-economic status plays a major role in the well being of a mentally retarded child. The family income will determine factors such as the type of housing, eating habits, child rearing practises and the type of medical treatment that can be afforded. Thus a low socio-economic status will impact negatively on the type and quality of care a mentally retarded child receives.

Islam, Durkin and Zaman (1993) found in their study of the socio-economic status and prevalence of mental retardation in Bangladesh that the prevalence of mild mental retardation was strongly and significantly associated with low socio-economic status (SES), while the association for severe mental retardation was weak and not significant. The sample included in this study was 2 to 9 year old children from the five regions of Bangladesh. A two-phase study design was followed in each

community. In the first phase, a house to house survey was conducted, and all 2 to 9 year old children were screened for disability. Information on a variety of indicators of (SES) such as parental education and occupation, land ownership, household possessions and housing conditions was collected. The second phase included the referral of all children with positive screening results and a random sample of 8% of those who screened negative for professional evaluation of mental retardation. Some of the factors that were found to have high factor loading on a single factor and to be internally consistent, with an alpha coefficient of .79 were: mother's education; father's education; main occupation of head of household and ownership number of household possessions (such as radio, television, bicycle, motor cycle, boat, cow and others) and housing conditions (number of rooms, individuals per room, floor material, source of drinking water and electricity). The authors of the above-mentioned study state that their findings is consistent with that of observations in developed countries of a strong association between the prevalence of mild mental retardation and low (SES) and a weaker or possibly no association between the prevalence of severe mental retardation and low (SES).

### **Cultural factors**

An individuals cultural and religious belief will impact significantly on their attitudes towards people with mental retardation. According to Sibaya (1993) the Black man's way of life was pervaded with strict attachment to prescriptions and his outstanding characteristic was order. Any deviation from the established norms and rules was subject to correction, discipline and extinction. Thus implicit in this desire for order and coherence was the fear and intolerance for the odd and unusual. Hence the birth of twins was an unusual occurrence; sickly, malformed children (e.g. severely mentally retarded) and a

number of individuals born at the same time were killed. Some of the explanations provided for the killing of these children were that they were bad omens and it was a disgrace for a human female to have offspring in a litter and their disfiguration was horrible (Kidd, 1906; Krige 1965, cited in Sibaya, 1983). Sibaya (1983) points out that this practise could have been a way of eliminating or eradicating the strange or unusual individual so that order could be maintained. It could also have been a way of sparing the handicapped person the suffering he or she would have to endure if allowed to live, or it could stem from a primitive religious belief that the exceptional individual did not belong to this world but had mistakenly come from the world of the ancestors. However, according to Vilakazi (1962) these primitive customs and practises had stopped with the spread of Christianity in Africa.

In Zulu traditional society, according to Laubascher (1937), mental retardation was not conceived as a weakness of the mind and a permanent mental defect but as delayed maturity and a slowness in the whole growth process. There was great tolerance and acceptance and people were prepared to wait, from year to year, for the 'child' to mature, according to their standards of judgement. Gqubule (1987) states that mentally retarded children were given the status of children and were not given tasks beyond their capacities. The people believed that abnormalities cannot affect the mind as a natural process. Any condition that produced an alteration of the mind, other than *ukutwasa*, was considered to be witchcraft (Laubascher, 1937).

Sibaya (1983) states that despite the drastic changes that have taken place in the past 80 years there is an inclination towards communality amongst Blacks. Blacks tend to put community interests before personal interests. Hence, Sibaya (1983) suggests that there is a positive perception of the handicapped person in the community.

In traditional Zulu culture, according to Ntombela (1991), the saying that *akusilima Sindleb'ende Kwabo* meant that even the mentally retarded child was accepted as a member of the family. The parents were hopeful that the child would be cured of the handicap if some beast is slaughtered and they pleaded with the ancestors. A piece of the skin of the slaughtered beast was then tied around the wrist of the handicapped child. Ntombela (1991) points out that this belief is gradually disappearing, as most Black people are becoming urbanised and adopting western culture. He adds that the pressures of industrialization and the movement from the extended family to the nuclear family make it difficult for the handicapped child to be readily accepted nowadays. Ntombela (1991) attributes this to the fact that there is often nobody around to look after the child when the mother goes out to fend for the other members of the family. He states that Christianity has also caused many Blacks to rely more on God for their needs than on the ancestors.

Davis, Oliver, Tang and Wu (2000) state that generally people in Western countries tend to possess more accurate information, demonstrate more positive attitudes, show more social acceptance, and are more supportive of the integration of people with mental retardation (p.75). However, they state that Asians tend to hold more moralistic, individualistic and fatalistic views of the condition. They quote an example from Chen and Tang (1997) and Cheung and Tang (1995) that in Chinese societies having a offspring with mental retardation is regarded as a form of punishment for parents violation of Confucian teachings, such as dishonesty, misconduct, or filial impiety. It is believed that the families, rather than the societies, should bear the full responsibility of these people. However, according to Cheung and Tang (1997) as cited in Davis et. al., (2000), Chinese families often engage in either avoidance coping strategies, such as wishful thinking, denial, and social withdrawal, or appeal to

supernatural power to deal with the situation and reject social integration of these family members to minimize the stigma attached to mental retardation.

## **THE ROLE OF PARENTS IN THE DEVELOPMENT OF THE MENTALLY RETARDED CHILD'S SELF CONCEPT, SELF ESTEEM AND SOCIAL FUNCTIONING**

Govender (1984) states that all children regardless of the severity and type of disability they have will develop self images and feelings about who they are and how they think others perceive them. According to Pringle (1975) the attitude of the significant others in the child's life determines how the child feels about himself/herself and about his/her handicap. The nature, severity and onset of a disability impacts less on how the child will function in the future, when compared to the impact of the attitude of his parents, first and foremost, and then of those of his peers, teachers and eventually society (Pringle, 1975). Grebler (1952) also believes that the parent's attitude towards their child impacts greatly on the child's sense of self. "A child's personality is mainly formed by his parents attitudes towards him, and a child's attitude towards himself is conditioned by the parents attitudes" (Grebler, 1952, p.475).

The most "significant others" in a mentally retarded child's life are their parents who are seen as primary socializing agents. This is in view of the fact that children with severe disability tend to be somewhat more sheltered than other children therefore their most frequent and intense interactions are even more likely than those of normal children to be with parents and other family members (Govender, 1984). Govender (1984) further maintains that handicapped children will have positive self concepts if they are defined positively by their "significant others" and negative self concepts if

their "significant others" do not evaluate them highly. Thus the role of parents and others such as siblings is of vital importance, especially for the mentally retarded child whose inter-personal experiences are mainly within the family context.

## **ATTITUDES ON MENTAL RETARDATION**

### **Attitudes towards mild, moderate, severe and profound retardation**

In an investigation of the attitudes of female undergraduate students towards mentally retarded persons, Gottlieb and Siperstein (1976) in Ferrara, (1979) found that they had more favourable attitudes towards mildly retarded persons than towards severely retarded persons.

Gottlieb and Siperstein (1980) conducted another study in which they examined parents and teachers attitudes towards mildly and severely mentally retarded children towards school and community integration practises. The sample consisted of only adult women. The study showed that the women were not generally supportive of school integration for severely retarded children, while they felt that regular classes would help the mildly mentally retarded to learn more and become more socially acceptable. The study also showed a difference in the women's attitude with regards to the prognosis of the mildly and severely retarded children with regards to living a normal life. The women felt that the severely retarded could not be expected to learn to live a normal life and reach a level of functioning equal to normal children. With regards to community integration, Gottlieb and Siperstein (1980) found that the severely retarded child is viewed as less of a threat. The explanation they offer

to this finding is that in the community neither children nor teachers are forced to come into contact with the severely mentally retarded child.

In a comparative study of perceptions of parents towards their mentally retarded children Greene (1970) found that there was a significant difference in the perception of parents towards their retarded children depending on the severity of the child's retardation. No literature was located on attitudes towards moderate and profound retardation. These two categories of mental retardation was found to be generally ignored in the literature.

#### **Attitudes of both parents**

In an investigation of the attitudes of parents of retarded children, living in a rural section of Western Minnesota, Condell (1966) found that some parents found it hard to accept that the child was mentally retarded and agreed that they needed help in getting more knowledge about the child's condition, they recognized a mistake in not seeking help earlier. The parents were satisfied with the attitudes and behaviour of their neighbours in relation to the retarded child. According to Condell (1966) parents of retarded children showed great concern and anxiety about the future, particularly the child's future. Parents wondered what would happen to the child if something should happen to them. This study also revealed that parents like to talk to other parents of retarded children since it creates a type of common bond and there can be an exchange of ideas. The study further showed that the largest number of parents continue to wish that their child could be normal.

According to Grebler (1952) it is assumed that parental attitudes towards mentally retarded children are magnified in their expression by the frustrating experience of having given birth to and bringing up a mentally retarded child. The above-named author examined parental attitudes towards mentally retarded children as reactions to frustration. The findings of this study were as follows:

- The feelings of parents of mentally retarded children are exposed to an experience of frustration due to elements inherent in the child's condition and the limitations imposed upon them by the outside world
- The parents react to this frustration in terms of their own personality problems
- Their reaction to the child's mental retardation is inter-related with their general attitude towards the child
- Parents who tend to condemn the outer world for the child's mental retardation tend to reject the child
- Parents who react with emotions of guilt and condemn themselves shows ambivalence towards the child, while parents who don't express any blame show acceptance of the child
- Due to unfavourable parental attitudes, mentally retarded children show behaviour problems, which in turn prevent them from using even their limited capacities

Ntombela (1991) states that emotional stress of parents is unavoidable due to the constant physical care, financial demands, restrictions placed on their normal lifestyles, the disappointment of having a handicapped child, the guilt feelings arising from their anger and rejection of the child and concerns about his/her future and life-long care.

According to Ntombela (1991) a common attitude of parents is *Hyperpaedophilia*, which is the pathological over-attachment to the child. When this happens the parents love for the handicapped child develops into a grossly exaggerated devotion and over-protectiveness which negatively affects the life and needs of other members of the family (Boswell & Wingrove, 1974 in Ntombela, 1991).

### **Attitudes of mothers**

Mothers generally occupy the position of greatest responsibility in familial child care and therefore, play a important role in determining the impact that retarded children have on their families (Gumz, 1972). According to Ntombela,(1991), apart from social and emotional problems, mothers suffer actual physical stress because of the higher mobility of the handicapped child, and the obesity and respiratory infections which are common amongst children with a severe mental handicap. Rangaswami (1995) conducted a study to determine parental attitudes of mothers towards retarded children with and without behaviour problems, from both rural and urban areas in Madras, India. This study revealed that the overall attitude of mothers of retarded children with and without behaviour problems differ significantly. The mothers of mentally retarded children with behaviour problems were found to have a significantly higher negative attitude towards their retarded children. Rangaswami (1995) state that the mothers of retarded children with behaviour problems have a problem in accepting their children. The findings of this study showed that the mothers of mentally retarded children are not hopeful about education, future of the children, home management and they also feel more hostile towards their children. According to Rangaswami (1995) the birth of a retarded child shatters the hope and aspirations, leading to hopelessness and negative attitude towards the child. This negative attitude as Rangaswami further maintains, can be a function of the degree of retardation, problem behaviour,

burden on the family, etc.. However, Condell (1966) points out that a mentally retarded child who does not experience acceptance and security in his house is in greater danger of developing behaviour difficulties than a normal child.

Weinger (1999) argues that although in practise the principle care-giver role in the family is usually assumed by the mother, she has socialized to sacrifice her own needs for the benefit of other family members. According to Weinger, "if this broader perspective is recognized, the mother and family may realize how the political has become personal, and free themselves from a facile acceptance of the way things have been" (p.76). This feminist perspective as Weinger (1999) further maintains will assist practitioners to reach out to mothers to assure them that their behaviours are based on choice rather than on feelings of powerlessness or necessity.

### **Attitudes of fathers**

There are very few studies available on the relationship between fathers and their mentally retarded children. This could be related to the fact that previously fathers did not take on an active role in their child's life. However, presently fathers are also very involved in the care of their children. Thus the attitudes of fathers will impact significantly on the mentally retarded child's sense of self.

In a study conducted almost three decades ago, Gumz (1972) found that father's perceptions of their mentally retarded child were more instrumental while mothers were more expressive. Fathers concerns centered mainly around the impact of the mentally retarded child on the family budget and the cost of providing help for the child, whether the child will achieve academic success and support him/herself

in adult life and whether the child could be a leader, a 'winner' and be able to stand up for himself. Mother's concerns generally focused on the emotional strain of caring for the retarded child, whether the child will be accepted by others and will be happy regardless of academic achievement or job success. The findings of this study may not be very relevant to the present time as the roles of mothers and fathers in family life have changed considerably.

### **Attitudes of siblings**

Ntombela (1991) describes some of the feelings and the effects that the brothers and sisters of a mentally retarded child experience. These feelings range from jealousy, shame, guilt, to frustration. The siblings may feel jealous and even rejected, as the mentally retarded child demands the parent's attention. These feelings are exacerbated by the material deprivation they may also experience due to the increased financial responsibilities towards the disabled child. They may feel ashamed and as a result become socially isolated as they feel that they cannot invite their friend's home, as other children often tease them. Frequent feelings of guilt, a tendency to blame the handicapped sibling for the problems in the family and depression may develop over a period of time. The siblings may feel frustrated due to the parents restrictions concerning the kind of games and outings in which their handicapped child and his/her siblings may be involved, so as to protect the handicapped child from injury. There is also concern regarding the freedom that normal brothers and sisters enjoyed prior to the birth of a child with a handicap and the chores and responsibilities assigned to them as a result of parent's involvement with the handicapped child.

According to Weinger (1999) siblings with more approving attitudes towards their brothers or sisters with mental retardation are more likely to perceive their family as being more emotionally responsive to each other.

### **Attitudes of teachers and students**

Due to the amount of contact that teachers have in most mentally retarded children's lives, their attitude would impact significantly on these children. A study conducted by Efron and Efron (1967) revealed that special class teachers expressed more favourable attitudes to the mentally retarded than do teachers of ordinary children (Rawlins, 1983).

According to Gotlieb (1975), in Rawlins (1983), only a small minority of teachers is in favour of integrating the mentally retarded into regular classes. He offers an explanation that "regular education teachers do not possess special positive attitudes towards children labelled mentally retarded (p.120). Gotlieb suggests that the move towards integration should be accompanied by programmes designed to influence and change teacher's attitudes to a more positive one.

A study conducted by Stephen and Braun (1980), in Rawlins (1983), showed that teachers who had taken courses in special education were more willing to accept handicapped children into their classrooms than were those who had not taken such courses.

In a cross-cultural study of attitudes towards the mentally retarded in South Africa, Rawlins (1983) found that Zulu teachers and Zulu University students strongly rejected the mentally retarded. However, the study also revealed that Zulu high school pupils were more accepting of this disability.

In his study of the perception of Black University students of the handicapped person in a Zulu speaking community, Sibaya (1984) found that student's attitudes were favourable towards the handicapped. However, the author reports incongruence between student's beliefs and behaviours. The study has revealed a tendency of the students to avoid contact with handicapped people. Rawlins (1983) attributes this rejection of mental retardation to the elevated status and authority given to individuals with advanced education, more especially in the Zulu culture. According to Gqubule (1987) Blacks in South Africa perceive higher education as a means to improve both their political and social lives and thus would reject anything that represents the opposite.

Johnson (1950) in Rawlins (1983) found that mentally retarded children were the most rejected children in twenty regular classes. Johnson concludes that these children were rejected because of their behaviour in the classrooms, playground and behaviour outside the school environment. Rawlins (1983) also cites a study by Lapp (1957) with contrary findings. He found that mentally retarded children were more rejected among their peers in special classes than among their peers in regular classes. Rucker, Howe and Sniden (1969), in Rawlins (1983), found that mentally retarded children in regular classes have a lower social status and are less well accepted by other children. Gottlieb (1975), in Rawlins (1983) looked into the acceptance of the retarded by their non-retarded peers. He suggests that retarded children are very seldom chosen as 'a best friend', irrespective of the organizational context of special classes or integrated settings.

Davis, Tang, Oliver and Wu (2000) found in their study of Chinese children's attitudes towards mental retardation that these children demonstrated favourable attitudes towards mental retardation and school integration. When compared to a sample of Irish children, the Chinese children were more positive towards school integration and were more willing to have social interactions and form social relationships with people who are mentally retarded. The study also revealed that younger Chinese children in kindergarten, as compared to older children in primary and secondary schools, tended to show the most positive attitudes towards mental retardation. However the authors state that it is unclear how these children attitudes will correspond to their actual behaviours in real life situations as in Chinese families small children are often trained to be polite and nice to people, especially those that are less fortunate than themselves.

### **Attitudes of employers**

Rimmerman (1998) states that the attitudes of employers play a major role in determining the success of employing workers who have been labelled with mild and moderate intellectual disability. According to Rimmerman (1998) employing such individuals not only reduces support and treatment costs of caring for these individuals and allows them to pay taxes, but also improves their self-confidence and independence.

Larger companies have been found to be more positive in their attitudes towards hiring persons with disabilities than small companies (Levy, Jones-Jessop, Rimmerman & Levy, 1993, in Rimmerman, 1998, p.246). Hartlage (1974) in Rimmerman (1998) found that corporate executives who were less educated are more biased against individuals with intellectual disability and therefore would be less

receptive to their employability. However, Posner (1968) in Rimmerman (1998) reported that less educated corporate executives may place less emphasis on the educational accomplishments of persons with disabilities and may be more favourable towards hiring them. Rimmerman (1998) state that the attitudes of corporate executives towards the employability of people with intellectual disabilities can be significantly related to their prior experiences with those persons. The author found in his study that corporate executives that had previous contact with persons with intellectual disability tended to be more favourable towards their employability. Rimmerman (1998) cites a study conducted by Levy et. al., (1992) that found that executives who had contact with persons with disabilities in the corporate work force expressed more favourable attitudes than executives who had no such prior experience.

Rimmerman (1998) found that corporate executives prefer to employ persons with intellectual disability who have vocational and social skills, and they avoid hiring persons whose intellectual disability raises concerns about their ability to integrate in the workplace.

In a study conducted by Florian (1974) in Rimmerman (1998), it was found that most of the corporate executives offered technical reasons, such as a lack of available positions or the lack of specific job skills as an explanation of their unwillingness to hire individuals with disabilities. Most of the employers indicated that economic benefits and/or legislation would not change their attitudes towards hiring individuals with disabilities.

## **Attitudes of rehabilitation workers and other people in helping professions**

Rutledge and Scott (1997) state that the trend towards deinstitutionalization and the movement of more mentally retarded people into community settings implies that more physicians are caring for mentally retarded patients in their daily practises. Thus physician's negative attitude will have a detrimental effect on the delivery and outcomes of medical services and may influence the beliefs and attitudes of others who assist in this health care. In a study on medical student's attitudes towards people with mental retardation, Rutledge and Scott (1997) found that most of the medical students did not have negative attitudes towards people with mental retardation. Seventy-seven percent of the students were willing to work with mentally retarded patients after they completed their training and 95% felt that people with mental retardation should live in the community.

Marais and Marais (1975) condemn those professionals who adopt a "clinical detachment" from their patients/clients and feel that such professionals should be working in a different field. The nature of such professional work according to Marais and Marais (1975), entails an intimate understanding of all the functions of their patient/client, yet there are some professionals who never touch them, never talk with them, but only at, about or through them and when discussing their interest with colleagues, refuse even to consider their feelings or those of their families. The above-named authors quotes two examples of personal contact with such professionals. They mention a hospital social worker who always kept a polythene cover on the passenger seat of her car when transporting mentally handicapped patients and a consultant psychiatrist who habitually talks about handicapped young people in their presence but without reference to them, using the third person, and very often the impersonal pronoun 'it'.

## THE EFFECT OF EDUCATION, SOCIAL AND EMPLOYMENT EXPERIENCE ON ATTITUDE CHANGE

In a study of the acceptance of mental retardation and help-seeking by mothers and fathers of children with mental retardation, Lewinstein, Nadler and Rahav (1991) found that parents who are more educated, belong to a higher social class, and have fewer children accept their child's retardation better and tend to cope with emerging difficulties by approaching external helping sources.

Nunnally (1961) in Sewpaul (1985) concluded through a series of classroom studies that it is more difficult to establish effective communication programmes for changing attitudes than for increasing popular knowledge. A study conducted by Morrison (1977) in Sewpaul (1985) indicated that negative attributions to mental patients can be changed in a positive direction by means of educational seminars. This study demonstrated that college student's attitudes towards mental illness can be changed effectively by means of didactic presentations, which do not reflect a medical paradigm. In a study which looked at high school students attitudes towards mental illness, Nunnally (1961) in Sewpaul (1985) found that students attitudes improved after receiving didactic presentations on mental illness. He concluded that attitudes towards mental health concepts can be improved and that these improvements last. However, according to Sewpaul (1985), researchers such as Attrocchi and Eisdorfer (1961) and Jaffee et. al., (1979) claim that didactic teachings alone are inefficient agents of attitude change.

Sewpaul (1985) makes a point that practical experience does play a role in attitude change. She describes a study by Gelfand and Ullman (in Rabkin, 1972) that compared the attitudes of student

nurses assigned to a psychiatric programme with the attitudes of nurses in non-psychiatric programmes. The study showed that students in the psychiatric programmes became significantly less authoritarian in their responses as compared to the student nurses that were not in the psychiatric programme. Sewpaul (1985) state that didactic teaching together with personal contact with mentally ill patients, and effective supervision, would be effective in allowing students to gain a sounder knowledge and more favourable attitudes of mental illness and the mentally ill.

## REHABILITATION/INTERVENTION

Ferrara (1979) states that the goal of rehabilitation and intervention is based on the assumption that after training, retarded individuals will acquire behaviour patterns that will ensure either full or partial integration into the 'normal' life setting and will be able to meet some or all of the expectations of society. Parental attitudes play a major role in the rehabilitation and treatment of the mentally retarded child (Witter, 1972; in Ferrara, 1979). In an investigation of attitudes of parents of mentally retarded children towards normalization activities, Ferrara (1979) found that parents of retarded children were more positive when these activities referred to a general group (mentally retarded persons) rather than to their own child. According to Ferrara (1979) the study indicates that parents will exercise their legislative prerogative and refuse such services for their child. Ferrara (1979) states that there is a need for parent-specific counselling and/or training as an integral part of the child's normalization plan. The author further states that a failure to meet this need will result in the defeat of normalization on a practical level. Ferrara (1979) states that in order for normalization activities to become realities for mentally retarded children, the attitudes of their parents must be assessed and areas of conflict and concern resolved. The information obtained from such an assessment, can assist policy makers and

implementers to construct strategies that will prevent or minimize a conflict between theory and practice (Ferrara, 1979).

According to Gqubule (1987) the aim of assessment is to intervene so as to effect positive changes in growth and development. The four main categories of intervention approaches in mental retardation are: the educational approach; behaviour modification and management; psychotherapeutic and the medical approach.

The behaviour modification approach aims to increase the repertoire of behaviour and skills through direct and indirect methods. The psychotherapeutic approach underlies attempts aimed at effecting positive changes in personality and social functioning. The educational approach, according to Hutt and Gibby (1976 in Gqubule, 1987) represents an attempt to evaluate carefully the capacity of each child and to assist in developing them to the highest degree of which he/she is capable of. Some of the skills, which are taught through special education, are aimed at protecting the mentally retarded child against common dangers, managing his/her social and economic affairs, accepting social responsibility and to contribute meaningfully to society. The socio-cultural approach, which appears to be the most widely used approach, stresses the role of culture and social agents in cognitive growth and development. It involves analyzing the physical and economic needs of the client and seeks ways and means of providing basic needs of food, clothing, shelter, medical care and school requirements. It also uses social, welfare, state agencies and other agents to secure sponsorships and a single care grant. The choice of approach, however, will depend on its suitability to the condition, the circumstances of the client and the intervention context (Gqubule, 1987).

The general objective of all intervention approaches is to help the retarded person to function comfortably and adequately at the present time and to prepare him for adequate functioning (within limitation of his capacity) as an adult (Blake, 1976; in Gqubule, 1987). Gqubule (1987) maintains that with training the client will be able to reach independence in basic self-care; perform (under supervision) useful domestic chores and occupational skills of sewing, knitting, packing, etc., but will need constant supervision in social and economic affairs. Functional academic achievements will be at a simple level of single word recognition, writing and simple number concept.

Nabuzoka and Ronning (1993) discuss the design and evaluation of intervention programs that are aimed at promoting the integration of children with disabilities in mainstream schools. Some of the interventions that they found to be useful in promoting interaction and social behaviour between children with and without intellectual disabilities were play-skills training of children with disabilities accompanied with teacher prompts and a 'special friends approach'. An increase in social behaviour was noticed in both the experimental and natural situations when the 'special friends' approach, associated with the non-disabled children taking the role of initiators of interaction was utilized.

## **FACILITIES AVAILABLE FOR REHABILITATION OF MENTALLY RETARDED INDIVIDUALS**

The role of special care centres are to provide day care facilities, residential care and stimulation programmes for the mentally retarded child (Ntombela, 1991). Day care facilities give the mother some relief from her emotional and physical stress while the child is away. Residential care are for

mentally retarded children whose parents are not able to look after them at home or who have no access to day care centres. Children who are so profoundly mentally retarded require residential care where all the necessary treatment facilities are available. Stimulation programmes assist the mentally retarded child to develop motor, sensory, communication and self-help skills as well as elementary health habits, depending on the degree of the child's handicap.

Historically in South Africa there appears to be no or very little provisions and facilities for people with mental retardation. Shirley (1996) states that there is no evidence to indicate that child patients were included among the so-called lunatics confined in asylums in South Africa prior to 1894. She thus makes the inference that mentally retarded children died in infancy, or remained in the custody of their families regardless of the severity of their handicap until reaching adulthood. Shirley further states that during this period no mention is made of the availability of educational or training facilities in South Africa.

The earliest proposals for special classes or special schools for mentally defective children did not come from a governmental source but from the South African Society for the Care of the feeble minded in 1913 (Vitkus, 1987; in Shirley, 1996). It was only in 1921 when the first institution, i.e., the state funded Alexandra institution in Cape Town, was opened for the training of the feeble-minded in South Africa. Feeble-mindedness at that time was not recognised in any other race thus this school catered only for white children. It was only in the 1940's that a change in perception towards the mentally retarded became apparent. There was a focus on the training of males in useful occupations with the assumption that they will earn a living in the open labour market. The assumption for the training of females was that most of them would marry and become parents (Shirley, 1996).

Shirley (1996) conducted personal interviews with parents in South Africa and in the U. K. in the 1990's. She found that parent's preferred that their mentally handicapped child be placed in a special class attached to an ordinary school. Parents felt that there would be less stigma attached to inclusion in a special class rather than in attending a special school. Attendance at a special school would have also resulted for many parents in their child living away from home. Thus the majority of parents were in favour of special classes (Shirley, 1996). However, there are both advantages and disadvantages in placing a mentally retarded child in a special class in mainstream school or placing them in a special school.

In the mid 1980's some of the facilities available for moderately and severely handicapped children included: special care centres (which is a day or residential centre catering for profound and severe range of intelligence); training centres (catering for the upper severe through to moderate intelligence) and a work and occupation centre (which are protective workshops and other settings, both day and residential, that provides regular employment for mentally handicapped adults). In the mid 1980's, in addition to the above, special pre-schools, for children below the age of seven, became available. However, this facility was only for whites (Shirley, 1996).

After reviewing the number of persons in need for special care facilities, according to race, Shirley (1996) makes a point that while the mentally handicapped of any race were disadvantaged, black mentally handicapped persons were even more so. In post apartheid South Africa, with a new Democratic government, and with the collapse of the previously racially biased Departments of

Education and Culture, one would assume that special care facilities are available to people of all race groups.

According to Shirley (1996) the needs of mildly mentally handicapped adults in South Africa were largely ignored, until recently. However, Shirley further states that an awareness of this need by Mental Health Societies has resulted in the provision of protective workshops and farms, for example, the recently established Sunnyside Protective Farm at Bulwer, KwaZulu-Natal. After personal interviews and observations, Shirley notes that a substantial change has taken place in these workshops from the mid 1980's to the mid 1990's. In the 1980's contract work was scarce and frequently the young people were under-employed. By the mid 1990's the quantity and quality of work at these workshops had improved. The increased training programmes for the workers allowed them to branch into unexplored areas of furniture repairs and certain forms of contract work which required slightly more skill than in the past. Shirley states that a new sense of purpose is apparent in the workshops and many are achieving a genuine sense of job satisfaction.

Sheltered workshops are mainly situated in urban areas. However, Mental Health Societies are currently increasing the number of sheltered farming schemes for young adults with mental handicap. These schemes also provide residential accommodation for the participants. The ultimate goal of such schemes is the ability to compete in the market place (Shirley, 1996).

Shirley (1996) agrees that even though some of these schemes are situated in rural areas they are presently not catering for mentally retarded individuals among rural communities. Currently what is happening is that residents from urban institutions are being translocated to the rural ones. One of the

major concern in rural areas is that so many individuals who are mentally retarded remain unidentified and consequently are deprived of appropriate care and education (Shirley, 1996). According to Gqubule (1987) almost all training centres for African mentally retarded children are situated in places where children remain in their homes, or are accommodated in foster homes, and benefit from services of special schools and whatever resources, such as social and welfare services, that are available.

Shirley (1996) further reports that according to the mental health societies involved the results of the established farms are positive. However, the main concern of workers in the State sector of mental health is whether the new government will provide sufficient funding to allow for the continuance of service provision. Ntobela (1991) adds that the lack of special care centres is a factor, which has a negative effect on the family of a mentally handicapped child. This is particularly so among Black rural communities where the lack of such facilities, especially the residential special care centres, is critical (Ntombela, 1991).

## **CHAPTER 3**

### **RESEARCH METHODOLOGY**

Makunga (1988) states that a researcher has many possible methods of investigation to choose from depending on the question that is being asked. In research the first step is to determine what is to be done in the study. Cherulnik (1983; in Makunga 1988) refers to this as the research design and Kerlinger (1973; in Makunga 1988) calls it the research programme.

#### **The current study**

The present investigation sought to canvass the attitudes of a range of parents with the aim of delineating how those suffering from mental retardation are perceived by others.

The study was designed to be carried out in two phases namely the exploratory or pilot study and the main study.

#### **PHASE I – PILOT STUDY**

Before embarking on the main study an exploratory study was undertaken to help identify problem areas in the use of the instrument identified for collecting data. A total of 25 questionnaires were distributed to parents of pupils at Thuthukani Special School and 16 returned representing a response rate of 64%. Table 1 shows the response rate of subjects in the pilot study.

**TABLE 1 - Response rate of subjects in the Pilot Study**

<b>PARTICIPANTS</b>	<b>DISTRIBUTED</b>	<b>RECEIVED</b>	<b>%</b>
Parents	25	16	64

Bush and White (1995) agree that with 64% of the questionnaires returned, the response rate can be regarded as good.

The pilot study revealed certain problems in the draft questionnaire which were solved before the commencement of the main study. The feedback received enabled the researcher to identify and solve problems in respect of, for example, the relevance of questions and the format of the questionnaire.

## **PHASE II - MAIN STUDY**

### **Method**

#### **Sample**

The subject pool consisted of 62 parents of mentally retarded children in KwaZulu-Natal. The majority of the sample consisted of parents with children attending Thuthukani Special School which caters mainly, for children from rural areas. The rest of the sample were parents of mentally retarded children who attended the Psychology Clinic at Empangeni Hospital, University of Zululand and Sundumbili Clinic in Mandeni. Forty-nine of these parents were females and 13 were males (See Table 2).

**TABLE 2 - Distribution of subjects for the main study sample**

GENDER	N	%
Females	49	79
Males	13	21
Total Sample	62	100

There was a higher proportion of females than males in the sample with approximately two-thirds females. The respondents were predominantly Zulu speaking (which reflected the dominant black language of the area in which the study was conducted). It can thus be assumed that the sample reflects to a large extent attitudes typically held by members of the "black" Zulu-speaking population group. All respondents were surveyed on a voluntary basis. Inclusion in the investigation strictly meant that a "diagnosis" of "mental retardation" to the child of a participating parent had been suggested or made by a mental health worker.

### **Confidentiality**

Makunga (1988) points out that because material revealed during research may at times be distressing to subjects, it is essential that they are reassured that their welfare will at all times be protected. Thus, subjects were assured that their answers would remain strictly confidential and that their anonymity would be protected. Subjects were informed that this data would not be released to other persons without their permission.

## **Research instrument**

A questionnaire comprising fifty statements of a Likert-type scale served as the measuring instrument. The researcher asked questions using a rating scale to obtain information that a yes/no answer would not divulge, (see Appendix A). A Likert type scale questionnaire provides questions which are standard and which can be compared from person to person. Less articulate respondents are not at a disadvantage. Respondents are also more likely to respond about sensitive issues when using such questions. Answers generated by these questions are more easier to code and analyse (Bailey, 1987; Behr, 1988; Neuman, 2000). A questionnaire as an instrument of research is extensively used and it continues to be the best available instrument for obtaining information.

The questionnaire for the present study was developed using statements from the Parental Attitude Research Instrument – PARI (Schaefer & Bell, 1958), the Thurstone Sentence Completion Test (Thurstone, 1959) and Parekh (1988). Questions were designed to provide information on parent behaviour, perceptions, reactions, values, feelings etc., which is the definition of attitude used in this study. The questionnaire was first translated into Zulu by a Zulu speaking post-graduate student in psychology. This translation was then checked by another Zulu speaking academic.

Respondents had to indicate to which degree they agree (or not) with each statement by encircling the number corresponding to one of five response categories varying from “strongly agree” to “strongly disagree.”

## **Procedure**

Research questions were distributed to parents at the end of a parents meeting held at Thuthukani Special School. Parents were first informed of the study by the school principal and then by the researcher. Parents consent to participate in the study was obtained. Parents who decided to participate were given time to complete the questionnaire. Instructions and questions were read out and explained individually to those parents who were illiterate. The same procedure was carried out at the various psychology clinics.

At the end, with questionnaires being completed, parents were thanked and informed that they should feel free to contact the researcher to discuss any issues that might have been raised by the survey. Parents were also informed that free professional counselling was available to any person who felt the need for such services.

## **Scoring**

Data collected was scored and coded by the researcher. All coding was rechecked by the researcher. Information on scoring is reported in Chapter 4.

## **Data analysis**

Frequencies and percentages of responses were tabulated for the total sample in an attempt to make sense of the data collected. Graphs and tables were also used to present findings. These results are presented in Chapter 4.

## CHAPTER 4

### PRESENTATION AND ANALYSIS OF DATA

As explained by Makunga (1988) raw data are by themselves meaningless, therefore, on completing the data collection the researcher must make sense of observed data. In an attempt to obtain answers to research questions, in this chapter data collected are presented with comments about significant findings.

#### ATTITUDES OF PARENTS TOWARDS THEIR RETARDED CHILDREN

Table 1 summarizes the responses of parents in the A, B, C, D and E categories, that is, distribution of responses along the “very negative” to “very positive” attitude continuum.

TABLE 1

CATEGORY	A	B	C	D	E
Attitude	Very Negative	Negative	Unsure	Positive	Very positive
Number of respondents	0	10	0	51	1
% of respondents	0%	16%	0%	82%	2%

The observed distribution of responses in Table 1 indicate that most respondents, that is, 82% of the subjects in the present study fell within the D category, which indicates positive attitude towards

mental retardation. Two percent of the respondents fell within the E category indicating a very positive attitude. Thus, 84% of the respondents in the present study expressed a positive attitude towards mental retardation. There were no respondents in the A or very negative and C or unsure categories. Only 16% of the respondents fell within the B category which indicates a negative attitude.

The histogram portraying this data will be as follows (see Figure 1 below).

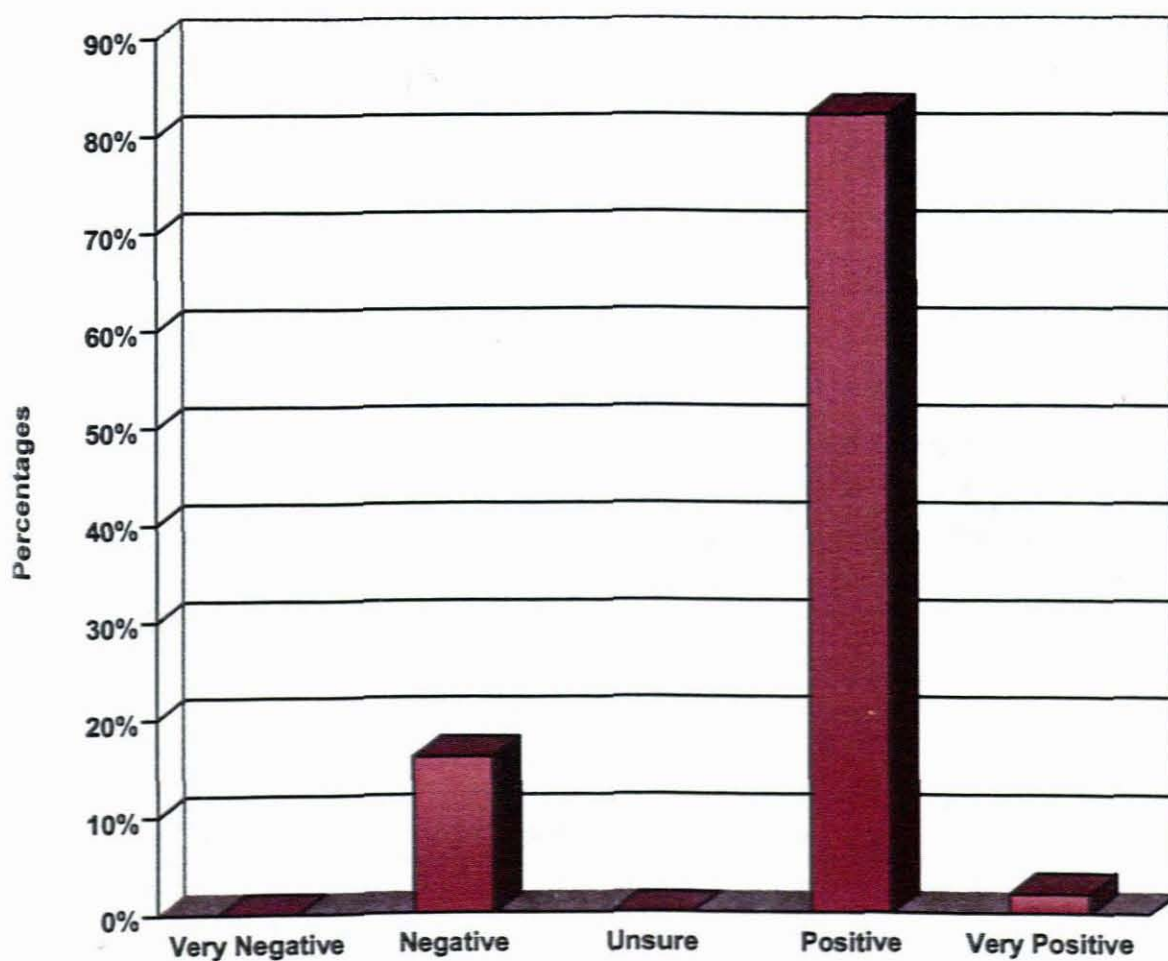


Fig. 1 Attitudes of Parents

## ATTITUDES OF MALES AND FEMALES TOWARDS MENTAL RETARDATION

Table 2 below summarizes the responses of mothers and fathers towards their mentally retarded children.

**TABLE 2**

		A T T I T U D E				TOTAL
		Positive	%	Negative	%	
	MALES	8	62	5	38	13
	FEMALES	44	90	5	10	49
	TOTAL	52	84	10	16	62

Of the 13 fathers of mentally retarded children 8 (62%) expressed positive attitudes towards their affected children and 5 (38%) indicated negative attitudes.

Forty four (90%) of mothers who had mentally retarded children indicated positive attitudes and in 5 (10%) cases negative attitudes were expressed.

Since both fathers and mothers did not display strongly negative attitudes, these were not included in Table 2.

The histogram portraying this data is as follows (See Figure 2).

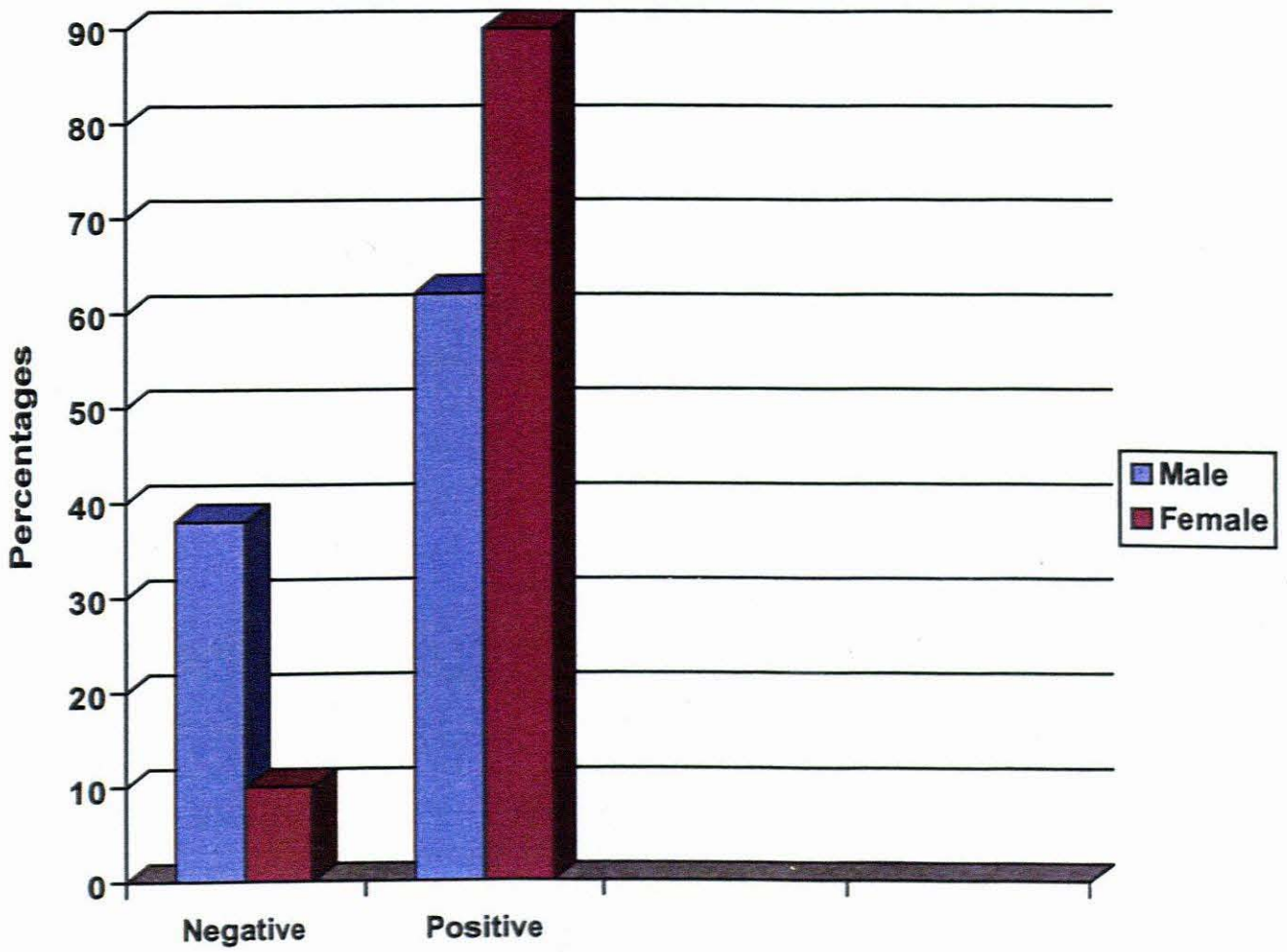


FIG. 2 Attitudes of fathers and mothers

## ATTITUDES OF PARENTS REFLECTED BY THEMES FROM THE QUESTIONNAIRE:

Five themes were drawn from the questionnaire and these included: love and acceptance, embarrassment, frustration, disappointment and over-protection (see Appendix E). The participants responses are as follows:

### Love and acceptance

The majority of parents (74%) as shown in Figure 3 responded positively to the theme of love and acceptance.

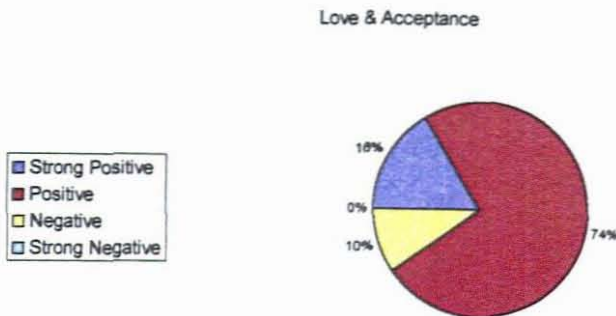


Fig. 3 : Theme of love and acceptance

## Embarrassment

As seen in Figure 4, most parents (71%) were found to have feelings of embarrassment towards their mentally retarded children

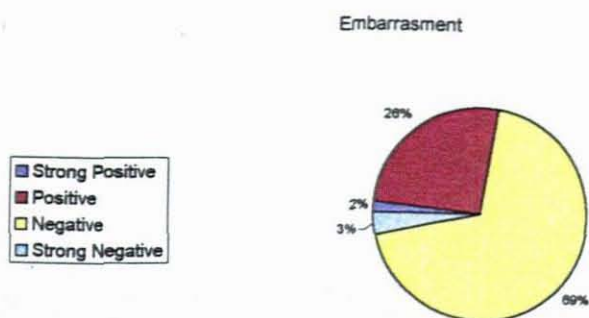
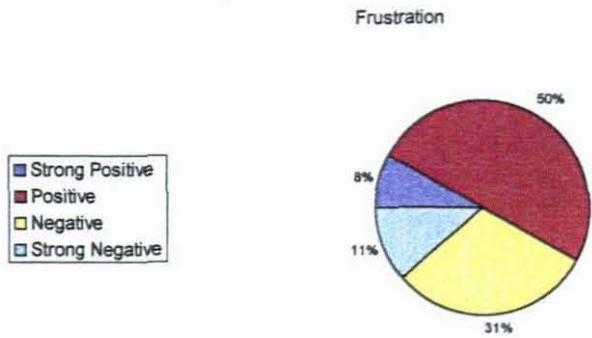


Figure 4 : Theme of embarrassment

**Frustration**

As seen in Fig. 5 below 58% percent of parents in the present study were not frustrated by their mentally retarded children while 31% were frustrated and 11% were greatly frustrated.



**Fig. 5 : Theme of Frustration**

## Disappointment

Figure 6 shows that 68 percent of parents expressed feelings of disappointment towards their mentally retarded children. Of this 68%, twenty four percent of parents were greatly disappointed by having a mentally retarded child.

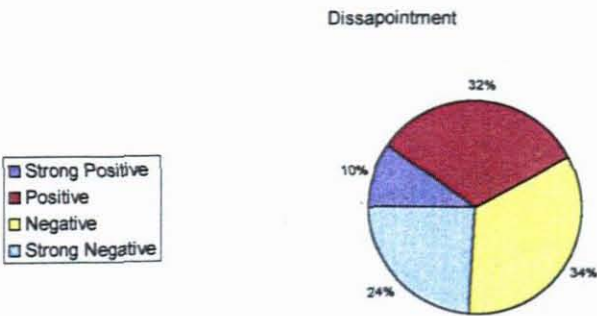
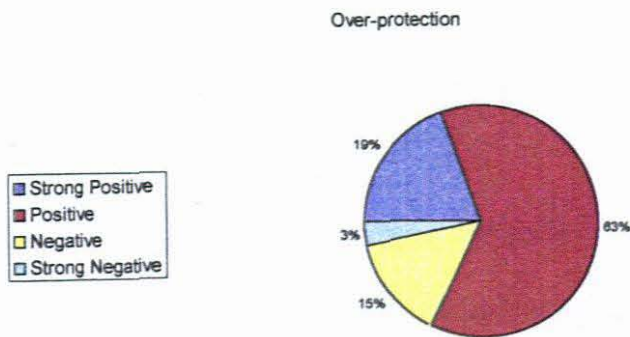


Fig. 6: Theme of Disappointment

## Over-Protection

Most parents (82%) as shown in Fig. 7 did not appear to be over-protecting their mentally retarded child, while 15% were over-protective and 3% were greatly over-protective of their mentally retarded children.



**Fig. 7 Theme of Over-protection**

## CHAPTER 5

### DISCUSSION AND CONCLUSION

The main objective of the present study was to investigate the attitudes of parents in rural areas of Zululand towards mental retardation.

The present study was conducted in response to previous work concerning attitudes towards mental retardation among samples. This work has yielded findings which have depressing implications for decisions about the treatment and management of mentally retarded individuals. This work has left an impression that mentally retarded individuals are rejected, worthless and seen as a burden.

However, the results of the present study suggest that such a scenario is not always evident. On the contrary the majority of parents in rural areas of Zululand were found to have a positive attitude towards their mentally retarded children. Although a small proportion of parents had a negative attitude, no parents were found to have a strongly negative attitude. When these findings are considered against the background of previous findings, the conclusion may be drawn that communal life amongst Blacks has led to the positive perception of the handicapped person in the community (Sibaya, 1984). It has been observed in the present study that although most mothers and fathers displayed positive attitudes, more mothers than fathers had positive attitudes. One important finding of this study is that both mothers and fathers did not display strongly negative attitudes.

Another important finding of this study concerns the fact, that irrespective of the child's disability, parents loved and accepted their children. A possible explanation may include cultural expectations in

a traditional Zulu society. According to Laubashcher (1937) and Ntombela (1991), in a Zulu traditional society and culture, there was great tolerance and acceptance of a mentally retarded child. It is possible to observe, as we have in the present study, a high rate of parents being positive towards mental retardation, given the fact that much of the rural areas in Zululand are still very traditional and rich in Zulu culture. The higher levels of acceptance of a mentally retarded child by their parents are associated with greater coping efforts by relying either on self or others (Lewinstein, Nadler & Rahav, 1991). Due to the extended family system in rural areas of Zululand the responsibility of caring for a mentally retarded child is shared. Ntombela (1991), however, explains that nowadays because of urbanization and breakdown of the extended family, mentally retarded children are not easily accepted.

The findings of the present study contradict those of a similar study conducted by Condell (1966) on the attitudes of parents of retarded children living in a rural section of Western Minnesota. According to Condell (1966) parents found it difficult to accept the presence of retardation. Thus, cultural factors do appear to play a role in the acceptance of a child who is mentally retarded.

In this study, it seems parents have feelings of embarrassment towards their mentally retarded children. This embarrassment could stem from the perceived negative attitude of the general population towards such children. According to McKeith (1973) embarrassment can lead to withdrawal from social contacts and consequent social isolation. Withdrawing from society can be detrimental to both the mentally retarded child and his/her parents.

Although parents expressed feelings of disappointment towards their mentally retarded children, they were not over-protective towards these children. Thus, hyperpaedophilia did not appear to be a significant variable in parents in the rural areas of Zululand.

However, it gives hope to observe a high number of parents being positive towards their mentally retarded children. In conclusion, the present study found that parents in rural areas of Zululand had positive attitudes towards their mentally retarded children.

The results of the present study, however, need to be treated with caution for the following reasons:

- The composition and small size of the sample, limits its representativeness thus we can not generalize from this finding. Also, the respondents were a select group of black parents, that is, those from rural areas.
- The study employed quantitative methods. In so far as this, there was a restricted exploration of underlying, ideological, issues and the respondents' subjective experiences and interpretations were ignored. Therefore, this further limits the extent to which the findings can be generalized. Further studies are required to confirm and elaborate findings of the present study. Such studies should include qualitative methods to gain access to respondents own understanding of their social behaviour.

Although the present study is limited in scope, it has provided a basis for much needed similar research in other rural areas either than those in Zululand.

## **RECOMMENDATION**

An attempt should be made to replicate this study and the present study can only be regarded as exploratory.

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## APPENDIX A

### Attitude Scale of Parents towards their mentally retarded children

(Adapted from Parekh, 1988; Schaefer & Bell, 1958; Thurstone, 1959)

***NB. All data obtained will be treated in a strictly confidential manner.***

Identifying particulars of parent:

a. Age: \_\_\_\_\_

b. Sex: \_\_\_\_\_

*Read each of the statements below and then rate them as follows:*

<b>A</b>	<b>B</b>	<b>C</b>	<b>D</b>	<b>E</b>
<b>Strongly agree</b>	<b>Agree</b>	<b>Unsure</b>	<b>Disagree</b>	<b>Strongly Disagree</b>

Indicate your opinion by placing a cross "X" in the box "A" if you strongly agree, "B" if you agree, "C" if you are unsure, "D" if you disagree and "E" if you strongly disagree with each statements.

Please note that there are no right or wrong answers.

1. When I think of my mentally retarded child, I think how lucky I am. God gave him so much more than a lot of kids have.

A	B	C	D	E
---	---	---	---	---

2. When people know you have a mentally retarded child they don't like to associate with you.

A	B	C	D	E
---	---	---	---	---

3. It would make me happy to know that my community respects my mentally retarded child.

A	B	C	D	E
---	---	---	---	---

4. Mentally retarded children will get on any woman's nerve if she had to be with them all day.

A	B	C	D	E
---	---	---	---	---

5. Mentally retarded children should be more considerate of their mothers, since their mothers suffer so much for them.

A	B	C	D	E
---	---	---	---	---

6. Raising mentally retarded children is a nerve-wrecking job.

A	B	C	D	E
---	---	---	---	---

7. One of the bad things about raising mentally retarded children is that you are not free enough of time to do just as you like.

A	B	C	D	E
---	---	---	---	---

8. Parents sacrifice almost all of their own fun for their mentally retarded children.

A	B	C	D	E
---	---	---	---	---

9. Taking care of a mentally retarded child is something that no woman should be expected to do by herself?

A	B	C	D	E
---	---	---	---	---

APPENDIX A

10. People who are mentally retarded might be a danger to society.

A	B	C	D	E
---	---	---	---	---

11. It hurts me to think that I am a parent of a child who is mentally retarded.

A	B	C	D	E
---	---	---	---	---

12. I felt disappointed when I found out that my child is mentally retarded.

A	B	C	D	E
---	---	---	---	---

13. I have accepted the fact that my child is mentally retarded.

A	B	C	D	E
---	---	---	---	---

14. I would love my child more if he/she were not mentally retarded.

A	B	C	D	E
---	---	---	---	---

15. I have contributed to my child's mental retardation.

A	B	C	D	E
---	---	---	---	---

16. The best way to discipline mentally retarded children is by hitting them.

A	B	C	D	E
---	---	---	---	---

17. I enjoy playing with my mentally retarded child.

A	B	C	D	E
---	---	---	---	---

18. I feel embarrassed to take my mentally retarded child with me when I attend functions.

A	B	C	D	E
---	---	---	---	---

19. I don't like my mentally retarded child to play with children who are not mentally retarded.

A	B	C	D	E
---	---	---	---	---

20. I give more attention to my child who is mentally retarded than my other children.

A	B	C	D	E
---	---	---	---	---

21. I don't think that my mentally retarded child would someday be able to find a partner and get married.

A	B	C	D	E
---	---	---	---	---

22. I think that someday that my mentally retarded child would get better.

A	B	C	D	E
---	---	---	---	---

23. I think that my mentally retarded child is capable of attending a normal school.

A	B	C	D	E
---	---	---	---	---

APPENDIX A

24. My mentally retarded child's problem or illnesses don't stand in the way of our family progress.

A	B	C	D	E
---	---	---	---	---

25. If my mentally retarded child were more pleasant to be with it would be easier to care for him/her.

A	B	C	D	E
---	---	---	---	---

26. Thinking about my mentally retarded child's future make me sad.

A	B	C	D	E
---	---	---	---	---

27. I don't worry too much about my mentally retarded child's health.

A	B	C	D	E
---	---	---	---	---

28. Professionals (nurses etc) in an institution would understand my mentally retarded child better.

A	B	C	D	E
---	---	---	---	---

29. My mentally retarded child feels that I am the only one who understands him or her.

A	B	C	D	E
---	---	---	---	---

30. I would rather be caring for my mentally retarded child than doing some other kind of work.

A	B	C	D	E
---	---	---	---	---

31. My mentally retarded child is very capable, well functioning person despite his/her other problems.

A	B	C	D	E
---	---	---	---	---

32. I always watch to make sure that my mentally retarded child does not do physical harm to himself/herself or others.

A	B	C	D	E
---	---	---	---	---

33. My mentally retarded child would be in danger if he/she got out of the house or yard.

A	B	C	D	E
---	---	---	---	---

34. When others are around my mentally retarded child I cannot relax, I am always on guard.

A	B	C	D	E
---	---	---	---	---

35. In his/her own way my mentally retarded child brings as much pleasure to our family as the other members.

A	B	C	D	E
---	---	---	---	---

36. I worry what will happen to my mentally retarded child when I can no longer take care of him/her.

A	B	C	D	E
---	---	---	---	---

APPENDIX A

37. I think that in the future my mentally retarded child will take up more and more of my time.

A	B	C	D	E
---	---	---	---	---

38. I am very careful about asking my mentally retarded child to do things, which might be too hard for him/her.

A	B	C	D	E
---	---	---	---	---

39. Parents should take care of their own mentally retarded children.

A	B	C	D	E
---	---	---	---	---

40. As the time passes I think it would take more and more to care for my mentally retarded child.

A	B	C	D	E
---	---	---	---	---

41. It is easier for me to do something for my mentally retarded child than to let him/her to do it for himself/herself and make a mess.

A	B	C	D	E
---	---	---	---	---

42. I feel that I must protect my mentally retarded child from the remarks of other children.

A	B	C	D	E
---	---	---	---	---

43. Sometimes I feel very ashamed because of my mentally retarded child.

A	B	C	D	E
---	---	---	---	---

44. It makes me feel good to know that I can take care of my mentally retarded child.

A	B	C	D	E
---	---	---	---	---

45. I try to get my mentally retarded child to take care of himself/herself.

A	B	C	D	E
---	---	---	---	---

46. I am disappointed that my mentally retarded child does not lead a normal life.

A	B	C	D	E
---	---	---	---	---

47. I don't mind when people look at my mentally retarded child.

A	B	C	D	E
---	---	---	---	---

48. If it was not for my mentally retarded child things would be better.

A	B	C	D	E
---	---	---	---	---

49. My mentally retarded child's need comes first.

A	B	C	D	E
---	---	---	---	---

50. I am not embarrassed when people question me about my mentally retarded child.

A	B	C	D	E
---	---	---	---	---

APPENDIX B

**OKUNGASHIWOLNEMIZWA YOMZALI ONENGANE EKHUBAZEKILE**

**QAPHELA: LONKE ULWAZI OLUTHOLAKELE LIYOTHATHWA NJENGA NEMFIHLO IMININGWANE WAKHO**

a. Umyaka: \_\_\_\_\_

b. Ubulili: \_\_\_\_\_

*Funda okungezansi ubusukunika ukubale nqalendlela:*

A	B	C	D	E
Ngiyavumelana Ngempela	Ngiyavumelana	Kanginaqiniso	Kangivumelani	Kangivumelani Sampela

Khombisa umbono wakho ngukufaka loluphawa "X" ebhokisini "A" uma uvuma kakhulu; "B" uma uvuma : "C" uma ungazi ukuthi uvume nome uphise; "D" uma uphika na "E" uma uphika kakhulu. Okufanele nikwazi yikuthi akukho impendulo ekuzona nokungezona.

1. Uma ngicabanga ngengane yami ekhubazekile ngibona nginenhlanhla ukuthi uNkulunkulu umnikeze okuningi kunezinye izingane.

A	B	C	D	E
---	---	---	---	---

2. Uma abantu bazi ukuthi unengane ekhubazeke ngokomqondo abathandi ukuzihlangenisa nawe.

A	B	C	D	E
---	---	---	---	---

3. Kungangijabulisa ukwazi ukuthi umphakathi engihlala kuwo uyayihlonipha ingane yami ekhubazekile.

A	B	C	D	E
---	---	---	---	---

4. Izingane ezikhubazeke ngokwengqondo zingazana zenze o mama bazo ukuba bahlukumezeke enhlalweni.

A	B	C	D	E
---	---	---	---	---

5. Izingane ezikhubazeke ngokwengqondo kufanele zibacabangele o mama bazo njengaba bezenzelo konke.

A	B	C	D	E
---	---	---	---	---

6. Ukukhulisa izingane ezikhubazekile kungumsebenzi onzima.

A	B	C	D	E
---	---	---	---	---

7. Enye yezinto ezimbi ngokukhulisa izingane ezikhubazekile ukuthi awunaso isikhathi sokwenza noma yini oyithandayo.

A	B	C	D	E
---	---	---	---	---

8. Abazali banikela yonke intokozo yabo benzela izingane ezikhubazekile.

A	B	C	D	E
---	---	---	---	---

APPENDIX B

9. Ukunakekela izingane ezikhubazekile engqondweni yinto okugeke kulindeleke ukuthi noma yimuphi umuntu wesifaza ne ayenze.

A	B	C	D	E
---	---	---	---	---

10. Izingane ezikhubazekile zingaba yingozi emphakathini.

A	B	C	D	E
---	---	---	---	---

11. Kungiphatha kabi ukwazi ukuthi ngingumzali wengane egula ngengqondo.

A	B	C	D	E
---	---	---	---	---

12. Ngizwa ngiphoxeka ngenkathi ngithola ukuthi ingane yemi ikhubazekile.

A	B	C	D	E
---	---	---	---	---

13. Sengikwemukele ukuthi ingane yami igula ngengqondo.

A	B	C	D	E
---	---	---	---	---

14. Ngingayithanda kakhulu uma bekuthiwa ayikhubazekile ingane yami.

A	B	C	D	E
---	---	---	---	---

15. Nginesendla ekukhubazekeni komntanami

A	B	C	D	E
---	---	---	---	---

16. Indlela engcono yokuqondisa ingane ezikhubazekile wukuyishaya.

A	B	C	D	E
---	---	---	---	---

17. Ngiyakuthanda ukudlala neizingane ezikhubazekile.

A	B	C	D	E
---	---	---	---	---

18. Ngizizwa ngiphoxeka ukuthatha ingane yami ezikhubazekile ngiye nayo emicimbini.

A	B	C	D	E
---	---	---	---	---

19. Angithandi ingane yami eikhubazekile ukuthi idlale nezingane ezingakhubazekanga.

A	B	C	D	E
---	---	---	---	---

20. Isikhathi sami esiningi ngisinakeza umntwane wami ezikhubazekile kunezinye izingane.

A	B	C	D	E
---	---	---	---	---

21. Angicabangi ukuthi izingane ezikhubazeke ngengqondo zingakwazi ukuthi ngelinye ilanga zithole umuntu ezingathandane nayo ziphinde zishade.

A	B	C	D	E
---	---	---	---	---

22. Ngicabanga ukuthi ngelinye ilanga ingane yami ekhubazeke ngomqondo iyoba ngcono.

A	B	C	D	E
---	---	---	---	---

APPENDIX B

23. Ngicabanga ukuthi ingane yami egula ngeqondo ingakwazi ukuhlanganyele esikoleni nezinye izingane eziphilayo.

A	B	C	D	E
---	---	---	---	---

24. Ukuhlukemezeka ngokomqondo kwegane yami kuwenzi ukuthi umndeni wethu ungaphumeleli.

A	B	C	D	E
---	---	---	---	---

25. Ukuba izingane ezihlukumezekile kumnandi ukuzimbakanya nazo, ngabe kulula ukuzinakekela

A	B	C	D	E
---	---	---	---	---

26. Ukucabanga ngekusasa lengane yami khubazekile kungenza ngiphatheke kabi.

A	B	C	D	E
---	---	---	---	---

27. Angikhathazeki kakhulu ngempilo yengane yami ehlukekile.

A	B	C	D	E
---	---	---	---	---

28. Ongoti kwezolwazi (ngengabahlengikazi) bangakwazi kangcono ukukhubazeka kwengane yami.

A	B	C	D	E
---	---	---	---	---

29. Ingane yami ekhubazekile icabanga ukuthi yimina ngedwa engikwazi ukuyizwa.

A	B	C	D	E
---	---	---	---	---

30. Ngingamene nginakekele ingane yami kunokuba ngenze omunye umsebenzi.

A	B	C	D	E
---	---	---	---	---

31. Ingane yami ngiyibona ikwazi ukuzenzela nomayini noma ikhubazekile

A	B	C	D	E
---	---	---	---	---

32. Ngihlale nginqophele ukuthi akazilimazi yena noma abanye.

A	B	C	D	E
---	---	---	---	---

33. Ingane yami ekhubazekile ingaba sengozini uma iphumela ngaphandle komuzi noma kwegceke.

A	B	C	D	E
---	---	---	---	---

34. Uma kukhona abantu eduze kwakhe ngihlala ngingadile.

A	B	C	D	E
---	---	---	---	---

35. Ngeyakhe indlela uletha intokoza emndenini njengamanye amalunga omndeni.

A	B	C	D	E
---	---	---	---	---

36. Ngikhathazwa ukuthi kuyokwenzekani kuye uma ngingasamnakekeli.

A	B	C	D	E
---	---	---	---	---

APPENDIX B

37. Ngicabanga ukuthi kusasa lengane izothatha isikhathi sami sonke.

A	B	C	D	E
---	---	---	---	---

38. Ngiyakunakekela ukuthi ngingamenzisi izinto ezingaba lukhuni ukuthi azenze.

A	B	C	D	E
---	---	---	---	---

39. Abazali kufanele bazinakekekelele bona izingtane zabo ezikhubazekile.

A	B	C	D	E
---	---	---	---	---

40. Ngokuhamba kwesikhathi ngicabanga ukuthi kuzodingaeka ngimnakekele kakhulu.

A	B	C	D	E
---	---	---	---	---

41. Kutula kakhulu ukumenzela zonke izinto (kunoku mumela) ukuthi azenzele bese enza umonakalo.

A	B	C	D	E
---	---	---	---	---

42. Ngibona kungcono ukuthi ngimvikele ukuthi engaconwa noma achwenswe ezinye izingane.

A	B	C	D	E
---	---	---	---	---

43. Kwesinye isikhathi ngizizwa nginamahloni ngoba ekhubazeke emgondweni.

A	B	C	D	E
---	---	---	---	---

44. Kungenza ngizizwe ngikhululekile ngenxa yokwazi ukuthi ngingamnekekela.

A	B	C	D	E
---	---	---	---	---

45. Ngiyazama ukumtshengisa nokumfundisa ukuthi kufanele azinakekele kanjani.

A	B	C	D	E
---	---	---	---	---

46. Ngiphoxekile ngokuthi ingane yami ngeke ikwazi ukuphila impilo ejwayelekile.

A	B	C	D	E
---	---	---	---	---

47. Anginandaba uma abantu bebuka ingane yami ekhubazekile

A	B	C	D	E
---	---	---	---	---

48. Ukuba bekungesikhona okwengane yami ekhubazekile ngabe izinto zihamba kahle.

A	B	C	D	E
---	---	---	---	---

49. Izindingo zengane yami ekhubazekile zihamba phambili.

A	B	C	D	E
---	---	---	---	---

50. Anginamahloni uma abantu bebuza ngempilo yenyane yami ekhubazekile.

A	B	C	D	E
---	---	---	---	---

APPENDIX C

University of Zululand  
Department of Psychology  
Private Bag X 10001  
Kwa-Dlangezwa  
3886

13/11/00

The Principal  
Thutukani School

Dear Madam

I request permission from you to conduct research at your school.  
The title of my research is: Attitudes of parents in rural areas  
towards their mentally retarded children.

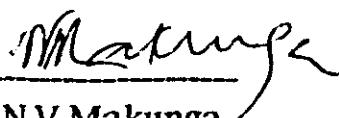
Thanking you.

Yours sincerely



Ms Nancy Govender  
M1-Clinical Psychology student

Supervised By:



Prof. N.V Makunga  
Senior Clinical Psychologist



# Thuthukani Special School

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Website:  
[www.thuthukani.org.za](http://www.thuthukani.org.za)

6/12/00

Ms Nancy Govender  
M1 - Clinical Psychology student  
University of Zululand

Dear Nancy  
You have my full permission to  
conduct your research at Thuthukani.  
I wish you the best in your  
studies. Our school re-opens  
on 23 January 2001.

Yours sincerely

Mrs PJ Stead

PRINCIPAL

## **APPENDIX E**

### **ATTITUDES OF PARENTS AS REFLECTED BY THEMES**

#### **1.. LOVE AND ACCEPTANCE (Questions 1, 13, 14, 30, 35, 44, 47, 7)**

1) When I think of my mentally retarded child, I think how lucky I am, God gave him so much more than lots of kids have.

13) I have accepted the fact that my child is mentally retarded.

14) I would love my child more if he/she were not mentally retarded.

30) I would rather be caring for my mentally retarded child than doing some other kind of work.

35) In his/her way my mentally retarded child brings so much pleasure to our family as the other members.

44) It makes me feel good to know that I can take care of my mentally retarded child.

47) I don't mind when people look at my mentally retarded child.

7) One of the bad things about raising mentally retarded children is that you are not free enough of the time to do just as you like.

**EMBARRASSMENT (Questions 18, 43, 50)**

18) I feel embarrassed to take my mentally retarded child with me when I attend functions.

43) Sometimes I feel ashamed because of my mentally retarded child.

50) I am not embarrassed when people question me about my mentally retarded child.

**FRUSTRATION (Questions 4, 6, 25)**

4) Mentally retarded children will get on any woman's nerves if she had to be with them all day.

6) Raising mentally retarded children is a nerve-wrecking job.

25) If my mentally retarded child were more pleasant to be with, it would be easier to care for him/her.

**4. DISSAPPOINTMENT (Questions 12, 26, 46)**

12) I felt disappointed when I found out that my child is mentally retarded.

26) Thinking about my mentally retarded child's future makes me sad.

46) I am disappointed that my mentally retarded child does not lead a normal life.

**5. OVER-PROTECTION (Questions 29, 32, 33, 34, 38, 42, 49)**

29) My mentally retarded child feels that I am the only one who understands him/her.

32) I always watch to make sure that my mentally retarded child does not do physical harm to himself/herself.

33) My mentally retarded child would be in danger if he/she got out of the house or yard.

34) When others are around my mentally retarded child I cannot relax, I am always on guard.

38) I am very careful about asking my mentally retarded child to do things, which might be too hard for him/her.

42) I feel that I must protect my mentally retarded child from the remarks of other children.

49) My mentally retarded child's needs come first.