Exploring Psychosocial Challenges of Children with Mental Retardation from Family Perspective in the case of Adama No-2 Elementary School

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Table of content

Contents

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Acronyms

AAMR …….American Association on Mental Retardation

AIDS……Acquired Immune Deficiency Diseases Syndrome

FGD……Focus Group Discussion

GO……..Governmental Organizations

HIV …….Human Immune Virus

ID……Intellectual Disabilities

IDEA……Implementing the Individuals with Disabilities Education Act

MR……..Mental Retardation

NGO……Non-governmental Organizations

RAPID…….Rehabilitation, Prevention, and Intervention of Disability

List of Tables

Abstract

The main purpose of this study was to explore the Psychosocial Challenges of Children with Mental Retardation are facing. The study was conducted in Adama, at No-2 Elementary School. The study followed on exploratory and descriptive research method. Fourteen (14) participants were selected using purposive sampling. The study utilized qualitative research tools to explore the deep feelings of the participants. FGD and Semi-structured interview were developed and used to explore the stated problems. The study analyzed and discussed data by using thematic analysis. Findings obtained from the study showed that children with mental retardation are facing different psychosocial challenges like stigma, discrimination, isolation, blame, shame, frustration, feeling of upset, self-insult, loneliness, losing respect, despairing (feeling of no hope), insult, anger and sadness. On the other hand, praying(Do'a), helping each other, reaction formation (insulting who insulted them), developing wishful thinking, and limiting one's interaction were some of the mechanisms explored from this study. The study finally recommends some measures to curb the negative belief systems of the communities towards the children with mental retardation.

Key Terms: Children, Mental Retardation, Psychosocial Challenges, Family Perspectives

Chapter One

Introduction

Background of Study

Mental retardation (MR), is a disability characterized by significant limitations both in intellectual functioning and in adaptive behavior as expressed in conceptual, social, and practical adaptive skills (Schalock, et al., 2007). Intelligence is both genetically and environmentally determined. Children born to parents with mental retardation are at increased risk of a range of developmental disabilities, but clear genetic transmission of mental retardation is unusual. Although advances in genetics, such as chromosomal microarray analysis, have increased the likelihood of identifying the cause of mental retardation, a specific cause cannot be identified in 60 to 80% of cases.

Mental retardation is a worldwide problem (Goswami, 2013). Mental retardation occurs once in every 33 people (Aslam et al, 2011). According to the World Health Organization (WHO), 10% of the world's population has some form of mental disability and 1% suffers from severe incapacitating mental disorders (WHO, 1989 as cited in Padhye,2012).

In every age of history, in all cultures, in every stratum of society, there have always been individuals who have had manifested "Subnormal" intellectual functioning. Many of these individuals do not have the ability to manage their affairs with ordinary schooling, and are unable to maintain themselves in the community (Coleman, 1964). From the above finding, we conceive that mental retardation is global problem.

Ethiopia is still among the least developed countries. Hence, poverty is severely affecting the lives of many people in both rural and urban settings. Persons with disabilities in general person with intellectual disabilities in particular constitute a large portion/segment of the society (Ethiopian National Association on Intellectual disabilities strategic plan, 2011).

In Ethiopia having a child with mental retardation is often associated with feelings of shame and embarrassment, and even in contemporary Ethiopian society misconceptions exist, such as this being a punishment from God. The child can often be viewed as a financial burden for families, many of whom are already financially deprived. Usually, families prefer to keep this kind of children hidden behind doors due to fear of the social stigma attached to it (Ethiopian National Association on Intellectual disabilities strategic plan, 2011).

According to World Health Organization statistics (2005) an average of 3% of the world population has learning and developmental disabilities. Based on this evidence, about 2 million people with disability are estimated to live within Ethiopia. Despite this there still exists a great

degree of prejudice and stigma attached towards those with learning and developmental disabilities in Ethiopia.

Children with mental retardation face many biopsychosocial problems. The research finding conducted by Thengal (2013) revealed the psychosocial problems these populations are facing. These are frustration, feeling of shame and guilt, social exclusion, unequal treatment, blame, stereotypes, stigma and discrimination**.**

On the other hand, students who are mentally retarded are sensitive to rejection and are easily hurt by teasing or ridicule (Coon 1983;Suinn 1975 as cited in Abraham Husain, 1998).

The psychosocial challenges of mental retardation don't stop on the sufferer only but also to their parents. The parents of the mentally retarded children lose hope, even be frustrated and ashamed of their children. Parents do not understand that mentally retarded child could be self supportive member of the family if the necessary parental care, assistance, and encouragement are given. Parents face emotional, social, economic, material challenges while raising their mentally retarded children(Chernet Tekle and Opdal, 2007).

Even though the problem is so damaging to both the sufferer (mentally ill children) and their families there are little researches conducted in our country and of them are biological (neurological) oriented and assess other aspects. For example Nema Behutiye(2000) conducted on assessment of adaptive behavior of some children with mental retardation in Ethiopia. Moreover, there is no research on the ways these children should be handled and treated psychologically and socially.

It was in light of the above rationale this study was undertaken on the psychosocial problems of children with mental retardation from family perspective.

Statement of the Problem

Mental retardation is a serious disorder. It affects the learning and the psychosocial relationship of the sufferers. Children with mental retardation face many psychosocial problems. Among them are frustration, feeling of shame and guilt, social exclusion, unequal treatment, blame, stereotypes, stigma and discrimination (Thengal, 2013)**.** An empirical evidence conducted by WHO (2000) also supports this realities.

On the other hand, mental retardation is not only a problem which affects the ill person but also his /her family members and relatives in particular and the community in general. As result, the families of children with mental retarded undergo through various challenges. Their challenges include psychological, social and economic aspects. The most common psychosocial challenges they face are blame, frustration, stigma, discrimination and social exclusion (WHO-Investing on mental health, 2003). The research finding by Nema Behutiye(2000) outlined that the stigma to mentally retarded children goes to educational aspect**.** He stated that though there are very few of

the disabled children in Ethiopia have got the opportunity or access to school, or appropriate education; the case seems more severe for the mentally retarded population**.** In addition to this WHOs research finding on mental health (2001) showed that the stigma and discrimination associated with the mentally retarded are the most prevalent challenges of families' of children with mentally retarded. The finding also put forward as the mentally retarded blamed for bringing on their own illnesses, and others may see them as victims of bad fate, religious and moral transgression, or witchcraft.

In relation to this, the research conducted by Chernet Tekle and Opdal (2007) revealed that some families hide or overprotect a member with mental retarded, keeping the person from receiving potentially effective care or they may reject the person from the family. Moreover, the their finding let out that, even today, as indicated in much of the world, the mentally ill are chained, caged or hospitalized in filthy and brutal institutions.

Even though the problem is intricate to both the sufferer (mentally ill children) and their families there are little researches conducted in our country and of them are biological (neurological) oriented and assess other aspects. For example (Abraham Husain, **1998) "***Parental Perspectives on Mentally Retarded Children in Ethiopia the Case of Addis Ababa*" he tried to assess the attitudes of parents toward their mentally retarded child, and themselves.

Another researcher named Nema Behutiye(2000) conducted an assessment of adaptive behavior of some children with mental retardation in Ethiopia. Moreover, there is no research on the ways these children should be handled and treated psychologically and socially. Hence, due to the paucity of adequate data on psychosocial problem of mentally retarded children, the need to address the gaps is of paramount importance.

To this effect, it was imperative to undertake a study to investigate the psychosocial problems of mentally retarded children. It was in light of this understanding; this study had been undertaken in Adama No.2 Elementary School.

Research Questions

To address the issue of the study, the following basic questions were stated**:**

1. What the psychosocial problems mentally retarded children are facing?
2. What is the perception of mentally retarded children families regarding the societal attitudes towards their children?
3. How do families perceive their mentally retarded children?
4. How do the families of the mentally retarded children respond (communicate) to the needs of

their children?

5. What mechanisms should be taken to reduce psychosocial problems mentally retarded children face?

Objectives of the Study

Based on the above stated research questions, the study had the following general and specific objectives.

General Objective

The main objective of this study was to explore the psychosocial problems of children with mental retardation from a family's perspective.

Specific Objective

The specific objectives of this study were:

- To explore the psychosocial problems mental retarded children are facing.
- To assess the perception of mentally retarded children families regarding the societal attitudes towards their children.
- To assess the perception of families having children with mental retardation
- To identify the way the families of the mentally retarded children respond to the needs of their children (communicate).
- To assess mechanisms which should be taken to reduce psychosocial problems mentally retarded children are facing.

Significances of the study

This study is geared towards the exploration of the psychosocial problems of mentally retarded children. To this end, the importance of identifying the psychosocial problems of mentally

retarded children is clearly understood to plan, develop and carry out appropriate strategies to bring about a difference in the lives of the mentally retarded children and their family.

As described elsewhere in the previous pages of this paper, children with mentally retarded face many challenges among them are stigma, discrimination, isolation, blame, guilt, frustration and so forth(WHO, 2003). Mental retardation has implication in the family relationship i.e. it affects the relation among mother, father, and siblings. So, from the above literature we can conceive that this study will helps the families' of children with mental retardation through critically understand, recognize and reduce (if possible solve) their problems. Goffman (as cited in Byrne, 2011) also stated that the mentally retarded people are not only stigmatized by non-family members (community) but also by family members. He put forward that the family and friends of mentally retarded person may put up a stigma by association, the so-called "courtesy stigma". Therefore, this study will helps the family by enabling them understand mental retardation scientifically and treat their children accordingly. In other word, by exploring the psychosocial problems of mentally retarded children and the way the community responds to such problem, the family will have the chance to properly understand the situation of their children and be able to provide necessary services. As a result, the mentally retarded children may get benefits through obtaining appropriate support from their family (caregivers).

This study finding benefits also goes to teachers, mental health professionals such like Psychiatrists, psychiatry nurses, Social workers, Psychologists and other health professionals who are working in the hospital and other health institutions by offering information about the psychosocial problems of the mentally retarded children are facing. As a result, they enable them to understand community related problems and the interventions too.

Likewise, it can also offer a clue for policy makers to advocate and lob about the problem.

Moreover, its finding partly will benefit the community in particular and the society in general by raising their awareness about mental retardation. As result, their attitude and interaction pattern for/with mentally retarded children will be improved.

Finally, the study result will serve as bedrock for other researchers who are interested in the area.

Delimitation of the study

This study was delimited to assess the major psychosocial problems that mentally retarded children are facing. The reason to focus on this aspect was most of the mental health studies conducted in Ethiopia are patient focused and biological oriented i.e. they give little attention to the psychosocial problems of mentally retarded children.

Moreover, the study was delimited to the area of Adama city, Adama No.2 Elementary School. The main reason to conduct this study on this area was the area conduciveness to get the estimated number of respondents necessary to obtain relevant data and no study conducted in this area. However, the research findings cannot be generalized to include other service providing centers in the country as well as the experience and reactions of mentally retarded children throughout the country.

Operational Definition of Terms

Children: - is a person whose age is between 5-19 and who is living with his/her parents or other significant others.

Family Perspectives refer to the issues of mentally retarded children seen from the views of the parents.

Psychosocial Challenges: - refers to the psychological and social problems that mentally retarded are facing. These are insult, mocking, stigma, discrimination, social exclusion, frustration, depression and so forth.

Chapter Two

Literature Review

Definitions of Mental Retardation

Here in this part, the researcher will try to bring the different definitions of mental retardation by which different scholars forwarded.

According to IDEA: "Mental retardation means significantly sub average general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period that adversely affects a child's educational performance."

The AAMR defines mental retardation as "substantial limitations in certain personal capacities. It is manifested as significantly sub average intellectual functioning, existing concurrently with related disabilities in two or more of the following applicable adaptive skill areas: communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work. Mental retardation begins before the age of 18."

Ysseldyke and Algozine as cited in Behutiye Seyato(2000) defined mental retardation as significantly sub average general intellectual functioning that exists concurrently with deficits in adaptive behavior and manifest itself during the developmental period and adversely affects the individuals educational performance.

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,2000).

Historical Background of Mental Retardation

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 around1500BC in Egypt (Scheerenberger, 1983 ac cited Govender,2002).

Historically, mental retardation has existed in all societies and socioeconomic strata irrespective of race and sex throughout human history. In fact it is with diverse conceptualization, varying views or attitudes and philosophy as well as characteristics according to the level of understanding and development of the knowledge and socioeconomic status of the society (Nema Behutiye, 2000).

Words used, in western countries, in earlier times to refer to people labeled mentally retarded included imbecile, feeble minded, moron and defective. 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 “hanged 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. The plight of individuals with mental retardation has been dependant on the customs and beliefs of the era and culture or locale (Trent, 1995 as cited in Govender, 2002).

The recorded history of mental retardation shows that the Greeks in 1552 BC and the Romans in 449 BC were among the first, to officially recognize people as mentally retarded (Heward et.al, 1988). Anthropological studies also generated evidences of mental retardation substantially pre - dating that of the Greeks and the Romans (Drew et.al, 1984 as cited Nema Behutiye,2000). These authors further strengthened the information by citing t he discovery of human skulls dating to the stone age, which indicate the crude surgical operations that had been performed during that time.

Since then, persons with mental retardation have experienced the hazardous effects of social stigma attached to mental retardation. In the primitive society, where the societies' knowledge about mental retardation and persons with mental retardation was at the minimum, mental and physical defects were viewed by the primitive nomadic tribes with fear and disgrace, largely because of the social stigma attached to such conditions by superstitions and myths. As society separate into levels ridicules of the mentally retarded people was common, superstition and myths developed, derogative words like idiot, imbecile and dunce were used. Giving birth to a child with mental retardation was viewed as a punishment from God for the parents' evil deeds or so. There was also economic influence on the people with mental retardation. For instance the unproductive members of the primitive society like the sick, physical and mental defects were abandoned, or sometimes even killed, because they were sharing the minimum what they have to

eat, contributing nothing for the attainment of the survival of the social group. In this regard, the people (the Greeks and the Romans often used to send the mentally and physically

Defectives to places far away from the community, where they would perish by their own

(Heward et al,1988 as cited Nema Behutiye,2000).

The earliest reference to intellectual disability dates to the Egyptian Papyrus of Thebes in 1552 B.C. (Harris, 2006 as cited in Harbou and Maulik, 2012). The ancient Greeks and Romans felt that children with ID were born because the gods had been angered. Often children with severe ID would be allowed to die of exposure as infants rather than permitted to grow up. However, the Romans did allow some form of protection to children with ID who were born to the wealthy, by allowing PWID property rights and allowing them to have guardians (Harris 2006 as cited in Harbou and Maulik, 2012). Before the 18th century, societies differed in how or whether they conceptualized intellectual disability. Those with mild ID who were socially competent received no special identification or treatment, and those with more severe conditions probably received protective care from their families or in monasteries. Some societies considered people with more severe ID to be capable of receiving divine revelation (Beirne-Smith et al. 2006; Harris 2006 as cited in Harbou and Maulik, 2012).

During medieval times, individuals with disabilities, including children were frequently sold to be used for entertainment or amusement (Scheerenberger, 1983 ac cited Govende,2002). Many of the unfortunate victims that were hounderade destroyed during the early seventeenth century, were people of low intelligence (Marais&Marais,1976 a cited Govende,2002).

During the middle age, as religion became a dominant force, society' s level of understanding of the condition and attitude towards persons with retardation has relatively been changed. More humanitarian views and positive attitudes were developed; asylums and monasteries were erected to care for the mentally retarded persons (Heward et al,1988 as cited Nema Behutiye, 2000).

The 19th century, as the era that produced institutions for mentally retarded persons and the 20th century, as the era of legislation and national support, as well as the 1970s as the era of normalization, child advocacy and litigation.

However, since the beginning of the 20th century, the efforts made to open public school classes for the mentally retarded children and promotion of better awareness among the society led to the beginning of special class movement. This resulted in the growth and development of special education and enrollment rate of the mentally retarded children (Heward et al.,1988 Nema Behutiye, 2000). In the same document what this group of authors further reported in education and care of men tally retarded children, reads as follow:

Today we are witnessing a move away from total reliance on the large state institutions and the self contained special education class to the trend towards more normalized community based facilities and education in the regular classroom for significant number of mentally retarded children.

As far as the researcher's work experience and the information from his field notes is concerned historically, mental retardation in the Ethiopian context has passed through similar pattern of development as has been discussed earlier. For instance, in its earliest stage of development people used to view mental retardation or having birth to a child with mental retardation as a punishment from God for the evil deeds of the individual, or his/her parents or ancestors. During this period, superstitions and myths were developed; ridicules of mentally retarded persons were common. Derogative words like, **Deddeb, Kewus, Jil, Kil, Mogn, Nehulala** and etc. which literally mean idiot, imbecile, dunce, fool were used. Moreover, a strong negative attitude was attached to giving birth to a child with disability, particularly with mental retardation.

Indeed, it has been a source of painful feeling, which has been reflected in isolation of the parents and siblings of the retarded child as well as hiding the child with retardation from the community they live in. The family unit had to suffer a lot from the social stigma vested upon them and their children and the economic problems that have direct relation with caring for the child under consideration. In fear of the social stigma attached to the condition, parents and siblings of the retarded child some times were involving themselves in the rejection, disguising and hiding the child behind doors. Later on, the development of religion and modern education as well as the influence of international relations enhanced the attitudinal change among the society. This can be considered as the second stage of development. With the introduction of the religious donor agents like, Mekaneysus church, the Brothers' and Sisters' Home etc., the awareness of some parents and families who got the exposure increased. As a result there appeared some change in the attitude and philosophy of some people. Such people at least started to view the condition and the problems attached to it, from the religious point of regard and sympathize for the retarded persons as well as their families. Considering the hardship of managing such problem under the impoverished condition, some philanthropists and persons started to give alms and some other material supports to the retarded children and their families. The awareness such family got could influenc;e some parents and families to accept the condition as it is. This also gave some way to avert the condition through opening of institutions that care for the retarded children, because the intervention programs (educational, Psychological, social, economic) arranged by the institutions helped the children to adapt independent living skills their possible restrictive environment. In this regard, the "Kassanchiz and Mekanissa Schools for the Forgotten", started in Addis Ababa, in 1986 by Mekaneyesus church would be worth mentioning. The third stage of development in the area under discussion started from the late 1988, with the conduction of a workshop on the development of curriculum for training teachers of mentally handicapped children organized by the department of Teachers Education, Ministry Of Education -(OTE- MOE' 1991). The Education and Training Policy of

the; Federal Democratic Republic Government Of Ethiopia(1994) article 3.2.9 states that special education and training will be provided for people with special needs. The Federal Negarit Gazeta (1995) article 37,under the rights of children, also noted under the rights of children, also noted that "when taking any measure related to children, any governmental or non governmental institutions or charity organizations, courts, administrative authorities or legislative organs/bodies should give primary attention to the well being and safety of the children"

From the above evidence there is much work were done on educational development sector in Addis Ababa city but less attention for psychological and social development supporter, along with the educational sector development were implemented on only in Addis Ababa, not including other part of the country.

However, the situation of mental retardation in this study area is different. Although, the number of mentally retarded individual in Adama town is not known. There is only one school which provides services to this group. Still, according to researcher observation, the services which are offered in the school and other institutions are not inclusive. Moreover, there is only one NGO named RAPID. Meaning, the different aspects of the mentally retarded children not addressed well.

Causes of Mental Retardation

According to the information obtained from researches so far, although it seems that there are a variety of possibilities that cause mental retardation, it is only 15 - 20% of the condition have known cause. The other 80 - 85% of mental retardation have no clearly identified etiology, except assuming to have connection with the environments in which the individuals are living. (Henley et al., 1996, as cited Nema Behutiye,2000)

Still there are others who believe that both organic and environmental factors could be causes of mental retardation.

In response to the question, "what causes mental retardation?" Cohen and his colleagues (1992) states that about 25 percent of all the cases of mental retardation are organic, or related to known physical disorders, including one or more of the following: birth injuries (such as lack of oxygen)are relatively rare but significant problem; fetal damage is a more common problem. Maternal drug abuse, and disease or infection contracted by the mother before birth, or by the child shortly after birth, can cause retardation. Metabolic disorders, such as cretinism and phenylketonuria could cause retardation

Explaining about the remaining 75 percent of the cases, Cohen and his colleagues (1992 notes that in the majority of retardation cases no known biological problems can be identified which is attributed to mainly to environmental factors. As observed by Cohen and his colleagues (1992) familial retardation, as it is called, occurs most often in very low income or impoverished households. In such homes nutrition, early stimulation, medical, and emotional support are

inadequate. Yet, even where a child's physical needs are being met, the intellectual and educational level of the home is typically low, making the chances of familial retardation high Cohen and his colleagues (1992).

Cohen and his colleagues (1992) reports that in one study, striking increases in IQ were observed when children were moved from an orphanage to more stimulating environments. Twenty- five children, all considered mentally retarded and un-adaptable, were moved to an institution where they received personal attention from adults. Later, these supposedly retarded children were adopted by parents who gave them love, a family, and stimulating environment - where the IQs of the children showed an average gain of 29 points. Cohen and his colleagues (1992) goes on to say that second group of initially less retarded remained in the orphanage lost an average 26 IQ points.

Cohen and his colleagues (1992) also observes that the educational level of parents creates another interesting environmental effects. In a study done in France, IQ scores for 32 adopted children were compared with the scores of brothers and sisters who remained with the biological parents. In most cases, the biological parents were poorly educated and worked in nonprofessional jobs. The adopted children had mostly gone to families of higher educational and socioeconomic status. As reported by It was found that average IQ scores matched almost perfectly those chil'dren from similar family backgrounds; that is, children who stayed with their biological parents had lower IQs than their adopted brothers and sisters. Basically, the adopted were reported to have had performed the same as non-adopted upper- middle-class children which was noted to be an encouraging indication that general intellectual ability could be raised by an improved environment.

Based on the American Association on Mental Deficiency Manual, Coleman (1964) presents the following 8 major groups regarding the causes of mental retardation:

1. Socio-cultural factors:

Adverse social and cultural factors appear to play major role in the etiology of mental retardation. Although mental retardation strikes children from all socio -economic levels, it is much more frequent in segments of the society where there are heavy concentrations of poorly educated families with low incomes. Families deprived of the basic necessities of life and of opportunity and motivation contribute a disproportionately high number of the society's mentally retarded children.

Severe environmental deprivation during infancy and childhood may retard the child's intellectual development even when his or her potential at birth is within a normal range.

This conclusion is supported by recent research findings which show that young children who have been living in impoverished environment and functioning at a retarded intellectual level often show marked improvement when placed in a more stimulating learning situation;

2. Genetic - chromosomal factors:

Mental retardation tends to run in families. This is particularly true of mild retardation, which presumably results from the action of multiple genes. However, poverty also tends to run in families, and early exposure to a culturally deprived environment may also be a primary or concomitant etiological agent in these cases;

3. Biochemical (metabolic) disorders:

There are some 25 rare biochemical diseases that are associated with mental retardation.

Often these diseases appear to result from mutant genes. Perhaps the best known of these is Phenylketonuria (PKU). This disorder occurs in infants who lack an enzyme needed to breakdown phenylalnine, an amino acid found in protein foods etc.

4. Infections:

Mental retardation may be associated with a wide range of conditions due to infection.

The fetus of a mother with certain virus diseases such as German measles, may suffer brain damage; apparently damage is greatest when the viral infection occurs during the first eight weeks of pregnancy. The fetus of a mother with syphilis may suffer infection and varying degrees of brain damage. Brain damage may also result from infections occurring after birth, as in the case of epidemic encephalitis;

5. Toxic agents:

A number of toxic agents, such as carbon monoxide and lead may lead to brain damage during fetal development or after birth. in some instance, immunological agents such as anti-tetanus serum or typhoid vaccine, may result in brain damage. Similarly, certain drugs administered to the mother during pregnancy may lead to congenital malformations, or an overdose of drugs administered to the infant may lead to toxicity and brain damage. In rare cases, brain damage results from incompatibility;

6. Trauma or physical agents:

Difficulties in labour due to malposition of the fetus or other complications may still damage the infant's brain at birth. Bleeding within the brain is probably the most common result of such birth trauma;

Anoxia, stemming from delayed breathing of the new born infant or other causes is another type of birth trauma which may damage the brain. Anoxia may also occur after birth as a result of cardiac arrest associated with operations, heart attacks, or drowning.

Serious postnatal head injuries, too, may result in permanent brain damage, although these injuries are not so frequent as is often assumed by parents, who may find it comforting to be able to attribute their child's retardation to accidental injury instead of to either faulty heredity or any possible failure on their part;

7. Ionizing radiation:

Recently a great deal of scientific attention has been focused on the damaging effects of irradiation on the sex cells and other bodily cells and tissues. Ionizing irradiation may act on the fertilized ovum directly or may produce gene mutations in the sex cells of either or both parents, which, in turn, lead to defective offspring;

8. Other causes:

Follow-up studies indicate that infants born prematurely, weighing less than 1500 grams at birth, reveal a high incidence of neurological disorders including mental retardation. In fact, very small premature babies are ten times more likely to be mentally retarded. In occasional cases, severe and prolonged emotional disturbances dating from an early age appear to block the normal growth and integration of intellectual functions - leading to mental retardation (Coleman, 1964).

According to some recent literature (e.g. AAMR Manual, The Arc's Human Genome Education Project Report -1992, 1997) the causes of mental retardation are categorized as follows:

a) Genetic condition -

These result from abnormality of genes inherited from parents, errors when genes combine, or from other disorders of the genes caused during pregnancy by infections, overexposure to X - rays and other factors. Inborn errors of metabolism which may produce mental retardation, such as PKU (Phenylketonuria), fall in this category.

Chromosomal abnormalities have likewise been related to some forms of mental retardation, such as Down syndrome and fragile X syndrome.

b) Problems during pregnancy -

Use of alcohol or drugs by the pregnant mother can cause mental retardation.

Malnutrition, rubella, glandular disorders and diabetes, cytomegalovirus, and many other illnesses of the mother during pregnancy may result in a child being born with mental retardation. Physical malformations of the brain and HIV infection originating in prenatal life may also result in mental retardation;

c) Problems at birth -

Although any birth condition of unusual stress may injure the infant's brain, prematurity and low birth weight predicts serious problems more often than any other conditions;

d) Problems after birth -

Childhood diseases such as whooping cough, chicken pox, measles, and HIV disease which may lead to meningitis and encephalitis can damage the brain, as can accidents such as blow o the head or near drowning. Substances such as lead and mercury can cause irreparable damage to the brain and nervous system;

Classification of Mental Retardation

There has been more or less similar variation in the classification of mental retardation to that of its definition among scholars. Currently, although the trend of classification for the sake of labeling is being discouraged, most scholars, associations or organizations classify it into four categories.

Some others divide the level into three, and still others classify mental retardation into five. For the details see the table below.

Table 1 - Level of Retardation along Measurement By Authors

Level Of Retardation Along IQ Measurement					
Name of Authors	Boarder line/Dull Normal/	Mild/Educable	Moderate/ Trainable	Severe	Profound/ custodial
AAMR (1961)	68- 83	52- 67	36- 51	20- 35	Below 19
Dunn	70- 84	55- 69	40- 54	25- 39	Below 25
AAMR (1983)		52- 67	36- 51	20- 35	Below 19
APA		50- 70	35- 49	20- 34	Below 20
WHO		50- 65	35- 50	25- 35	Below 25
Drew et al	75- 80/90	50- 75/80	20- 49		Below 20
Heward et al	50- 55-70-75	35- 40- 50 - 55	20- 25-35- 40		Below 20- 25

Kauffman et al		50- 55-70-75	35- 40- 50 - 55	20- 25-35- 40	Below 20- 25
Smith et al		50- 65	30- 49	20- 29	Below 20
Terman(1916)	70-79	50- 69 Moron	24-49 imbecile	idiot24/Below	
AAMR (1973)		52- 67	36- 51	20- 35	Below 19
Weschler(1958)	70- 79	50- 69 Moron	30- 49	29/Below	
Kirk et al		50- 55-70	35- 40- 55		Below 35
Gearheart et al		50- 55-70-75	20- 30- 50 - 55		Below 20- 25

N.B. This information is taken from a researcher named Nema Behutiye(2000) who took this data from various researchers.

Table 2: General Achievements and Behavior of Persons with Mental Retardation

According to Child Assessment service (2008), children with mental retardation show different achievement and behaviors according the severity of the illness and the school age phase.

	Pre-school phase(0-5 years old)	**School age phase (6-15 years old)**	**Adolescence and adulthood (16 years old or above**)
Mild MR	*Overall development is slower than peers. *Developmental problems may not be easily identified until the child starts primary school.	*Can master basic learning skills (e.g. writing, reading and numeracy skills) *Can acquire proper pre-vocational skills	*Can integrate into community with assistance *With assistance, can be employed in simple work, and lead a social life in community

Moderate MR	*Overall development is obviously slower than peers *Can acquire basic communication skills and simple self-care abilities	Can learn some practical skills for daily living *Can live independently to a certain extent in familiar environment and with proper support	Can learn to perform simple tasks in specially designed working environment
Severe/ Profound MR	*Significant discrepancy in overall development when compared with peers *Some children may also have physical disabilities *Limited communication abilities and response to the environment	*Delayed development in motor abilities *Can learn limited communication skills and simple self-care tasks	*Possess simple communication skills * Can master limited basic self-care skills with special support

Theories of Mental Retardation

Although the researcher can't find many theories of mental retardation, the following are some:

1. **Constitutional** or **The tool little theory of Mental Retardation**

This theory attributes mental retardation with a congenitally low potential for development not obviously related to disease process i.e. to too little mind or intelligence which is called oligophernia. Thus, this theory related mental retardation to genetical factors (Davis, no year).

2. **Stress Theory**

This theory attributes mental retardation with different social stressors.

The researcher criticizes this theory that most mental retardation are at birth by which children are free from any stress although it can aggravate the severity of the problem.

3. **Attachment Theory**

This theory correlates mental retardation with improper biopsychosocial attachments(Davis, no year).

4. **Sociological Theory**

This theory associate mental retardation to failure in social adjustment. According to Tregold as cited in Goswami(2013), Mental deficiency is a state of complete mental development of

such a kind and degree that the individual is incapable of adapting himself to the normal environment of fellows in such a way as to maintain existence independently of supervisor, control or external support(Goswami, 2013).

The researcher criticizes this theory like he did to stress and attachment theory in such way that this theory doesn't take into consideration children who born with mental retardation.

5. **Theological View**

This theory aligns MR to the curse of God or evil spirit possessions (Anonymous, Disability Theory).

6. **Disordered Theory of Mental Retardation**

In contrast to the above theories, this theory doesn't give specific etiology for mental retardation rather multiple and various factors. This theory advocates prevention more than cure (Davis, no year).

The researcher strongly advocates this theory because it take into considerations the multiples causes of mental retardation.

Attitudes towards Mental Retardation

The measurmente of attitudes towardes children with mentaly retareded is difficult because of the varaity of characterestic and degree of mental retaredation. For instance sevaral investigator indicated that mildly retareded individual percieved more favorably more severeyl retareded ones(Worden, 1976).

Parental Attitudes towards Mental Retardation

Parental attitudes influence the way parents treat their children and their treatment of the children, inturn, influences their children's attitudes toward them and the way they behave. Fundamentally therefore, the parent-child relationship is dependent on the parents attitudes. If parental attitudes are favorable, the relationship of parents and children will be far better than when parental attitudes are unfavorable(Goswami,2013)

Negative attitudes toward people with disabilities hinder them from bringing about their life goals (Antonak & Livneh, 2000 as cited in Akrami et al, 2006) and narrow their possibilities to fully exercise the rights conferred on them by community law, for example, the right to express their feeling.

Birth of child with mental retardation in a family is usually an unanticipatory and unwelcome event. The parents are confronted with not only feeling of guilt, grief, resentment and shock but also new role and responsibilities which are largely unknown to them. Social stigma that itself attaches to the family and frustration and helplessness for not able to cure the condition leave parents sad and depressed. They have to make changes in their lifestyle, restriction are imposed on their social life, they have less time for themselves, their leisure and recreational activity get compromised. This causes stress which leads to psychological morbidity, and disturbances in marital harmony. They seek support from the relatives, neighbors and friends which they seldom get. The impact is not only on the parents but also on the other family members including siblings. In fact upbringing and emotional development of the mentally retarded child is also affected by family responses. Distress felt by parents not only due to stressful situation but also dependent on congenial appraisal of stressful situation, coping skills of the parents and coping resources available (Kumar & Sharma, 2013**).**

When parents have turned to professionals for help in the diagnosis or treatment of a child suspected of being mentally retarded, they have all too frequently met with disappointment and frustration.

Many professionals have known little about mental retardation, in spite of being trained in one of the biological or behavioral sciences. They have tended, therefore, to react with "embarrassment" And to "do nothing. " Furthermore, professionals trained in mental health have, until recently, typically considered parents of retarded children to be "disturbed." They were likely to attribute to these parents such "challanges" as: (a) inability to "accept" the fact that their child was retarded, usually attributed to "denial of reality" (b) pathological depression, usually assumed to be the product of "internalization of unacceptable death wishes" toward the retarded child; over protectiveness of the child, stemming from repressed latent hostility toward the child; (d) irrational hostility, usually focused on professionals, interpreted as "displacement of hostility" originally directed toward the child; and (e)tenuous marital relationships, resulting from "displacement and projection" of hostility.

As a result of the general lack of understanding of mental retardation by many professionals and the prevalence of destructive stereotypes of parents of the mentally retarded, it is not surprising that professional handling of parents has often been less than helpful.

Societal Attitudes towards Mental Retardation

Mentally retardation carries such a stigma, discrimination that to admit its presence in a family is like revealing a shameful secret. As a result, very little is done for retarded children or adults, apart from locking them away. And yet the problem is widely prevalent, and millions of people suffering from it receive no professional attention or care(American Association on Mental Retardation, 2002).

Mental retardation is the most challenging problem of childhood. It doesn't only affect the child but also his parents, siblings, and the community. The mentally retarded children are found in every socio-economic class though they are suffered from various psychosocial challenges(Aslam et al., 2011).

Because of inability the retarded child is frequently excluded, stigmatized and insulted from their neighbourhood and peers leading to further frustration and feeling of inadequacy(Goswami,2013).

Psychosocial Challenges of Children with Mental Retardation

A study conducted by American Association on Mental Retardation(2002) stated that person with mentally retardation carries such a stigma, discrimination, ignorance, blame, depression, aggressiveness and stress that to admit its presence in a family is like revealing a shameful secret. As a result, very little is done for retarded children or adults, apart from locking them away. And yet the problem is widely prevalent, and millions of people suffering from it receive no professional attention or care.

Approaches to Psychosocial Challenges of Children with Mental Retardation

WHO (2003) study suggested the ways to Develop and strengthening families' ties and social support network for children with mental retardation. It argued that it is essential to enable families to make an open discussion about the problem and to help each other. A strong social support network is often useful for the distressed person to release his/her negative feelings and frustration and to receive social support. The more social support an individual has, the better he or she is able to deal with stress. Moreover, the American Psychiatry Association (2000) study revealed that if family therapy, public education and other awareness creation program implanted, the problem can decrees at alarming rate and meet mental health goal.

According to Child Assessment service office (2008), parents can help their children with mental retardation by employing the following basic strategies

- Involve in the child's training so as to master the training methods and communicate with the instructors

- Join parent self-help groups and make good use of community resources
- Share feelings with others to relieve negative emotion and stress

Chapter Three

Research Methodology

Study Design

The study employed both exploratory and descriptive method of research. The researcher opted to use this kind of research design considering the desire to acquire first hand data from the respondents to formulate rational and recommendations for the study. According to Creswell (as cited in Cummings, 1994) the descriptive method of research is vital to gather information about the present existing condition. In addition, since this study will focus on exploring the psychosocial challenges of children with mental retardation, the two methods are the most appropriate to use.

The study utilized qualitative research tools in order to explore the deep feelings of the participants. Qualitative methods helps to explore the meaning individual or group ascribe to a social or human problem which involves relatively small number of participant and it will lead researcher to assess the feelings, values and perception of families toward mental retarded children.

Thus, to identify the major different psychosocial challenges that affect the life of children with mental retardation, FGD and semi-structured interview were developed to fit the situation of the study area and to collect all the necessary data.

Study Area

Adama is a capital city of Eastern Shoa Zone of Oromia region. It is located at 8.54°N 39.27°E at an elevation of 1712 meters, 99 km southeast of Addis Ababa. The city sits between the base of an escarpment to the west, and the Great Rift Valley to the east. This study is conducted in Adama No. 02 Elementary School found in Kebele 04.

Adama No.2 Elementary School is the specific study area of this research. It established in 1886 E.C and give service for mental retarded children since established. It is the only schools in Adama which try provide education for mental retarded children. There are 22 students mental retarded children found in the school and get education service. But school gives less treatment and care for his student because of limited professional man power on treatment of mental retardation. The school have uneducated and unprofessional teacher who give care unknowing their need.

Study Population, Sample size determination and Sampling Techniques

The target population of this study was the family of children with mental retardation who were selected purposefully.

All the families of the children with mental retardation who were found in the data collection site at data collection period were a sample of the study. They were fourteen (14) in number. Accordingly, by using purposive sampling technique, the researcher conducted an interview and FGD with six (6) and eight (8) families of children mental retardation respectively. Hence, a total number of 14 participants were used as the sample of the study.

Data Collection Instruments and Procedure

This study gathered data using primary form of collecting data. Data was collected using two tools. These were Focus Group Discussion (FGD) and semi-structured interview. Both of them were developed by the researcher. The interviews took the form of a face-to-face conversation.

All the instruments were translated into Amharic, with the consultation of language experts regarding the agreement on both forward and backward translations. The translations were made mainly to avoid language barriers and facilitate the process while the respondents were responding to the interview questions.

After all the above activities conducted well, the next procedure that done was data collection. First, permission (ethical approval) from the School administrators was asked. As soon after the researcher got the permission, the researcher briefed for each participants about the purpose of the research before the interview. After they were provided with the necessary information's including ethical considerations (gaining consent, expressing their freedom to stop in the middle of the session if they were not comfortable with some issues, the right of the interviewer to paraphrase and ask questions while he/she need for clarity, confidentiality and data Protection), the Amharic version interview and FGD questions asked for six and eight children with mental retardation families respectively.

Pilot study

For checking the validity and reliability of the instruments, the researcher conducted two interviewees. Bloor and Wood, (2006) stated the benefit of piloting in creating opportunity for informed reflection on, and modification of the research design, the research instruments, costing, timing, researcher security. Accordingly, the researcher modified some questions which were not clear from the respondents view.

Data Analysis Tools, Procedure and Interpretation

Since this research was purely qualitative, descriptive forms of data analysis was employed. The interpretations were made after both the FGD and semi structured data set categorically. The findings of the study also interpreted and discussed with prior researchs in the issues under the study.

Ethical Approval

Although no consent paper signed from both parties, there were many works done to protect the confidentiality of the respondents. Among them, they were oriented as they are free either to stop or to talk in the middle of the interview, refuse to disclose those issues the respondents which they consider private and so forth. The interviewer also told his rights such like paraphrasing the questions while he need for clarity, not speak his private issue and so forth.

Chapter Four

Findings and Discussions

This section presents the findings of the study. It has two main subsections. First, the background information's of participants was presented. The second, findings obtained from the qualitative data were presented.

Background Information of Respondents

Table 3. Respondents' Background Information (N=14)

Variables	Categories	N	%
Sex	Male	2	14.3
	Female	12	85.7
	Total	**14**	**100**
Age	18-30	1	7.1
	31-43	10	71.4
	>43	3	21.5
	Total	14	**100**
Educational Level	Not attended at all	6	42.9
	Basic Education (read and write)	2	14.3
	Primary level (1-8)	2	14.3
	Secondary level(9-12)	4	28.6
	Tertiary (College or University)	0	0
	Total	14	**100**
Marital Status	Single	1	7.1
	Married	10	71.4
	Widowed/r	1	7.1
	Divorced	2	14.3
	Total	**14**	**100**
Employment	Daily Laborer	5	35.7
	House Wife	7	50

	Other		2	14.3
	Total		14	**100**
Relation with children with Mental Retardation	Parents	Father	2	14.3
		Mother	11	78.5
	Siblings	Brother	0	0
		Sister	1	7.1
		Wife	0	0
	Total		14	**100**

Fourteen (14) families of children with mental retardation were participated in this study. Among these, 2(14.3%) were males while the rest 12 (85.7%) were females. As **Table 1 above** shows, of the total fourteen respondents, 1(7.1%) participants' age ranges from 18-30 years, 10(71.4%) of respondents' age range from 31-43 and the rest 3 (21.5%) was above the age of 43. With regard to their educational level, 6(42.9%) were not attended at all, basic education (read and write) 2(14.3%), primary education 2(14.3%) and the rest 4 (28.6%) were followed secondary level. Concerning the marital status of participants, 10(71.4%), 2(14.3%), 1(7.1%) and 1(7.1%) were married, divorced, widower and single respectively.

Finally, regarding the care givers relation with the children with mental retardation, 11(78.5%), 2(14.3%) and 1 (7.1%) were mother, father and siblings respectively.

Table 4. Background Information about the Children Mental Retardation

Variables	Categories	N	%
Sex	M	8	57.1
	F	6	42.9
	Total	14	**100**
Age	5-10	0	**0**
	11-16	14	**100**
	17-22	0	0
	>22	0	0
	Total	14	**100**
The onset of the	At Birth	14	100

illness	After Birth	0	0

Of the total fourteen (14) children with mental retardation, 8(57.1%) were males and 6(42.9%) were females. As **Table 2 above** shows, participants' age ranges found between 11-16 years(100%). With regard to the onset of the illness, all children acquire this illness at birth.

Findings from Semi-structured Interview

The semi-structured interviews were held with six people. Among them, two were males and the remaining four were females. The finding of this study obtained from semi-structured interview presented and describes as follows:

1. Community's Understanding about Mental Retardation

Regarding this questions, the data obtained from the six participants were similar. They revealed as their community attitudes towards mental retardation, as participants stated, is differ based on some factors such as level of literacy and culture. For example, with regard to literacy, the interviewees stated as the literate (not all but the majority) treat them positively and they also told to the researcher as the opposite was true. The participants of interviewees of this study offered their communities definition/understanding of mental retardation, which they defined it as an illness which makes the persons' thinking ability totally dysfunction, in their language "out of use", is transmitted and untreatable. However, they also disclosed as there are people who don't see on such way. Moreover, the participants revealed as youngsters {their peers) are the most threatening age groups who are stigmatizing children with mental retardation.

Concerning the causes of mental retardation, the participants stated as their communities attributed it with the different beliefs. These were, the curse from God, demon possession or by evil spirit what they call in their language "likefete", "yebete tata", "Bemetete" , tears of person on the family, "ergoze hone tsebel metetate", hereditary, "yaletegebere gebre", economic problem-poverty and so forth.

2. Attitude of the Community towards Children with Mental Retardation

Data gathered from all the interviewee shows the existence of negative attitude of the communities especially among peers towards children with mental retardation. They revealed as these negative attitudes of the community manifested on their beliefs they do have on and during interaction they make with them. The followings are some of the beliefs and ways of interactions of the communities do have towards children with mental retardation which were outlined from the interviewees:

- The participants expressed that when they see individual with mental retardation **they**

run, this interaction pattern is common among person with same age. These individuals also initiate them to aggressive "Yetenekusutale". Almost all the communities see them in **surprise "በመገረም ያዩታል".**

- They also revealed as they don't want to: be seen with them, make friendship with them, and play with them
- Moreover, they revealed that they don't greet them even at school although they can give response.
- Furthermore, most interviewees stated as this negative attitude of the communities does not stop only on children with mental retardation but also to their family members.

3. ***Psychological Challenges***

As stated by all interviewees' children with mental retardation are facing the following psychological challenges. These are: being upset (sadness) "**Am I Not Human Being"**, tearfulness (cry), feeling of hopelessness, feeling of upset, inferiority feelings, frustrations and so forth.

4. ***Social challenges***

The *social challenges, as outlined from* interviewees', children with mental retardation are facing are: they want to use their labor, they motivate them to learn bad behaviors they are doing(e.g. abuse drugs), they isolate them, unequal treatments, they insult them(e.g.**Ibid, Borko), harassments,** peers don't want to play with them, they don't want make friendship and even beating them especially by their peers and so forth.

5. Managing the Psychological and Social Challenges

The mechanisms, as revealed by the interviewees, employed to reduce the psychological and social challenges children with mental retardation are facing. The following listed were some of them identified among the interviewees of this study.

- **Pray to God or "Do'a"**

  "Tearing to God"), having a belief of "all were by him, God knows" were the most frequently stated mechanisms.

- **Helping each other**

- **Offering love & care:** for example one of the interviwee stated that "they will lead better life if we love them although their problem is dangerous"
- Although there were no significant helping institutions sited **Church**, **Mosque** and **family** were the most frequently put forward institutions which they offered help for this people. The support they gave was emotional.

6. Suggestion to be done at individual, family level (collaboratively), community or societal (government) level to reduce (if possible to solve) the problem

The interviewees of this study suggested some actions which should be taken to reduce (if possible to solve) this problem. These were:

Individually

Since the problem affects the life of everyone, as they stated, they suggested as every person need try to know about the problem through reading different materials. This in turn will help them to reduce the negative attitude they do have towards children with mental retardation and as a result to treat them with due care.

At family level

If there is an open discussion in family, as they stated, it will reduce it to minimal level and accordingly to provide the necessary care and support. They also stated its emotional benefit it does for the family members. In line with this one of the interviewee stated that "**We all are illed due to her".** This implies that family should work together to deal with problem.

At governmental level

The interviewees of this study stated as this problem is not only a problem of an individual but also societal in such way that it affects the life of other and the development of a country. Thus, the following were some tasks they gave for it. These were financial subsidy, moral support, distributing different services that are vital to them and safeguarding the rights of children with mental retardation.

Findings from FGD

Participants of the FGD were eight in number. From the FGD like the semi-structured interview, this research tried to explore the experience and views of the interviewee in relation to: the psychosocial challenges (i.e. stigma, discrimination, stress, frustrations and other burdens) that children with mental retardation faced and the mechanisms to reduce the challenges. The researcher found a similarity in findings between the semi-structured interview and FGD. In order to present the findings easily and in understandable manner, like he did in the case of semi-structured interview, the researcher opted to put the main issues as topic and then present and discus the issues explored from the study.

1. Community's Understanding about Mental Retardation

Like the participants of semi-structured interview did, the participants who participated in the FGD of this study offered their communities definition/understanding of mental retardation, as most stated, which they defined it as an illness which makes the persons' out of use and which could not be treated. Among the eight participants, three were agreed as their communities have awareness about mental retardation. However, all participants including this three revealed as their communities do have negative attitudes towards mental retardation, children with mental retardation and to their family members. To justify their idea for the existence and prevalence of such attitudes towards that people, they forwarded some ideas. Firstly, no one can recognize him/her as human being, don't want to go or do any activities with him/her and at large they want to fulfill their own needs, "**Yetekemubatal**" as one of the participant revealed. The "normal" people **attribute** their mistakes on them because they children with mental retardation couldn't express and defend their feelings like them. The other was, according to them, they (their neighborhood, at large the community) were reluctant to help them in the time of crisis. However, all the participants disclosed as there are people who helped them (but too few).

Moreover, the participants expressed that these communities' challenges/threats don't stop only on the children with mental retardation but also to their families' members.

Regarding the causes of mental retardation, all participants uncovered as the view of their community differ. The following were some views of the community regarding the causes of mental retardation which had been outlined by the participants of this study. These were:

- ***God's punishment***-"A response for one's misconduct/breaking of God's commandments".
- ***Possession by evil spirit***, what they called "likefet"
- Genetic or hereditary

2. Psychosocial challenges of Children with Mental Retardation

Concerning this issue, all the participants of the study stated as their communities hold negative attitude to and low interaction with children with mental retardation. The below listed behaviors, as outlined from the participants, were some of the ways which signify the negative attitudes of the communities towards children with mental retardation. These were:

- ***Isolation***

"They don't want to go/work with them. They don't have trust on them. No responsibility given for them even if they do have potential.

- ***No audience***

It is to mean that no one who can hear or give value to their ideas or sayings. They are degraded on all aspects of their life.

- **Blame**

The participants put forward as their children with children with mental retardation have been insulted. They revealed that this may takes place nonverbally.

- The labeling of **"Ibidu, Duda".**

Most participants of the study disclosed as this negative attitudes toward children with mental retardation is not only from outside but also from the family members too (e.g. related to this, one of our participant shared one case which he faced from their home, "one guest asked my brother (mentally ill children) about the life style of the city, when he tried to answer the question, our elder brother stopped him, by saying 'why you ask him?, he don't know nothing. Ask me".

Although all participants agreed as such attitude and interaction pattern (psychosocial challenges) exist in the studied community there were individuals who have **positive attitude** and are helping them.

In sum, all the participants have noted that their communities do have negative attitude and low interaction towards children with mental retardation. Based on the above findings, the researcher noted as children with mental retardation are suffering from innumerable psychosocial challenges such as stigma, discrimination, isolation, blame, fear, shame, hopelessness, frustrations and being upset.

3. Managing Psychosocial Challenges

The participants of this study revealed as they use different psychosocial management styles in response to such above mentioned challenges. The following were some:

- Praying to God

This was the most repeatedly stated mechanisms used by all the participants the study.

- *Reaction formation*(insulting them)
- Developing wishful thinking**,**
- Limiting ones interaction.
- Let them to join special schools
- Giving verbal praise and hope
- Regarding the kind of support they got, as they stated, was emotional.

4. Things to be done at various level to reduce (if possible to solve) the Challenges

Participants of this study have suggested some ways to solve this problem. Their suggestions lie at three levels i.e. individually, family and governmental.

At Individual level

They suggested as every individual should look him/herself since mental retardation can occur on everybody. They disclosed that improving ones understanding about mental retardation and related issues would help a person to change oneself, this could be achieved through many ways such like reading materials which give clue about the problem. They also disclosed as teaching others (e.g. friends) could help others to know about the issue and change their attitudes.

At Family level

An open discussion about the issue and family support (helping each other) were some of the suggestions stated by the participants. Treating them equally and giving due respect as we do for others.

At Governmental (societal) level

All the participants of the study has put forward as government had not work or didn't give attention to this group of people (children with mental retardation) and their family members. Thus, they suggested the following tasks which should be done by it.

Giving education to create awareness about the problem using different meanness like mass media, community based education ("it can use the model which has been working on HIV/AIDS" as it has been said by one of participants).

Help economically-beside the behavioral change, the participants suggested if the government work in subsidizing financial costs to the children with mental retardation. This idea was highly supported and suggested by the most participants.

They also associated it with issue of human rights. Regarding this, the participants expect the government to work to protect the rights of this group of people.

Discussions

The purpose of the present study was to explore the major psychosocial challenges that the children with mental retardation are facing. Based on the findings presented in the analysis part, a discussion was made inline with former studies conducted in the area here under.

This study revealed the major psychosocial challenges children with mental retardation are facing. These challenges are various like frustration, sadness, insult, harassment, stigma, discrimination and isolation because of negative attitudes, misunderstandings, and negative stereotypes towards mental retardation. A study conducted by American Association on Mental Retardation(2002) support this finding and it stated that person with mentally retardation carries such a stigma, discrimination that to admit its presence in a family is like revealing a shameful secret. As a result, very little is done for retarded children or adults, apart from locking them away. And yet the problem is widely prevalent, and millions of people suffering from it receive no professional attention or care.

Roos (1977) empirical evidence state that this psychosocial challenges of children with mental retardation doesn't stop only to the sufferer but also to their parents. Parents of children with mental retardation face such like psychosocial challenges: loss of self esteem, shame,

ambivalence, depression and so forth. Likewise the study finding of Cherenet Tekle and Opdal(2007) also revealed as the parents of the mentally retarded children lose hope, even be frustrated and ashamed of their children. This (the current) study finding also consistent with the above two finding.

Based on the above points the researcher understood that the communities where by the interviewees of this study live in, did have negative attitudes towards mental retardation. The researcher also noted as there are people (among the community) who have good understanding about it.

The mechanisms that the families and children with mental retardation used were, the other findings obtained from the present study. These were pray to God("tearing to God") or Do'a, being silent, helping each other(self-help group, discussing about the issue with family and close relatives), rethinking the situation in a positive way, reaction formation(insulting back), developing wishful thinking**,** teaching them about the issue for those who are willing, limiting one's interaction, and telling as the problem may also occur on them and so forth. This study finding is consistent with McGrath (2003), which stated that the most frequently used and considered mechanisms that family and children with mental retardation are such like, looking for information, learning experience, acquiring social support, escape/avoidance and having positive hope. Thus, this research finding is reliable the above mentioned researchers findings.

The researcher also noted from this study that children with mental retardation and their families employ different management styles to reduce the psychosocial challenges they face. The participants employ these mechanisms especially when the frequencies of the challenges become tense and usual.

Chapter Five

Summary, Conclusions and Recommendations

This chapter summarizes and concludes the results of this study. Finally, it presents the recommendation part.

Summary

The main objective of the present study was to explore the major psychosocial challenges that the children with mental retardation are facing.

Fourteen participants were selected for this study by using purposive sampling. Among these, 2(14.3%) were males while the rest 12 (85.7%) were females. Among fourteen, six were for semi-structured interviewee and the remaining eight were for FGD.

Findings from both FGD and semi-structured interviewee data show as children with mental retardation are suffering from the stigma, discrimination, blame, isolation, insult, frustration, shame and other psychosocial challenges due to misunderstandings, and negative stereotypes and attitudes surround mental retardation.

This study also explored the mechanisms that the families and children with mental retardation employed in response to the psychosocial challenges they face. These were praying to God ("tearing to God") or Do'a, not going out of home- limiting ones interaction, reaction formation(insulting back), discussing about the issue with family and close relatives, and so forth.

Conclusions

Based on the findings of the present study, the following conclusions were made:

Children with mental retardation are facing a double burden. The first is from the illness itself and the other is psychosocial challenges (e.g. frustration, sadness, insult, harassment, stigma, discrimination and isolation) they are confronting because of negative attitudes, misunderstandings, and negative stereotypes towards mental retardation.

Thus, the findings of the present study witnessed that, children with mental retardation are loaded down by the above mentioned psychosocial challenges.

This study also explored the mechanisms that the families and children with mental retardation employed in response to the psychosocial challenges they are facing. These were praying to God ("tearing to God"), not going out of home- limiting ones interaction, reaction formation(insulting them), discussing about the issue with family and close relatives, and so forth.

Thus, the findings of the present study indicated that the families and children with mental retardation are suffering from a number of circumstances that erode their strengths and resources. Being burdened by various psychosocial crisis and challenges, their management skills are minimum unless they receive extra professional support.

To sum up, the findings of this study in line with the evidences found by other researchers in the field help/ have important practical implication to such institutions; health, educational and so forth. It helps educational and health institutions to accommodate their needs and do in favor of them. It helps policy makers to make advocacy and initiate to implement the strategies regarding this issue (the finding pointed out as the rights of children with mental retardation violated by the community they are living in).

Moreover, the study has practical implication to those NGOs, GOs and civil societies who are working on this target groups.

Implications of the Study

Nowadays, as it is obtained in the present findings, children with mental retardation as well as their families are facing stigma, discrimination, isolation and other psychosocial challenges due to the misunderstandings, and negative stereotypes and attitudes surround mental retardation. The findings of the study show that measures at various levels aiming at reducing/eliminating the problem. Thus, the researcher wants to offer some recommendations with the suggestions that have been proposed by the participants of this study.

Implications for Family of Children with Mental Retardation

Developing and strengthening families' ties and social support network is essential to enable families to make an open discussion about the problem and to help each other. A strong social support network is often useful for the distressed person to release his/her negative feelings and frustration and to receive social support. The more social support an individual has, the better he or she is able to deal with stress (WHO, 2001).

Implications for Government and other concerned bodies

Mental retardation is not only a problem which affects the sufferer and their family members but also the society where they are living them. It affects a society both psychosocially and economical (development of the country). Thus, if we accept this reality, government and other concerned body should do tasks which could be remedy for it. The followings are some of the tasks by which the researcher and the participants of this study suggested for them.

- ***Public Education***

The government should give public education campaign to create awareness about the problem. It can do this action through mass media, workshops, counseling, etc. Both electronic media and press are appropriate instruments since they can address a number of people throughout the country. Workshops and counseling services can be organized and extended by concerned bodies to those who need the programs. In all forms of the programs, the target populations that need to be addressed include: governmental officials of various sectors and levels, potential employers from the government, non-government and private sectors, religious leaders, and other citizens.

This will changes the negative belief systems of the community towards the problem. The researcher speaks this confidently because we have success on HIV/AIDS, which had a great stigma and discrimination towards it.

- ***Advocacy, lobbying and other initiatives***

The lobbying and advocacy activities are more or less similar or can be part of that of awareness raising programs. This can be done by both government and other concerned body (e.g. NGOs).

- ***Distributing the services***

Government should expand its centers to different localities of the country.

- ***Safeguarding the rights***

Government also should work to protect of the rights of children with mental retardation.

- ***Religious and other institutions***

They should teach their fellows about the problem.

- ***NGOs***

Even if the problem is creating this impact, in the researcher observation, there is only one NGO (RAPID) who is working on it. Thus, the researcher highly recommend for NGOs to work on it.

- ***Researchers***

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 children with mental retardation.

After these all, the concerned body should initiate follow up through conducting research in order for observing changes

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Appendixes

Appendixes A English Interview and FGD Version Questions

Appendixes B Amharic Interview Version Questions

Adama Science and Technology University

School of Humanities and Law, Department of Sociology and Social Work

Postgraduate Program

Questionnaire to Be Filled by Families of Children with Mentally Retarded

Dear participants,

This interview questions is prepared to assess the major psychosocial problems that children with mental retardation are facing and the mechanisms should be taken to reduce the problems. Accordingly, for the success of this research, your contribution in responding this interview questions is considered as an indispensable input. For this reason, you are requested to cooperate in giving genuine and reliable information to the interview questions. For confidentiality purpose, the researcher is not going to write your name. If you get any unclear interview questions, you can ask the interviewer. Once again I would like to thank you in advance for giving me a genuine and reliable answer.

The researcher

Part I: Background Information of Participants

1. Code No._____ 2. Age._____ 3. Sex: M ☐ F ☐

4. Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed/r ☐ Other ☐

5. Educational Background A. Not attended at all B. Basic Education (read and writes)

C. Primary level (1-8) D. Secondary level (9-12) E. Tertiary (College or University)

6. Occupation: A. Daily Laborer B. House Wife C. Self Employed D. Employee (NGO, GO…)
E. Others (specify) --------

7. Relation to the mentally retarded child

a. Mother b. Father C. Siblings D. Grandparents E. Uncle F. Aunt G. Other (_____)

Part II: Background Information Concerning Mentally Retarded Child

A. His/her Age_____ B. Sex_____ C. Onset of the Problem (in years)_____

Part III. Semi-structured Interview

7. How does your community understand mental retardation?

7.1. What do they say about its causes?

7.2. What do they say about the cause of your child's mental retardation?

8. What do you think the attitude of the community towards children with mental retardation?
9. What do you think the interaction pattern of the community towards children with mental retardation?
10. What psychological challenges your child with mental retardation are facing due to his/her mental retardation problem?

10.1. If your child with mental retardation faced such psychological challenges, how did you manage it?

10.2. In times of such psychological challenges, to whom do you turn to get support (extended family, families, friends, agencies, self-help groups, church, health professionals, and so forth)?

10.3. What kind of support do you get?

11. What social challenges your child with mental retardation are facing due to his/her mental retardation problem?

11.1. If your child with mental retardation faced such social challenges, how did you manage it?

11.2. In times of such social challenges, to whom do you turn to get support (extended family, friends, families, agencies, self-help groups, church, health professionals, and so forth)?

11.3. What kind of support do you get?

12. What do you suggest to be done at individual, family level (collaboratively), community or societal (governmental) level to reduce (if possible to solve) the problem?
13. Lastly, anything you need to say,_____

Part IV. Focus Group Discussions (FGD) Guide

This group discussion will contain 6 families of mentally retarded children. Regarding where and when the discussion will be hold, it will be decided based on the agreement of the researcher and the participants. Concerning the rule which should be abided during the discussion are listed as follows: **the first** is no man can speak until s/he got the chance. **The second** is discouraging /not tolerating the ideas of other is forbidden. In relation to this, even if asking question is the unlimited rights of each participant and also it is a necessary thing, it will be better if s/he waits the person until finish his/her ideas. At the end, each participant without any fear or shyness will be encouraged to give reflection on the ideas that will be raised in the discussion room. The following guiding questions are presented to be discussed by this group.

- How does your community understand mental retardation?
- What are the challenges children with mental retardation are facing?
- How do you manage such challenges?
- What do you suggest to be done at individual, family level (collaboratively), community or societal (governmental) level to reduce (if possible to solve) the problem?

Appendix B

የአዳማ ሳይንስና ቴክኖሎጂ ዩኒቨርሲቲ

የሂዩማኒቲስና የህግ ት/ቤ ፣የሶሾሎጂ እና ሶሻል ወርክ ትምህረት ክፍል

ድህረ ምረቃ ፕሮግራም

በአዕምሮ ዝግመት ህመምተኛ ልጆች ቤተሰብ የሚሞላ መጠይቅ

ውድ ተሳታፊ

ይህ በከፊል የተደራጀ ቃለ መጠይቅ የተዘጋጀው የአዕምሮ ዝግመት ህመም ያለባቸውን ልጆች ዋና ዋና ስነልቦናዊና ማህበራዊ ችግሮች ለመዳሰስ እና ችግሮቹን ለመቀነስ የሚያስችለውን ዘዴዎች ለመጠቆም ነው፡፡ በመሆኑም የሚሰጡት እውነተኛና ሚዛናዊ መረጃ ለዚህ ለጥናታዊ ጽሁፍ መሳካት በጣም አስፈላጊ መሆኑን በመረዳት የበኩልዎን ትብብር እንዲያደርጉልኝ እጠይቃለሁ፡፡ የእርስዎን ሚስጥር ለመጠበቅ ሲባል አጥኚው ግለሰብ ስምዎን አይፅፍም፡፡ ግልጽ ያልሆኑ ጥያቄዎች ካሉ ቃለ መየይቅ አደራጊውን ግልሰብ መጠየቅ ይችላሉ፡፡ ለሚቀረቡት ጥያቄዎች እውነተኛና ሚዛናዊ ምላሽ እንደሚሰጡኝ በመተማመን ምስጋናዬ ከወዲሁ እገልጻለው፡፡

ክፍል አንድ፡ ሀ. የተሳታፊው/ዋ ግላዊ መረጃዎች

ውድ ተሳታፊ የሚከተሉት ግላዊ መጠይቆች ለዚህ ጥናት እንደ አንድ እሴት ስለሆኑ የእርሶን ትክክለኛ መረጃዎች እንድትሰጡኝ ስል በአክብሮት እጠይቃለንሁ፡፡ የግል መረጃ ፣ (ኮድ.ቁ) የሚለው የእርሶን ሚስጥር ለመጠበቅ የተዘጋጀ በመሆኑ መረጃ ሰብሳቢው ኮድ ቁጥሩን የሚሰጠት ይሆናል፡፡

1. ኮድ.ቁ---------- 2. ዕድሜ---------- 3. ጾታ፡ ወ ☐ ☐

4. የትዳር ሁኔታ፡-ያላገባ ☐ *ያገባ* ☐ *የፈታ* ☐ *ባለቤቷ/ቱ* ☐ *ይወት የሌለ/ች* ☐

5. የትምህርት ደረጃ፡ ሀ. መደበኛ ትምህርት ያልተከታተለ ለ. መሰረታዊ ትምህርት የተከታተለ

ሐ. መጀመሪያ ደረጃ የተከታተለ/ች(1-8) ሠ. ሁለተኛ ደረጃ(9-12) መ. ከኮሌጅ/ከፍተኛ ደረጃ የተመረቀ/ች

6. የስራ ሁኔታ፡ ሀ.የቀን ሰራተኛ ለ. የቤት እመቤት ሐ. የግል ሰራተኛ መ. በምነግሰታዊ/ ምነግሰታዊ ባልሆን ድርጅት የሚሰራ/ትሰራ ሠ. ሌላ ካለ(ጥቀስ)------

7. ከአዕምሮ ዝግመት ህመምተኛው/ዋ ጋር ያለዎት ዝምድና፡ ሀ.እናት ለ.አባት ሐ.ወንድም/እህት መ. አያት

ሠ. አጎት ረ.አክስተ ሸ.ሌላ( )

ክፍል ሁለት. የአዕምሮ ዝግመት ህመምተኛው/ዋ ግላዊ መረጃዎች

ነ. የአዕምሮ ዝግመት ህመምተኛው/ዋ ዕድሜ------ 2. ፆታ---- 3. ህመሙ የጀመረበት ዘመን-------

ክፍል ሶስት. በከፊል የተደራጀ ቃለ መጠይቅ (Semi-Structured Interview)

1. የሚኖሩበት አካባቢ ማህበረሰብ የአዕምሮ ዝግመት ህመምን እነዴት ነው የሚገነዘበው?

   1.1. እነዴትስ ሊከሰት ይችላል ብሎ ያስባል?

   1.2. ሰዎች የእሱን/እሷን የአዕምሮ ዝግመት ህመም መንስኤው ምንድነው ይላሉ?

2. የሚኖሩበት ማህበረሰብ ስለ እሱ/እሷ ምን አይነት አመለካከት አለው ብለው ያስባሉ?

3. የሚኖሩበት ማህበረሰብ ከእሱ/እሷ ጋር ያላቸው ማህበራዊ መስተጋብር ምን ይመስላል?

4. ማህበረሰቡ እሱ/እሳ ባለበት/ባት የአዕምሮ ዝግመት ህመም ምክንያት ምን አይነት ስነልቦናዊ ችግሮች ይደርስበታል/ባታል?

   4.1. እሱ/እሳ የአዕምሮ ዝግመት ህመምተኛ በመሆኑ/ኗ የሚደርስበት/ባት ስነልቦናዊ ችግሮችን እነዴት ነው የምትቋቋሙት?

   4.2. እሱ/እሳ የአዕምሮ ዝግመት ህመምተኛ በመሆኑ/ኗ በሚደርስበት/ባት የስነልቦና ችግሮችን ለመቋቋም ከማን ከማን ነው ድጋፍ የሚያገኙት(ከቅርብ ዘመድ፤ከቤተሰብ፤ከጓደኛ፣በጎ ፍቃድ አድራጊዎችና ድርጂቶች፣ሀይማኖታዊ ተቋዋማት፤የጤና ባለሞያዎች እና ሌሎች?

   4.3. ምን አይነት ድጋፍ ነው ያገኛችት?

5. ማህበረሰቡ እሱ/እሳ ባለበት/ባት የአዕምሮ ዝግመት ህመም ምክንያት ምን አይነት ማህበራዊ ችግሮች ይደርስበታል/ባታል?

   5.1. እሱ/እሳ የአዕምሮ ዝግመት ህመምተኛ በመሆኑ/ኗ የሚደርስበት/ባት ማህበራዊ ችግሮችን እነዴት ነው የምትቋቋሙት?

   5.2. እሱ/እሳ የአዕምሮ ዝግመት ህመምተኛ በመሆኑ/ኗ በሚደርስበት/ባት የማህበራዊ ችግሮችን ለመቋቋም ከማን ከማን ነው ድጋፍ የሚያገኙት(ከቅርብ ዘመድ፤ከቤተሰብ፤ከጓደኛ፣በጎ ፍቃድ አድራጊዎችና ድርጂቶች፣ሀይማኖታዊ ተቋዋማት፤የጤና ባለሞያዎች እና ሌሎች?

   5.3. ምን አይነት ድጋፍ ነው ያገኛችት?

6. በግልና በቤተሰብ እንዲሁም በመህበረሰብ ደርጃ ይሄን የማህበረሰብ ተጽኖ ለመቀነስ ብሎም ለማጥፋት ምን እያደርጋችሁ ነው ምንስ መደረግ አለበት ትላላችው?

7. በመጨረሻ የሚሉት ነገር ካለ?

ክፍል አራት. የቡድን ውይይት(Focus Group Discussion) መምሪያ

ይሄ ቡድን ወይይት 8 የአዕምሮ ዝግመት ህመምተኛ ቤተሰቦችን የሚያካትት ይሆናል፡፡ የውይይቱ ቦታና ሰዓት ጥናቱን በሚያጠናው ግለሰብና በተውያዮቹ የሚወሰን ይሆናል፡፡ በውይይቱ ወቅት መከበር ስላለባቸው ህጎችን በተመለከት እነደሚከተለው ነው፡፡ 1ኛ. ማንኛውም ሰው ዕድል ሲሰጠው ብቻ ነው መናገር የሚችለው/ቢናገር ይመረጣል፡፡ ሁለተኛው ማንም ሰው የሌላውን ሀሳብ መንቀፍ/ማንቋሸሽ አይፈቀድለትም/አይችልም፡፡ ከዚህሁ ጋር በተያያዘ ጥያቄ ያለው ሰው መጠየቅ ያልተገደበ መብቱ ሲሆን ብሎም አስፈላጊም በመሆኑ አንድ ሰው ሀሳቡን ከጨረሰ በውህላ ቢሆን ይመረጣ፡፡ በመጨረሻም ማንኛውም ሰው በሚነሱተ ሀሳቦች ላይ ካለምንም ፍራቻ የሚመስለውን ነገር እነዲናገር/እንዲያካፍል ይበረታታል፡፡ ለዚህ የቡድን ውይይት የቀረቡት ጥያቄዎች እንደሚከተሉት ናቸው፡፡

- የሚኖሩበት አካባቢ ማህበረሰብ የአዕምሮ ዝግመት ህመምን እነዴት ነው የሚገነዘበው?
- የአዕምሮ ዝግመት ህመምተኛ ምን አይነት ተግዳሮቶች ነው የሚገጥማቸው?
- እነዚህን ተግዳሮቶች እነዴት ነው የምትቋቋሚቸው?

በግልና በቤተሰብ እንዲሁም በመህህበረሰብ ደርጃ ይሄን የማህበረሰብ ተጽኖ ለመቀነስ ብሎም ለማጥፋት ምን እያደርጋችሁ ነው ምንስ መደረግ አለበት ትላላችው?

Adama Science and Technology University

School of Humanities and Law, Department of Sociology and Social Work

Postgraduate Program

Questionnaire to Be Filled by Families of Children with Mentally Retarded

Dear participants,

This interview questions is prepared to assess the major psychosocial problems that children with mental retardation are facing and the mechanisms should be taken to reduce the problems. Accordingly, for the success of this research, your contribution in responding this interview questions is considered as an indispensable input. For this reason, you are requested to cooperate in giving genuine and reliable information to the interview questions. For confidentiality purpose, the researcher is not going to write your name. If you get any unclear interview questions, you can ask the interviewer. Once again I would like to thank you in advance for giving me a genuine and reliable answer.

The researcher

Part I: Background Information of Participants

1. Code No._____ 2. Age._____ 3. Sex: M ☐ F ☐

4. Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed/r ☐ Other ☐

5. Educational Background A. Not attended at all B. Basic Education (read and writes)

C. Primary level (1-8) D. Secondary level (9-12) E. Tertiary (College or University)

6. Occupation: A. Daily Laborer B. House Wife C. Self Employed D. Employee (NGO, GO…)
E. Others (specify) --------

7. Relation to the mentally retarded child

a. Mother b. Father C. Siblings D. Grandparents E. Uncle F. Aunt G. Other (_____)

Part II: Background Information Concerning Mentally Retarded Child

A. His/her Age_____ B. Sex_____ C. Onset of the Problem (in years)_____

Part III. Semi-structured Interview

14. How does your community understand mental retardation?

14.1. What do they say about its causes?

14.2. What do they say about the cause of your child's mental retardation?

15. What do you think the attitude of the community towards children with mental retardation?
16. What do you think the interaction pattern of the community towards children with mental retardation?
17. What psychological challenges your child with mental retardation are facing due to his/her mental retardation problem?

    17.1. If your child with mental retardation faced such psychological challenges, how did you manage it?

    17.2. In times of such psychological challenges, to whom do you turn to get support (extended family, families, friends, agencies, self-help groups, church, health professionals, and so forth)?

    17.3. What kind of support do you get?

18. What social challenges your child with mental retardation are facing due to his/her mental retardation problem?

    18.1. If your child with mental retardation faced such social challenges, how did you manage it?

    18.2. In times of such social challenges, to whom do you turn to get support (extended family, friends, families, agencies, self-help groups, church, health professionals, and so forth)?

    18.3. What kind of support do you get?

19. What do you suggest to be done at individual, family level (collaboratively), community or societal (governmental) level to reduce (if possible to solve) the problem?
20. Lastly, anything you need to say,_____

Part IV. Focus Group Discussions (FGD) Guide

This group discussion will contain 6 families of mentally retarded children. Regarding where and when the discussion will be hold, it will be decided based on the agreement of the researcher and the participants. Concerning the rule which should be abided during the discussion are listed as follows: **the first** is no man can speak until s/he got the chance. **The second** is discouraging /not tolerating the ideas of other is forbidden. In relation to this, even if asking question is the unlimited rights of each participant and also it is a necessary thing, it will be better if s/he waits the person until finish his/her ideas. At the end, each participant without any fear or shyness will be encouraged to give reflection on the ideas that will be raised in the discussion room. The following guiding questions are presented to be discussed by this group.

- How does your community understand mental retardation?
- What are the challenges children with mental retardation are facing?
- How do you manage such challenges?
- What do you suggest to be done at individual, family level (collaboratively), community or societal (governmental) level to reduce (if possible to solve) the problem?

DECLARATION

I hereby confirm that this thesis is my original work and has not been presented in any other universities and that all the resources of any materials used for this thesis have been properly acknowledged.

Name: _____

Signature: _____

Date of Submission: _____

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

Name: _____

Signature: _____