

**EVOLVING RELATIONSHIPS WITH PERSONS  
WHO HAVE MENTAL RETARDATION:  
AN EXPLORATORY STUDY**

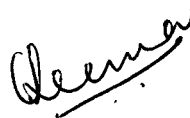
*A dissertation submitted  
in partial fulfilment of the requirements of the degree of*  
**DOCTOR OF PHILOSOPHY**  
*in*  
**PSYCHOLOGY**

*By*  
**LEEMAMOL MATHEW**

**DEPARTMENT OF PSYCHOLOGY  
UNIVERSITY OF CALICUT  
KERALA, INDIA  
2006**

## DECLARATION

I, Leemamol Mathew, do hereby declare that this thesis **EVOLVING RELATIONSHIPS WITH PERSONS WHO HAVE MENTAL RETARDATION: AN EXPLORATORY STUDY** has not been submitted by me for any Degree, Diploma, Associateship, Fellowship, Title or Recognition in this or in any other institution. This work or any part of it has not been sent anywhere for publication or presentation purpose.

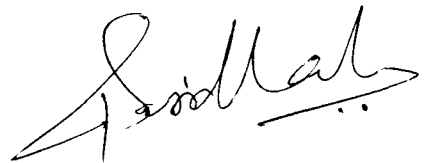


**Leemamol Mathew**  
Research Scholar  
Department of Psychology  
University of Calicut

University of Calicut  
23/11/2006

## CERTIFICATE

Certified that this report on **EVOLVING RELATIONSHIPS WITH PERSONS WHO HAVE MENTAL RETARDATION: AN EXPLORATORY STUDY** is a record of bonafide study and research carried out by **Ms. Leemamol Mathew** under my supervision and guidance. The report has not been submitted by her for any award of Degree or Diploma in this or in any other University.



University of Calicut  
29/11/2006

**Dr. T. Sasisdharan**  
Sr. Lecturer  
Department of Psychology  
University of Calicut

## Acknowledgment

The emotions towards the people who contributed to make this dissertation are much beyond than I could express in words. My first thoughts while writing these lines of 'big thank you' are about all the students of all the four schools, where I did the fieldwork to collect data that stands alive from the first to last line of this dissertation. My special thanks goes to my eleven participants who have not only contributed data to this study, but also provided lessons for my life. Let me also thank all the parents, and siblings of my participants who had showed concern and co-operation in my work, without any reluctance.

This study would not have been accomplished without expert guidance from my supervisor, Dr. T. Sasidharan at the Department of Psychology, University of Calicut. By providing sufficient freedom for methodological innovation and providing constant support, he has guided me through out this exercise. He has been a patient listener, mature teacher and above all, a source of inspiration to tread the paths those are seldom travelled in the discipline of psychology. Let me express my deep most gratitude to him.

Sincere thanks due to, Dr. C. Jayan, the head of the department of Psychology, University of Calicut, for his support and co-operation through the period that I have been a student.

Professor John Baby has been extremely helpful throughout my student life at the Department of Psychology, University of Calicut. Let me acknowledge him at this stage.

Professor Anitha Ravindran, at the Department of Psychology, University of Calicut has been very helpful with her timely advice and support during this study. Let me record my appreciation for her help.

I express my gratitude to Dr. Asha, Professor at the Department of Psychology, University of Calicut, for her support and co-operation throughout my student life. Thank you Dr. Asha.

I thank, Dr. Sari for her support in the study.

My gratitude goes to all the non- teaching staff of the department of Psychology, University of Calicut, for their co-operation and timely help throughout the study.

I am indebted to the staff and management of MV Shetty Trust Colleges, Mangalore, where I taught while doing the fieldwork of this dissertation. They have been accommodating and helping me to flexibly carry on my doctoral work while teaching the students there.

I thank all the principals of all the four schools for the support in my study. My special thanks goes to Indu Prasad, the Principal, the teachers, carers and other staffs of Chethana Special School, Mangalore, for their co-operation and immense help in my field work.

Let me pen my gratefulness to the library staff at various libraries of Calicut and Oxford University, NIMHANS Bangalore, IISH Mysore and many others facilitating my reference work.

Many professionals such as clinical psychologists (especially Aneeta Mary Nicholas, Medical Trust, Ernakulam), physiotherapists, speech therapists, occupational therapists, and social workers have provided expert opinions on my work and enhanced my limited knowledge at various stages of the study. Let me record my gratitude to them all.

I must thank the staff at Mencap Oxford, UK who provided exposure to the issues and management of children with mental retardation in UK.

Many thanks are also due to Christina Silver, University of Surrey, UK for providing training on qualitative software (Nvivo).

Often dissertation work is a lonely journey. Friends had been immense source of strength to carry on this journey. Let me thank all of them profusely. Many thanks are due to Shanthi, Lisa, Shabana, Teresa, and George for their support and cooperation during this work. My sincere thanks also goes to my parents, brother, and sisters who have supported me throughout my work, especially during the weekends when I decided to forget all about my dissertation, spending time with them.

Finally, my gratitude goes to my loving husband, who joined me at the final stages of this study, which I think, made a big difference.

**Department of Psychology  
University of Calicut,**

**Leemamol Mathew**

## Table of Contents

<b>Chapter 1: Introduction.....</b>	<b>1</b>
1.1 Story of Faizal.....	1
1.2 A subjective history of research.....	3
1.3 Research problem.....	5
1.4 Objectives of the study.....	6
1.5 Methodology.....	6
1.6 Structure of the report.....	7
<b>Chapter 2: Relationships among people with mental retardation.....</b>	<b>8</b>
2.1 Relationship.....	8
2.1.1 The nature of relationship.....	9
2.1.2 Interaction as the building block of relationship.....	10
2.1.3 Intimacy theory.....	11
2.1.4 Learning about relationships.....	12
2.1.5 Relationship in the family.....	13
2.1.6 Friendships.....	15
2.1.7 Satisfaction from relationship.....	16
2.1.8 Power and autonomy in relationship.....	16
2.1.9 Attachment theories and relationship of young children.....	17
2.2 Happiness: concept and issues.....	22
2.3 Happiness from relationships.....	23
2.4 Mental Retardation.....	25
2.4.1 Concept.....	26
2.4.2 Classification.....	26
2.4.3 Diagnosis.....	28
2.4.4 Characteristics.....	28
2.4.4.1 Mild mental retardation.....	29
2.4.4.2 Moderate mental retardation.....	30
2.4.4.3 Severe mental retardation.....	31
2.4.4.3 Profound mental retardation.....	32
2.4.5 Associated conditions.....	34
2.4.6 Prevalence.....	35

2.4.7 Causes.....	36
2.4.7.1 Genetic conditions.....	37
2.4.7.2 Environmental conditions.....	39
2.4.8 Interventions.....	42
2.4.8.1 Education.....	42
2.4.8.2 Psychotherapeutic Intervention.....	44
2.4.8.3 Psychopharmacology.....	47
2.4.8.4 Home and Community based services.....	48
2.4.8.5 Other Interventions.....	49
2.5 Relationships in mental retardation.....	50
2.5.1 Friendships in people with mental retardation.....	50
2.5.2 Types of friendships in mental retardation.....	52
2.5.3 Pattern of friendships in mental retardation.....	53
2.5.4 Effectiveness of having a close friend.....	54
2.6 Demography and service in India for mental retardation.....	56
2.7 Rationale of the study.....	59

### **Chapter 3: Methods.....61**

3.1 Research design.....	61
3.2 Exploratory stage.....	64
3.2.1 Emerging ideas from the exploratory study.....	66
3.3 Case focussed stage.....	67
3.3.1 Sample selection procedure.....	67
3.3.1.1 Selection of the setting.....	67
3.3.1.2 Case Selection.....	74
3.3.2 Sources of data.....	77
3.3.2.1 Participant observation.....	77
3.3.2.1.1 The process of developing relationships.....	78
3.3.2.1.2 Interactions in group situations.....	78
3.3.2.1.3 Individual interaction.....	79
3.3.2.1.4 Observations regarding relationship building.....	81
3.3.2.2 Systematic case history tracking.....	81
3.3.2.3 Interviews.....	82

3.3.2.4 Secondary data.....	83
3.4 Data processing and analysis.....	84
3.5 Limitations of the Study.....	85
3.6 Ethical consideration.....	86

**Chapter 4: Evolving relationships with persons who have  
mental retardation.....87**

**Section I:**

4.1 Individual analysis of the pattern of relationship development.....	87
4.1.1 Challenging behaviour as a mechanism for developing relationship: Faizal.....	88
4.1.2 Unrealistic expectation of the significant adults poses emotional insecurity: Nithin.....	97
4.1.3 Loss of attachment figure is a reason for loneliness: Radhika.....	105
4.1.4 My aspiration to develop 'we-self': Rahul.....	115
4.1.5 Clinging behaviour is a reflection of attachment relationship: Seema.....	124
4.1.6 Interpersonal chemistry through 'Shyness': Naveen.....	133
4.1.7 Relationship through other skills: Bhavya.....	142
4.1.8 Empathy in the relationship of an adolescent boy with mental retardation: Rajeev.....	149
4.1.9 Stigmatisation in people with mental retardation leads to close relationships with non-handicapped persons: Navaz.....	155
4.1.10 Attachment relationships facilitate deficit services: Vinaya.....	162
4.1.11 Interpersonal relationship through complaints: Stanley.....	170

**Section II:**

4.2 Towards a general relationship pattern of the children in their family and school.....	180
4.2.1 Relationships in the family.....	181
4.2.1.1 Parent-child interaction.....	182
4.2.1.2 Sibling relationships.....	190

4.2.1.3 Others in the family.....	192
4.2.2 Relationships at school.....	193
4.2.2.1 Service provider-service user relationship.....	193
4.2.2.2. Mutual exchanges of the disabled peer group.....	196
4.2.2.3 Relationships with others in the school.....	198

**Section III:**

4.3 Conflict and disagreement in interaction.....	199
4.3.1 Reasons for emotional insecurity in the family.....	200
4.3.1.1 Lack of sensitive interaction between the mother and the child.....	200
4.3.1.2 The arrival of younger siblings reduces the attention of the attachment figure.....	202
4.3.1.3 Loss of attachment figure is a threat to attachment security.....	204
4.3.1.4 The traditional beliefs of the family can be a threat to emotional security.....	205
4.3.1.5 Over protectiveness of the parents.....	206
4.3.2 Reasons for emotional insecurity in schools.....	207
4.3.2.1 Deficit based services focus only on functional independence.....	208
4.3.2.2 Unrealistic expectation about the skills reduces attachment security.....	210
4.3.2.3 Punishments are threats to emotional security.....	211
4.3.2.4 Neglect could be a factor for emotional insecurity.....	212

**Section IV:**

4.4 Interpersonal chemistry in a new dyadic interaction.....	213
4.4.1 Significance of the dyadic relationship.....	214
4.4.1.1 Attachment security in a maternal level sensitive interaction.....	215
4.4.1.2 Reciprocal exchanges reflected the peer group interaction....	216
4.4.1.3 Unusual behaviours were treated as communications.....	216
4.4.2 Pattern observed in the dyadic relationship.....	217
4.4.3 The effectiveness of the dyadic relationship.....	218

4.4.3.1 Emotional dependence is guaranteed in  
the dyadic relationship.....219

4.4.3.2 Bringing out empathy in children.....224

4.4.3.3 Emergence of functional independence in the  
dyadic relationship with the researcher.....226

4.4.3.4 Interpersonal chemistry among the children during  
the 10 months interactions with the researcher.....227

4.4.3.5 Change in the approach of the teachers towards children.....230

4.4.4 Concluding remarks.....231

**Chapter 5: Summary and Conclusions.....234**

5.1 Objectives and Methodology.....234

5.2 Major findings.....235

    5.2.1 Pattern of relationship in children with mental retardation.....235

    5.2.2 Emotional and social issues in the relationships.....237

    5.2.3 Possibility of developing an intimate relationship.....238

5.3 Educational suggestions for implementation.....240

5.4 Methodological contributions and suggestions for future research.....243

**References.....247**

**Appendices**

**Appendix 1**

**Appendix 2**

**Appendix 3**

## **List of Tables**

Table 3.1 Comparison of schools visited during exploratory stage.....	65
Table 3. 2 Characteristics of the participants.....	76
Table 4.1 The major behavioural change resulted in the children from the dyadic relationship with the researcher.....	223

## **Abstract**

The study is an exploration on the means to enhance happiness in children with mental retardation through developing intimate relationships. The over indulgence of the elders in the life of children with mental retardation result in a number of issues, as these children have to move in the framework developed by the elders. This put them under pressure and frustration. The emphasis on the development of skills for these children result in considerable negligence towards the relationship needs, blocking the spontaneous expression of the emotions, especially joy and happiness. The present study has adopted a qualitative case study method through grounded theory approach in contrast to the quantitative approach to the issues relating to the children with mental retardation.

Through the exploratory and the case focussed stages, the researcher reached at some psychological insights regarding the issues that affected the children with mental retardation. The researcher attempted to build intimate relationships with selected 11 children. A pattern of relationship building was conceptualised through this attempt of forming intimate relationships. Though all the participants could develop a strong bond, the relationship building process varied between children primarily depending on their past relationship experience. The initial behaviour (resistance-invitation) was the benchmark for further interaction. The reestablishment of attachment security in the new relationship resulted in enormous behavioural changes for the children. The alternative intervention this research proposes is to reduce the resistance of the children by getting involved into the worldview of the children through a process of love, care and unconditional acceptance. This process of relationship building has important bearing for the educational intervention for the children with mental retardation.

## **Abbreviations**

MR – Mental Retardation

DS – Down syndrome

NPS – Not a Participant in the Study

EB – Elder Brother

ES – Elder Sister

YB – Younger Brother

YS – Younger Sister

*Chapter 1*  
***Introduction***

## Introduction

### 1.1 Story of Faizal<sup>1</sup>

Faizal was a 13-year-old boy with Down syndrome, who needed intermittent support. He was the youngest child to parents, who were daily wageworkers. Of his eleven siblings two others were also with special needs. I first met Faizal on the first day of my visit to Sadhana School for children with mental retardation<sup>2</sup> during the fieldwork, on a rainy day in June. I saw him tied with a cloth to the grill of the window. On the other side of the window, the pre vocational class, to which Faizal belonged, was going on as normal with six children in the class. Faizal was a 'problem boy' for others in the class and to the teacher. During my subsequent visits to the school, I realised that severe punishments were common and frequent with Faizal.

Professionals who visited Sadhana School had identified two major deficits in Faizal: poor muscle tone and speech impairment. Thus, the physiotherapist and the speech therapist had set different goals and were trying to achieve them. But Faizal, who did not enjoy these therapies, kicked the physiotherapist while an exercise of stretching the legs was being carried out. On another occasion, Faizal spat on the speech therapist who made him to repeat some words. As usual, punishment was the immediate consequence.

Being one among twelve children, Faizal received little attention from home. He longed more attention and love in the school. Often, his behaviours to gain this

---

<sup>1</sup> The names of participants and schools used in the study are anonymous, so as to protect the privacy of the students and schools.

<sup>2</sup> Currently there is very live debate regarding the use of the term 'mental retardation'. At the global level, mental retardation, mental deficiency, mental sub normality, mental handicap, intellectual disability, cognitive disability, learning disability, learning difficulty, general learning disorder and mentally challenged are used to refer to the same condition. Since the term, "Mental Retardation" is well known; it will be used in this research.

attention were interpreted as nuisance in the way to achieve the aims of the class by the teachers. Thus, the attempts of Faizal to gain love and care (required essentially for his growth), were interpreted as 'problem behaviours' that require correction through punishments. I approached Faizal differently. Allowing him to take the lead, I joined him in his activities. In few days, I observed that he enjoyed my company, and started to seek me for his needs.

On one occasion, Faizal threw a duster at a teacher, who had shouted at him for taking the book of another student. I found Faizal tied to the usual window for this reason. Having had a bond between us, Faizal requested to free him. On being free, he hugged me to express his gratitude. The next day while playing one student overturned a table and it fell on me, hurting my knee severely. While other students were passive to my pain, Faizal jumped forward to massage my knee, and then rushing to hit the boy who overturned the table over me. I was observing the changes in emotional responses in Faizal.

However, it was not pleasant for Faizal in the evening. The teacher, who was angered with the throwing of duster, complained to the father of Faizal about the misdeeds. This promptly angered his father leading to severely spank Faizal in front of the teacher and other students. While spanking I heard his father saying: "You have been troubling me too much. I am going to tie down you when you reach home".

This thesis, through eleven cases of the children like Faizal, is an attempt to understand the life and problems of persons with mental retardation.

The field of mental retardation is usually dominated by the 'how to' questions of applied psychology. For such questions, the researchers usually never come out with a simple and natural answer: through love and care. The behaviour of persons with mental retardation is always attributed to, and interpreted in terms of, their

limitations. This style is common to psychologists as well as general public. As a result, their life becomes dominated and defined by their limitations. This need not be the case. This thesis argues that another pattern of life is possible - a more comfortable, more emotionally pleasant, and more enriching kind of life. The life of persons with mental retardation will change if and only if we change our attitude towards them.

## **1.2 A subjective history of research**

My academic and personal interest in mental retardation can be traced back to my M. Phil days. My dissertation was on the stress of teachers of special education. My occasional interactions with children with mental retardation while studying the teacher stress ultimately triggered feelings of empathy towards the children. From then on I was interested to know more about this marginal section of the society. As a first step, I read more about the concept of 'mental retardation'. But I was disappointed at the over emphasis of conventional methods - measurements, classifications, limitations and future prospects of each level, methods of skill training, modification of negative behaviour patterns, and methods of teaching them – to study the children. However, literature provided me an insight into the feelings and behaviour of the children who were victims of the conventional methods. Therefore, I decided to work more on the emotional side of children with mental retardation for my PhD. The idea was, of course, stimulating and challenging. However, I did not have a clear plan on how to go about with my research work. The field experience at this stage provided me more information on the feelings of children with mental retardation who were most of the time undergoing some deficit-based interventions. Therefore, I looked out for an alternative intervention to increase the happiness of these particular children.

The first stage of the study was therefore an exploration to find out an alternative intervention to increase the happiness of children with mental retardation. During my fieldwork in four schools in the first stage, I observed that majority of the children undergoing deficit services are prone to some or the other problems. I have also observed that most of the time, children with mental retardation did not have good relationship/friendship with the people who provide services to them. Therefore, towards the end of the first phase I could come with a proper research plan to study the possibility of developing intimate relationship with children with mental retardation. The experiences in the field taught me the way I should go ahead in my research. The setting and the sample in the study were in fact emerged during the fieldwork. Developing a close relationship with each of the children was in fact a challenging choice for me. However, I was confident about my style of interaction. I defined it in this way – loving, caring, unconditional to the maximum extent possible, not at all trying to change anything, understanding, pleasantly involving in their activities, appreciating their actions, non evaluative, playing, singing, dancing freely talking, doing what they like, and moving where they lead. Thus, the present research was an enriching pleasant experience for me. My notion of people with mental retardation has changed drastically as an end product of my fieldwork. This thesis is a summary of psychological insights gained from such experiences.

This research poses several challenges to the existing conventional research methodology. It doesn't follow the steps dictated by textbooks. It doesn't follow the methodology that is common and suggested by the literature on mental retardation. It doesn't accept the 'objectivity' doctrine. It is neither a 'hypothesis - testing' research nor a 'hypothesis – generating' research. It starts with a problem, and ends with an improved understanding of the problem. During the process of research, the existing

theory has become more concrete, more illuminating and more clarifying. An alternative kind of knowledge is the result of this kind of research.

The fundamental reinforcement for this study is the responsiveness of the participants - eleven children with mental retardation. To clarify the point, let me narrate one specific instance. The dominant behaviours of one participant – Radhika- were unhappiness and loneliness. Relationship building with Radhika was significantly difficult. However, when I expressed concern and empathy in our interactions, she responded to me with the same intensity. We could establish an attachment relationship. When I visited her after one year of the completion of data collection, I could observe that she could sustain the behavioural changes she expressed during the study. She could recognise me and I could recognise that her styles of functioning had undergone basic changes. This illustrates the nature of reinforcements I received from my work. This thesis is devoted to the participants who became my friends and taught me some of the important aspects of mental retardation.

### **1.3 Research problem**

The intervention models for children with mental retardation are deficit focussed because these interventions aim at developing those skills that are absent or low in them. Professionals approach the child with specific goals to achieve with specific therapies, which are efficient in themselves. The focus on the deficit skills has many unintended consequences for the natural growth of the personality of the child. Most important of these consequences is that the social and emotional needs of the child with mental retardation are not met, since the therapies designed in deficit-intervention model focus only on skill development. The literature review on intervention models for mentally retarded children showed that there are no

systematic methods or attempts to understand or to focus on the emotional and relationship needs of the children with mental retardation. Meeting the emotional needs of children with mental retardation is essential to keep them happy, and to help them to grow in mature relationships<sup>3</sup> with the persons they deal with. Hence, the present study attempts to focus on the emotional and social aspects of the life of persons with mental retardation.

#### **1.4 Objectives of the study**

The overall aim of the study is to generate psychological insights regarding mental retardation through developing an intimate relationship with children with mental retardation. However, it was disaggregated to three sub-objectives.

i) To study the possibilities of developing an intimate relationship with persons who have mental retardation. (ii) To understand the life pattern and relationship pattern of persons with mental retardation. (iii) To identify the emotional and social issues of persons with mental retardation.

#### **1.5 Methodology**

The study, with an exploratory design, adopted qualitative methodology. The study has two distinctive stages. In the first stage four different schools for children with mental retardation were visited. In the second stage, one school was narrowed down and 11 participants were selected. The researcher had attempted to build an intimate relationship with each of the participants. The interaction continued for one academic year. Further, the significant people related with them were interviewed. Based on all these, individual level analyses were prepared. Also, some broad

---

<sup>3</sup> In one of the relationship skills models, there is a distinction of instrumental skills and relationship skills especially for the children with Asperger syndrome, autism and pervasive developmental disorder (Gutstein and Sheely, 2002). However, in such a model, the relationship is taught like deficit skills. In this study, I consider relationship skills are already inherent in them.

generalizations regarding the emotional and social life of persons with mental retardation were derived from the experiences.

### **1.6 Structure of the report**

This dissertation report is divided into five chapters. After this introductory chapter, the second chapter provides the theoretical and empirical review on the relationships of people with mental retardation. The third chapter is devoted to the narration of the methods used in this study. Individual - level analyses and the inferences derived from them are presented in the fourth chapter. The final chapter describes the summary of the methods and findings of the study.

*Chapter 2*  
***Review of Literature***

# **Relationships among people with mental retardation**

The purpose of this chapter is to provide an overview of the chief concepts used in this study by reviewing the existing research and literature. Important concepts dealt here in this regard are the concepts of relationships, happiness and mental retardation. The specific focus is to provide a perspective on the impact of close relationship in mental retardation.

The first section of the chapter deals with the concepts of relationships, which is followed by describing the concepts on happiness. The third section is a brief description about the concept, classification, diagnosis, characteristics, associated conditions, prevalence and causes of mental retardation. Fourth section deals with the relationships in mental retardation. The chapter ends with a section formulating the rationale of the present study.

## **2.1 Relationship**

It is commonsensical knowledge that happiness derived from social interaction, especially that of intimate relationships is the corner stone for personal growth and human development. Formulating his attachment theory, Bowlby (1988:121) asserted that “capacity to make intimate emotional bonds with other individuals...as a principal feature of effective personality functioning and mental health”. After an extensive review of relevant literature, Argyle (1987) concluded, “social relationships are a major source of happiness, relief from distress, and health” (p.31). It is significant to note that the emerging field of evolutionary psychology makes the “need to belong” (Baumeister and Leary, 1995) – that is, the pervasive desire to form and maintain enduring relationships with others – as central factor in the evolutionary design of mechanisms for perception, cognition, and action (Barkow et al., 1992; Kenrick and Trost, 1997).

But, what is this 'relationship'? It has been increasingly been shown that there is no consensus on this dynamic concept. Planalp and Dexas (1994) have made painstaking attempt to summarise the perspective from the disciplines of linguists, communication scholars, psychologists, social psychologists, sociologists and philosophers. Such a wide array of inter-disciplinary perspectives into this concept indicates the complexity of the definitional issues involved. It is exactly this failure to consider the multi-disciplinary nature of this concept that has led the researchers to treat 'relationship' in abstraction and to lose sight of the everyday lived experiences of the same (Duck and Acitelli, 1996). Before entering to tackle this definitional issue one important development is worth mentioning. Prior to 1970s, psychologists addressed 'relationship' primarily from the understanding of cognitive and emotional theories. However in recent times (especially after 1990s) attention is being paid to how the contexts are shaping the relationships. It is in this later tradition of research this thesis finds its place.

### **2.1.1 The nature of relationship**

Hinde (1995) has pointed out some of the key factors on the nature of relationship. (i) *Relationships exists over time*: A relationship between two individuals involves a series of interactions (real or imagined) over time, such that each interaction may be affected by preceding ones and by expectations about the future. Every relationship exists over time and must be seen not as a fixed entity, but as a dynamic flux. (ii) *Relationships involve properties beyond those of the constituent interactions*: Because relationships involve series of interactions over time, they have properties that are not present in the interactions themselves, but depend on their nature, frequencies, and patterning. This interdependence means that many of the standard techniques of social psychology are not applicable to the study

of relationships. To make generalizations about relationships, it is necessary to study as many types of interaction as possible in each of a number of relationships, describe each relationship, and only then proceed to a generalization about relationship. (iii) *Relationships involve both overt behaviour and subjective experience*: Behaviour and subjective experience are interdependent – behaviour within the relationship affects the subjective experience of the participants, and experience affects behaviour. Just because relationships exist over time, and each interaction affects subsequent ones, full understanding requires a study of process. There is thus a great need to study the ways in which interactions affect psychological states in individuals and vice versa. The progress of a relationship is often traced through periods of marked change or crisis, but it is essential to remember that change may also be gradual, occurring in the course of everyday life. (iv) *Individuals and relationships*: Each relationship involves at least two individuals. Relationships thus have properties that are not predictable from the characteristics of either participant alone (v) *Every relationship is unique in at least some respects*. (vi) *Relationships exist in a social context*: No relationship can be considered independently from the social, cultural, and temporal situation in which it is embedded. Relationships both affect and are affected by the socio cultural structure – that is, the system of values, norms, stereotypes, myths, and institutions, and so on of the group.

### **2.1.2 Interaction as the building block of relationship**

“The term relationship refers to an enduring association between two persons. The existence of a relationship implies that these persons have established an ongoing connection with each other; that their bond has special properties, including a sense of history and some awareness of the nature of the relationship; that they influence each

other's thoughts, feelings, and behaviour; and that they expect to interact again in the future" (Reis, 2001: 61).

The above definition clearly points to the continuous nature of 'relationship' as different from 'interaction', which may be a single event. It is a series of interactions between two persons through verbal and non-verbal exchanges over a period of time in 'mutuality' is what is meant by relationships (Hinde, 1997). However, in the process of self-exchanges, a common meaning is created between the persons. This meaning building activity is part of coping "with the uncertainties of an unfolding future that places yesterday in a sequence of other days" (Duck, 1994: viii). This is the reason why two persons in relationship are able to keep up their relationship without interaction.

At the behavioural level, a relationship involves a series of interactions between two individuals, each interaction being relatively limited in duration but affected by past interactions between the same individuals and affecting future ones. But a relationship can persist in the absence of interactions, and involves also subjective aspects-including especially memories of past interactions and expectations of future ones, which have both cognitive and affective aspects (Hinde, 1988: 1).

### **2.1.3 Intimacy theory**

Continuous interaction may lead to development of trust through a process of long-term negotiation, and this stage the relationship transcends the specifics of single events of interaction. This nature of relationship is often referred as 'intimate' or 'close' relationship<sup>1</sup>. Intimate relationships provide individuals with social support and contribute to healthy personality, emotional, and social development (Reis & Shaver, 1988). Reis and Shaver (1988) described intimacy as a dynamic process by

---

<sup>1</sup> Hinde (1997) proposes a distinction of close and intimate relationships. According to him, the term 'intimacy' refers to romantic or sexual relationship and refers to self-disclosure. However, in this study, both terms will be used interchangeably.

which individuals learn things about each other. According to their process model, “Intimacy is an interactive process with three components: one person’s expression of self-relevant thoughts and feelings through verbal, nonverbal, and behavioural channels; the partner’s response, in terms of appropriateness and supportiveness; and the person’s perception of the partner’s response. Intimacy is experienced when the sequence of self expression and partner response leads one to feel understood, validated, and cared for” (Reis, 2001: 63). Therefore, both self-disclosure and partner response is important in the development of intimacy. Self-disclosure is more a dynamic relational process than the act. Both the intra-personal and inter-personal open-ended processes constitute the self-disclosure of partner (Dindia, 1994). The process model of intimacy is useful because it emphasises the contribution of both individuals in a dyadic exchange.

#### **2.1.4 Learning about relationships**

“The individuals bring into relationships their individual characteristics and factors that reflect their point in the life cycle and their developmental achievements. Individuals are influenced by the social settings (situational, cultural, linguistic, and societal) in which the relationship takes place; they are constrained and influenced by the structural, transactional, behavioural, and communicative contexts” (Duck, 1994: viii).

It is also important to limit the discussion of relationship into ‘dyadic’ realm especially when this has to be applied for mentally retarded children. However, every dyadic relationship occurs within a social setting. Different experiences that the persons involved in the dyadic relationship brings is emergent from the social setting of the personalities involved in it. Therefore, a triangular play of personality, dyadic

relationship and social setting is inevitable in the discourse of relationship (Hinde, 1979).

'How does a relationship starts' has been subject of much research. Though attraction does not mean relationship (Duck, 1998), the subject of attraction has received lot of attention from those who has studied the initial stage of relationship. Important bone of contention here has been whether it is similarity or complementarity, which is the factor of attraction. The similarity in personal characteristics and behavioural patterns act as the starting point of shared meaning. A number of other reasons are also suggested as to why similarity gives rise to relationship. Hinde (1997) identifies following: propinquity, social pressures and social norms, inherited predispositions, priority preferential pairing, role satisfaction, reinforcement, and enhancement of self-esteem. Equally important is the studies on whether differences/complementarity leads relationships. Complementarity acting as the basis of reciprocity is essential for a relationship. This provides social support, opportunity for nurturance, reliable alliance and reassurance of worth.

### **2.1.5 Relationship in the family**

From a systems perspective, family is a complex, integrated whole, with organized patterns of interaction that are circular rather than linear in form (Minuchin, 1988). The basic principle maintains that elements (people) in a system are necessarily interdependent, contributing to the formation of patterns and organized in their behaviour by their participation in those patterns.

In the study of relationships, the individual is dealt with 'not as an isolated entity but as a social being, formed by and forming part of a network of relationships which are crucial to its integrity' (Hinde & Stevenson-Hinde, 1987, p1). 'When two individuals interact on successive occasions over time, each interaction may affect

subsequent ones, and we speak of them as having a relationship. Their relationship includes not only what they do together, but the perceptions, fears, expectations and so on that each has about the other and about the future course of the relationship, based in part on the individual histories of the two interactants and the part history of their relationship with each other... While the nature of an interaction depends in part on the individuals involved, it is affected also by the relationship in which it is embedded.... However, that is not all... Each relationship is influenced by the social nexus of other relationships in which it is embedded...' (Hinde & Stevenson-Hinde, 1987, p2-3).

Family is a system, where a number of dyadic relationships take place: mother-child, father-child, and sibling-sibling. The relationship inside the family influence each other are important. Parents and children relate to each other on many dimensions (eg.love, authority, dependence) and in many kinds of interaction (involving care, control, instruction, companionship)(Radke-Yarrow, et. al., 1988). For children, parents are the most important individuals while speaking of the social setting of relationship. The role of parents in teaching about the relationships is undisputed. Parents act in the roles of designer (arranger of a play setting), mediator (initiating and relating the child to new peers in relationship and situations), supervisor (direct advising and observing) and consultant (clarifying the doubts) to modify the ways in which children relate with others (Ladd et al., 1993; Pettit and Mize, 1993).

As the child develops, attachment relationship depends more extensively on linguistic expressions of needs and feelings. "Availability" becomes more abstract and no longer requires constant, immediate physical presence. "Responsiveness" changes, depending on the needs to which an attachment figure is expected to respond

(Sternberg and Hojjat, 1997). It is in this advanced stage that relationships become solidly based on communication patterns, how the persons in dyadic relationships represent their worlds to oneself and the other through conversations (Duck, 1994). Establishing a good relationship essentially means acquiring certain behaviour skills and patterns that can be used for reciprocating meaningfully to the other in the relationship.

### **2.1.6 Friendships**

Friendships are special case of dyadic relationships. All the key attributes we discussed earlier, voluntariness, intimacy, equality and reciprocity define what friendship is, suggests Wall (1998). For Richardson and Ritchie (1989:1), the deeper aspects of friendships mean the kind of friends who provide a real sense of closeness and intimacy, sometimes known as 'special friends'. More specifically, it is a matter of feeling a sense of attachment (Richardson and Ritchie, 1989).

Friendships play an important role in the social life and adjustment of all children (Heiman, 2000), contribute to their emotional, mental and physical health, and play a major part in maintaining our well being (Knox and Hickson, 2001). In his interpersonal theory, Sullivan (1953) emphasised the critical role played by social interaction for a developing personality. He stressed that friendships with peers are important for the development of sensitivity, the exploration of identity, and the validation of the self. The same line of thinking can be seen in the views of Heslop (2005) i.e., friendships are central to a sense of our own identity and of social inclusion. Firth and Rapley (1990) has the opinion that friendship may meet the needs of company, intimacy, self-esteem, self-identity, help and advice. Thus, it becomes a well-known fact that friendships confirm and strengthen our sense of ourselves as valued and valuable members of a community.

While emphasizing the essential conditions for forming friendships Willmott (1987) suggested that opportunity, common interests, mutual attraction, empathy, social skills, positive effort, and style of life are essential conditions for friendships. Richardson and Ritchie (1989) advocate that we need both opportunities and abilities to make friends whilst Firth and Rapley (1990) state that relationships, which develop beyond brief acquaintance, demands certain conditions, such as motivation, opportunity, confidence, and skill. The intimacy characteristic of close friendship is particularly associated with trusting the friends, feeling able to confide in them and looking to them for the most demanding kinds of support (Willmott, 1987). There are implications involved when two people with different attachment styles attempt a relationship, especially the process of avoidant and ambivalent. An "ambivalent" infant could represent an individual who has difficulty relating to others as a result of inconsistent responsiveness or availability on the part of the caregiver (Rothbard and Shaver, 1994).

### **2.1.7 Satisfaction from relationship**

An amusing aspect is that the studies on satisfaction from relationships outnumber the studies on relationship itself. The existence of various scales to measure satisfaction on the one hand, and the multiplicity of the meaning of relationship is the main reason for this paradox. However, there are few studies that have assessed satisfaction from the perspective of self-reported nature of relationship of the participants (see Sternberg and Hojjat, 1997 for a compendium).

### **2.1.8 Power and autonomy in relationship**

Issues of power and autonomy are a particular aspect of relationship. One partner can be said to have power over the other if he or she can influence the quality of the consequences of the other's behaviour (Thibaut & Kelley, 1959). Often one

partner exercises power in some content areas and the other partner in other areas. The way power is exerted may be assessed by the quality of the interactions (Hinde, 1995). The exercise of power by one participant involves reduction in the autonomy of the other, but what matters is how the latter perceives this power differential. In some relationships or contexts, or for some individuals, both may see the exercise of power by one partner over the other as proper or desirable. On the other hand, well-meaning moves towards closeness by one partner may be seen as constraining and decreasing the autonomy of the other. Lack of agreement or acceptance of where power lies leads to conflict (Hinde, 1995). Researchers of personal relationships have focussed on the coercive nature of power. The emphasis has been on forms of verbal and physical aggression (Mills & Duck, 2000).

### **2.1.9 Attachment theories and relationship of young children**

Attachment theories focus on the development of children at the infancy stage. However, here the attempt is to give a brief review of the attachment theories and to summarise the chief findings from the scanty existing works on application of the attachment theories in the life beyond infancy. The existing theories of attachment are largely based on cognition and emotion. Though this thesis is focussing on how the contexts shape relationships, it is important to understand existing theories based on cognition before detailing the effects of contexts.

Attachment relationships provide a sense of security and self-efficacy, facilitating confident and competent engagement with the social environment (Ainsworth, 1989). A person may form multiple, distinct attachment relationships (for example, to mother and to father), but none substitute for existing attachments (Ainsworth, 1989). Bowlby (1969) says, attachment behaviour is regarded as a class of social behaviour of an importance equivalent to that of mating behaviour and

parental behaviour. It is held to have a biological function specific to itself and one that has hitherto been little considered. Sucking, clinging, following, crying and smiling are patterns of behaviour described as contributing to attachment (Bowlby, 1969). Attachment behaviour is regarded as what occurs when certain behavioural systems are activated (Bowlby, 1969).

According to the evolutionary perspective of attachment theory (Bowlby, 1969), human beings are innately equipped with attachment and care giving behavioural systems, among other important behavioural systems. A behavioural system is a species-universal, innate neural program that organizes an individual's behaviour in ways that serve an important survival or reproductive function (Belsky, 1999). The behavioural systems themselves are believed to develop within the infant as a result of his interaction with his environment of evolutionary adaptedness and especially of his interaction with the principal figure in that environment, namely, his mother (Bowlby, 1969). According to Bowlby, the function of the attachment behavioural system is to protect a person from danger by assuring that he or she maintains proximity to caring and supportive others (attachment figures). The function of the care giving system is to respond to requests for help and provide protection, support, and relief in times of adversity. Gillath et al (2005) emphasize that the operation of the care giving system is most evident in the emotional and behavioural reactions of parents to their young offspring's signals of need or distress, but it is also considered to be the locus and foundation of empathy and compassion in all situations where one person reacts to another person's pain, need, or distress.

Interaction of the infants with their primary caretakers (or attachment figures) largely determines the attachment patterns of the child. The dimension of care taking behaviour that seems to be related most strongly to infant attachment patterns is

sensitivity to the infants' signals (Ainsworth et al., 1978). Children formulate 'working models' or internal representations from these experiences of interaction. These working models are dynamic cognitive structures that guide expectations about relationships and interpretation of the relationships (Bowlby, 1973: 204). Experience with people who are understanding, trustworthy, and responsive to one's needs will lead to positive views of others, whereas relationships with people who are unresponsive and rejecting will lead to negative views of others. Most crucial is the fact of how child learns to rely on attachment figures for security and support (Bartholomew, 1993). Ainsworth et al., (1978) have identified three distinct patterns of infant attachment: secure, ambivalent, and avoidant. *Secure* infants perceive caretakers as reliable sources of security and protection. These infants actively seek contact with their caretakers when distressed and are readily soothed and reassured by that contact. Secure infants also tend to explore the environment confidently under non-threatening conditions. On the other hand, the infants showing *ambivalent* attachment patterns show ambivalent behaviour towards the caretaker when distressed. These infants respond with angry resistant behaviour, and are not easily comforted. Finally, infants showing *avoidant* patterns of attachment actively avoid contact with the caretaker when distressed. Thus, both ambivalent and avoidant infants fail to use their caretakers to gain security when distressed. Besides, both groups of insecure infants show deficits in using their attachment figures as a secure base for exploration.

Cognitive skills, which help the children to create their own perspectives, are developed as the children grown beyond the first year of life. This helps them to express to others verbally (Bretherton and Beeghly, 1982). How satisfaction and dissatisfaction is expressed largely depend on these cognitive skills. The attachments

developed are also dependent on these cognitive skills to great extent. Secure children can articulate their emotions verbally, and can understand and label other people's emotions (Beeghly and Cicchertti, 1994; Morissert et al., 1990). For example, Bretherton et al., (1990) studied the responses of 29 children aged 3 years to a series of potentially anxiety-provoking situations, and assessed their behaviour during separation and reunion episodes. Security of responses during separations and reunions was associated with children self-described ability to cope with a potential two-week separation. *Secure* children talked about feeling angry or upset, but also about doing something constructive about the situation. In contrast, *avoidant* children said 'I don't know' when asked about how to deal with a potential separation; *ambivalent* children responded in odd nonsensical or excessive violent ways. Secure children were also more likely than insecure children to imagine a happy reunion with their parents, saying they would hug their parents or go out for pizza with them (Koski and Shaver, 1997).

Compared with ambivalent and avoidant children, the secure children's ability to express themselves verbally is evident through out their development. In a study of 5 year olds, Slough and Greenberg (1990) found security to be correlated with less avoidant and more emotionally open responses to pictures of potential separation. In a sample of 6 year olds, Main et al., (1985) found security in infancy to be correlated with the security and reasonableness of later narrative responses to potential separations. Secure children in this study were also more likely to respond positively (smiling and showing interest, making positive comments) to photographs of their families, where as children who had been classified as insecure in infancy were more likely to respond with discomfort or lack of disinterest.

The contrast in emotional expressions of secure and insecure children have also been by looking at the relationships and the forms and the satisfaction experienced in those relationships. Secure children are more nurturing (Troy and Sroufe, 1987), more involved with others (LaFraniere and Sroufe, 1985), and more agentic and independent (Erickson et al., 1985) than insecure children. In contrast, anxious children are relatively dependent and helpless, have difficulty interacting with others, and are likely to be victimized by peers (see Cassidy & Berlin, 1994 for a review). Berlin, Cassidy and Belsky, (1995) found that 5-7 year old children who had been classified as anxious during infancy reported more social loneliness than children who had been classified during infancy as secure or avoidant. Whereas anxious children tend to emphasise their emotional vulnerability in interaction with others (Berlin et al., 1995), avoidant children de-emphasise or dismiss their need for attachment figures. In response to potential separations from parents, avoidant children minimise their distress (Cassidy, 1988; Main et al., 1985) are rigid and tense in their representations of attachment relationships and are more likely to pick on other children (Troy and Sroufe, 1987). Disorganised children, who have been studied less extensively to date, exhibit hostile behaviours toward their peers and engage in controlling, role-reversing behaviour with their parents (Main and Solomon, 1990).

Longer-term studies of the sequences of infant attachment patterns also reveal theoretically predictable effects on close relationships. Children aged 10 and 11 years who were secure with their mothers as infants enjoy close friendships with a small number of children later on (Elicker et al., 1992; Grossman and Grossman, 1991) and seek help and comfort from their parents when they need it (Grossman and Grossman, 1991). Children who were avoidant or anxious as infants report having either no

friends or many friends whose names they cannot remember (Grossman and Grossman, 1991). These children also harbour relatively negative impressions of relationships and tend to lack social skills (Elicker et al., 1992; Sroufe et al., 1993). In short, extensive research suggests that as children develop beyond infancy, early behavioural indicators of satisfying or distressed relationship with attachment figures become transformed into a more complex array of cognitive, linguistic, and empathic tendencies and skills.

As we have seen above, one of the aims of, and result of relationship is happiness. This equally complex topic, like relationship, needs to be disaggregated for proceeding meaningfully.

## **2.2 Happiness: concept and issues**

“It is better to be an unhappy Socrates than a happy pig”. This old saying reveals the complexity around the term itself. Research on happiness is enmeshed in the confusion around the term itself. Often, the term ‘happiness’ is used as synonymous to ‘good’, ‘welfare’, ‘well-being’, ‘mental health’, and ‘life satisfaction’. Researchers while assessing these concepts have either considered ‘what they think’ (cognition) or ‘how they feel’ (emotion) (Veenhoven, 1990; Argyle, 2001). Thus, assessments on whether a person is happy involved some sort of self-rating. Therefore, the concept of happiness came to be associated with subjective well-being (Strack et al., 1990), as opposed to objective well-being<sup>2</sup>.

A distinction of *subjective* and *objective* happiness is possible. “Asking respondents to state how happy they are” assesses subjective happiness. Objective happiness is assessment of the records of instant utility (subjective experience reports)

---

<sup>2</sup> Objective well-being involves assessment of income and health. See Sen’s (1981) writings on distinguishing entrenched deprivation from welfare of persons from an economic perspective. In an attempt to use both subjective measure and objective measure Diener and Suh (1997) compared 40 nations on the indices of subjective well-being and Quality of Life Index. Though both indices were correlated at 0.57 there were large discrepancies.

over relevant period by an observer (Kahneman, 1999:5). The subjective responses often have the problem of recall and bias. Stone et al (1999) has suggested the 'Ecological Momentary Assessment' method to avoid this problem. Here subjects' behaviour and experiences are studied in the natural environment where they decide.

Michael Argyle (1999, 2001) in his famous study on correlates of happiness identifies various components in life, which are correlated with happiness. Among the variables studied, social relationships were major sources of well-being. Being married, being employed, not belonging to ethnic minority groups, or religious associations had positive correlation with happiness. Age has small positive effects because of declining goal achievement gap. Education is positively correlated with happiness (especially in third world countries) because of its effect on income and status. Social class is also positively correlated, not only for the same reasons as education, but also because class affects leisure and health. Income has complex and weak correlation with happiness.

### **2.3 Happiness from relationships**

Satisfying interpersonal relationships are vital for people's mental and physical well-being (see Baumeister & Leary, 1995). "Intimate attachments to other human beings are the nucleus around which a person's life revolves, not only when he is an infant or a toddler or a schoolchild but throughout his adolescence and his years of maturity as well, and on into old age. From these intimate attachments a person draws his strength and enjoyment of life" (Bowlby, 1980:442). Though the concept of 'close relationship' is unclear, the instances of such relationships such as marriage, friendships have proven to enhance happiness. On the other hand, the short-term intimate relationship (eg. prostitutes) does not enhance happiness. Therefore, it is an enduring intimate relationship, which is crucial to happiness. For example, the

enduring relationships in marriage and friendships bring various roles to the persons involved in it. Besides, the mutual sharing and self-disclosure involved in it reciprocated through intimacy and mutually supportive equity brings happiness (Myers, 1999).

Three important components seems to have causal effects on happiness: 1) the frequency and degree of positive affect, or joy; 2) the average level of satisfaction over a period, and 3) the absence of negative feelings, such as depression and anxiety (Argyle and Martin, 1990).

“Joy is the emotional side of happiness, in contrast to satisfaction-the cognitive side” (Argyle, 2001:23). Emotion is mostly expressed through facial expressions. Thus, happiness is expressed through smiling. Facial muscles are controlled by *pons* brainstem, which is controlled by hypothalamus. But, when this facial expression is controlled, motor cortex intervenes there (Argyle, 2001). This control could be due to the social learning aspects of facial expressions. These expressions not only reflect what people are feeling, but also what they want to communicate (eg. what they want others to think that they are feeling). For example, people smiled at an interesting film when someone else was watching or believed to be watching (Fridlund, 1991). Another way of expression of emotion is through voice. Both the tone and words spoken are important here. While elation and joy are notified through raised pitch and gentle changes, depression is expressed through low pitch or weak intensity (Argyle, 2001).

Most reported common cause for joy is social relationships (Scherer et al., 1986). Argyle (2001) has documented most common activities that cause joy. They are eating, social activities and sex, exercise and sport, alcohol and other drugs, success and social approval, use of skills, music, other arts and religion, weather and

environment, and rest and relaxation. However, weak-side of the happiness research has been that it is not sufficiently theory driven. For example, one of the causes of happiness is sports and play, and physiological explanation for this is that sports induce positive moods. Sociological explanation here is that sports induce self-esteem due to the effect of sporting with other people. Much more theory-driven research is required to explain different aspects of happiness.

At the level of satisfaction, the cognitive aspect of happiness, the research has measured mostly the satisfaction with life as a whole or its particular domains. Though these are self-reports of research subjects, they tend to measure objective factors such as income, health, employment, social relationships, leisure, housing and education. The satisfaction also differs according to the comparison they make themselves with other individuals (Argyle, 2001). Emotional state affects satisfaction hugely, and some of the cognitive aspects such as perceived control could be important determinants of satisfaction. Both meeting the affiliation needs and intimacy needs were positively correlated with satisfaction (Prager and Buhrmester, 1998).

Having briefly dealt with two important concepts of relationship and happiness, a scene is set to understand the subjects for whom these concepts are relevant in the context of this research, i.e., children with mental retardation. However, conceptual clarifications are necessary at the outset for mental retardation as well. This is the aim of next section.

## **2.4 Mental Retardation**

This section is to conceptually clarify aspects related with mental retardation such as classification, diagnosis, characteristics, associated conditions, prevalence, causes and interventions in mental retardation.

### **2.4.1 Concept**

The American Association on Mental Retardation (AAMR), defined mental retardation as a “disability characterized by significant limitations both in intellectual functioning and in adaptive behaviour as expressed in conceptual, social, and practical adaptive skills. This disability originates before age 18” (Luckasson et al., 2002, p.13).

Five assumptions are essential to the application of this definition, which are:

- (i) limitations in present functioning must be considered within the context of community environments typical of the individual’s age peers and culture;
- (ii) valid assessment considers cultural and linguistic diversity as well as differences in communication, sensory, motor, and behavioral factors;
- (iii) within an individual, limitations often coexist with strengths;
- (iv) an important purpose of describing limitations is to develop a profile of needed supports; and
- (v) with appropriate personalized supports over a sustained period, the life functioning of the person with mental retardation generally will improve (Luckasson et al., 2002, p.13).

### **2.4.2 Classification**

A comprehensive classification system was developed by AAMR (Luckasson et al., 2002), based on the intensities of supports<sup>3</sup> needed by individuals with mental retardation. The intensity of needed support varies across people, life situations, and life stages. This classification focuses more on the capabilities of the individuals with mental retardation rather than on the limitations. Thus an individual’s specific needs in specific areas are classified irrespective of his/her IQ. The capabilities describe the

---

<sup>3</sup> “Supports are resources and strategies that aim to promote the development, education, interests, and personal well being of a person and that enhance individual functioning” (AAMR, 2002:151).

level of support required and they are: intermittent support, limited support, extensive support, and pervasive support.

There are other classification systems developed by various professionals to understand the diversity of individuals who are identified as having mental retardation. These classifications are:

The first of these is the classification by specific etiology or medical classification based on the cause. The potential causes include: infections and intoxications, trauma of physical agents, problems associated with metabolism or nutrition, postnatal gross brain disease, unknown prenatal influence, chromosomal anomalies, conditions during perinatal period, psychiatric problems, environmental influences, and other unspecified conditions (NIMH, 1999).

The next classification system is by the educational categories, which include educable mentally retarded (EMR)(IQ=50-75), trainable mentally retarded (TMR)(IQ=25-50) and, severely and profoundly mentally retarded (SMR/PMR) or custodial mentally retarded (CMR)(IQ<25) (Taylor et al., 1995).

Another classification system is based on the severity or degree of mental retardation, or otherwise known as the psychological classification. This establishes four levels of intellectual-adaptive functioning, they are: mild mental retardation: IQ level 50-55 to  $\approx$  70, moderate mental retardation: IQ level 35-40 to 50-55, severe mental retardation: IQ level 20-25 to 35-40, and profound mental retardation: IQ level <20 or 25 (World Health Organization, 2002).

Still another classification is on the basis of physical and physiological characteristics. They are: brain damaged child, mongoloid, cretin child, phenylketonuria (PKU), and microcephaly and hydrocephaly (Bhargava, 1994). Thus

professionals use either one or more of these classification systems to categorise people with mental retardation.

#### **2.4.3 Diagnosis**

AAMR (2002) process for diagnosing and classifying a person as having mental retardation contains three steps and describes the system of supports a person needs to overcome limits in adaptive skills. The system focuses on the capabilities of the retarded individual rather than on the limitations: (i) The first step in *diagnosis* is to have a qualified person give one or more standardized intelligence tests and a standardized adaptive skills test, on an individual basis. (ii) The second step is to describe *the person's strengths and weaknesses across four dimensions*. The four dimensions are: (a) Intellectual and adaptive behaviour skills, (b) Psychological /emotional considerations, (c) Physical/health/etiological considerations, and (d) Environmental considerations. Strengths and weaknesses may be determined by formal testing, observations, interviewing key people in the individual's life, interviewing the individual, interacting with the person in his or her daily life or a combination of these approaches. (iii) The third step requires an *interdisciplinary team to determine needed supports across the four dimensions*. Each support identified is assigned one of four levels of intensity - intermittent, limited, extensive, and pervasive.

#### **2.4.4 Characteristics**

A common misconception among professionals from multidisciplinary fields and general public has been the belief that people with mental retardation is a behaviourally homogeneous group. In fact, retarded individuals constitute a heterogeneous group. However, some generalizations can be made regarding their characteristics.

The characteristics of mental retardation typically have been taught by relating characteristics of interest to the level of severity represented by the traditional classification system – mild, moderate, severe, and profound (Luckasson et al, 2002). In each of the levels the characteristics can again be classified under four heads – intellectual, social, motor, and communication.

#### **2.4.4.1 Mild mental retardation**

Children with mild mental retardation score in the range of 50 to 75 IQ. 75% to 90% of all mental retardation comes under the mild category and they function at one half to two thirds of chronological age. They often have only mild or moderate developmental delays. In intellectual functioning, they found to have learning difficulties with marked delays in academic. As cognitive disability and learning difficulties generally become evident in a formal school setting, they are often not identified until they enter the school setting. By and large children in the mild category have problems with attention, perception, memory, problem solving and logical thought. Generally they learn slowly and often fail to grasp what is being taught. Even if they learn, they do not demonstrate learned skills spontaneously and they have difficulty in generalizing the learned skills to new situations or problems. Abstract concepts and complex skills are very difficult for them to learn. They can acquire reading and math skills up to grades 3 to 6 level by late teens. Despite the fact that the cognitive development of children with mild mental retardation is delayed, studies have shown that it is as orderly and organized as that of typically developing children (Hodapp et al., 1998, cited by Peled et al., 2004). Children with mild mental retardation found to have delays in sensory and motor development. Motor coordination is found to be slightly impaired at the preschool age. In a study Kozub et

al., (2000) have found out that children with mental retardation are less persistent at challenging motor tasks than are peers without disabilities. Delayed speech and other speech problems are common among individuals with mental retardation. With mildly retarded, communication skills develop during their first five years, though it is delayed. Hence diagnosis becomes difficult during the early years. Children with mild mental retardation develop social skills during their first five years. During school period they can be expected to learn appropriate social skills. Adults with mild mental retardation can usually achieve enough social and vocational skills for self-support, and obtain independent employment. Many adults with mild mental retardation marry, have children, and integrate themselves into the community. They can live independently with the support of family, community, and social services. They are likely to need only intermittent to limited support as they can live relatively independently.

#### **2.4.4.2 Moderate mental retardation**

About 10% of those with mental retardation are considered moderately retarded with IQ score in the range of 35 to 55. They can function at one third to one half of chronological age. Their development is often significantly delayed. Children with moderate mental retardation can learn simple instructions, though the process is very slow. They may have academic potential at the kindergarten or 1st grade level and have limited ability to read. With supervision, school age children can learn some skills, however they face difficulty in demonstrating and generalizing learned skills. They found to have delay in sensory and motor development. However, their motor coordination is comparatively fair. The higher incidence of visual and hearing impairment interferes in skill acquisition for adults with mental retardation. A study

conducted by Shinkfield et al., (1997) also reported similar findings. Their findings revealed that perceptual and motor-reproduction inadequacies interfere in skill acquisition. Children with moderate mental retardation may have some unusual physical signs and generally "look" different from their non-disabled peers. Hence they are typically identified as infants or toddlers. During early childhood, these children are able to learn to talk and communicate. Though they have noticeable delays, especially in speech, these children are able to learn to talk and communicate during early childhood. School age children with mild mental retardation can be expected to learn appropriate social and occupational skills, though there is a significant delay. They can learn elementary health and safety habits and can take care of their personal needs with supervision. The poor social skills and awareness cause them to have difficulty in developing friendships. As these children reach adulthood, they can work well in a supervised setting, such as a group home. They may achieve self-support by performing unskilled or semiskilled work under sheltered conditions. They need limited to extensive supports throughout their lives. As adults, most individuals with moderate mental retardation will not achieve total independence; rather, they are likely to continue to need, limited to extensive support.

#### 2.4.4.3 Severe mental retardation

Children are classified as severely retarded when their IQ scores fall in the range of 20 to 40. This group accounts for only 3 to 4% of the mentally retarded population. They function at one fifth to one third of CA. They have marked and obvious delays in all the areas. Children with this level of mental retardation are unlikely to be able to learn to read or write. They have poor muscle and motor coordination, especially in the preschool age. The motor milestones are noticeably

delayed in children with severe mental retardation. They are generally below norms in height and weight. The prevalence of hearing deficits in people with mental retardation is greatest among the severely impaired. They are more likely than mild or moderate children to have visual impairment. Children with severe mental retardation have little or no communication skills, which is manifested by the poor content and quality of communication. However they may have some understanding of speech and show some response. At the preschool level they can say a few words or minimal words. They can learn some basic communication skills by school age. Delayed speech and other speech problems are common among students with severe disabilities. Their language development may be inhibited or significantly delayed. These children have meagre social skills. They may be taught daily routines and repetitive activities. Though they have limited self-care skills during early childhood, they can learn some basic self-care skills by school age. They need direction and supervision throughout their lives, as they have difficulty in performing life skills. This group usually require total supervision and support for daily living activities. They are found to be uninterested in people around them and they have poor eye contact. They engage in isolated or inappropriate behaviours. Adults with severe mental retardation may contribute partially to self-care under complete supervision. They can even develop some useful self-protection skills in controlled environment.

#### **2.4.4.3 Profound mental retardation**

Children with profound mental retardation have IQ scores under 20 to 25. Only 1-2% of the mentally retarded population is classified as profoundly retarded. They function at less than one fifth of CA. They have marked delays in all areas. Congenital abnormalities are often present with profound mental retardation. Their

communication deficits make it difficult to accurately assess their intellectual functioning; in educational settings, they may be placed along with students with moderate to severe mental retardation or in their own classroom. Children with profound mental retardation have little or some motor coordination, throughout their lives. They have delays in such areas of motor skill development as mobility, body image, and control of body actions. These children have little muscle coordination during early childhood and do not reach developmental milestones, such as walking and talking. However, they may respond to regular physical activity and social stimulation. They have limited or no communication skills. As they grow older, they may be able to develop basic communication skills, especially speech skills with appropriate support and training. They are likely to have multiple disabilities, particularly in the areas of mobility and communication. Therefore, many use wheelchairs and alternate forms of communication. The social functioning of the profoundly retarded is too limited or very poor. They require skilled nursing care and constant supervision. They may be able to develop basic self-care under intensive support and skilled training. The profoundly retarded need a high level of structure and supervision. Some adults with this level of retardation remain in institutional settings, but most currently live in-group homes. This group generally needs services at the pervasive level, typically throughout their life. Their retardation is often caused by an accompanying neurological disorder. Associated conditions like cerebral palsy, spina bifida, seizure disorders, hydrocephalus, and cardiovascular disorders are very common with severe/profound retardation. Studies have shown that those with severe to profound mental retardation have a shortened life expectancy due to diseases that are often associated with these degrees of retardation.

It is essential for professionals to study the behaviour pattern of individuals with mental retardation as it provides better understanding regarding the intervention strategies.

#### **2.4.5 Associated conditions**

In addition to the deficits in intelligence and adaptive behaviour, majority of the children with mental retardation has associated handicaps. Some of the most common problems encountered are cerebral palsy, seizure disorders, autism, ADHD<sup>4</sup>, and other motor or sensory disabilities (Bowley and Kerr 2000; Crane, 2002).

In a review, Bowley and Kerr (2000) reported that the frequency of epilepsy occurring in people with mental retardation is much higher than in the general population, which increases with the severity of disability. The prevalence of epilepsy among people with mental retardation range from 14% to 44%, reported by the same authors. Ratey et al.,(2000, cited by Crane, 2002) has reported that approximately 10 percent of those with mental retardation also have cerebral palsy. Sensory disabilities are present in about 5-10 % of persons with mental retardation.

Apart from this a full spectrum of psychiatric conditions can also be seen in this population. A number of studies have shown that there is an increased incidence and prevalence of psychiatric disorders among people with mental retardation (Turner, 1989; Jacobson, 1990; Fletcher and Poindexter, 1996; Pyles et al., 1997; Dykens, 2000; Koskentausta et al., 2002). Schizophrenia, affective disorder, neurotic disorders, conduct disorders, personality disorder, organic psychiatric disorders, sexual problems and behavioural disorders are the commonly found disorders in people with mental retardation. (Sarason, 1953; Jakab, 1982; Benson, 1985; Gelder et.

---

<sup>4</sup> ADHD-Attention Deficit Hyperactivity Disorder

al., 1989; Nezu and Nezu, 1994; Clarke, 1999; Stavrakaki, 1999; Ross and Oliver, 2003; Kishore et. al., 2004).

Among people with mental retardation, the pooled results of studies suggest rates between 2 and 6 percent for schizophrenia, usually diagnosed among people with mild or moderate retardation (Clarke, 1999). Kraepelin in 1896 and 1902(cited by Quinn, 1986) indicated that low intelligence might form the basis for the development of psychoses, such as manic-depressive conditions. Clarke (1999) has reported that the collective results of studies suggest rates between 3 and 8 percent for affective disorders in mental retardation. In a study by Deb et al. (2001) on people with mental retardation have found out that majority of the subjects (60.4%) had at least one behaviour disorder of any severity or frequency. In a factor analytic study, Rojahn et al. (2004) stress that behavior problems are associated with psychiatric conditions.

The associated conditions always add the severity of the condition of the people with mental retardation. Since the majority suffer from associated conditions, the interventions are generally focused on alleviating the conditions associated with this. However, the focus of the present study is to improve the overall functioning of children with mental retardation, rather than focusing on reducing their problems.

#### **2.4.6 Prevalence**

Estimates of the number of disabled vary a great deal, depending on the definitions, the source, the methodology and the extent of use of scientific instruments in identifying and measuring the degree of disability. Problems in identification make completely accurate counts of incidence and prevalence impossible. Because of the uncertainty involved with incidence statistics, prevalence rates are seen as a more reliable index of the relative frequency of mental retardation.

Experts generally agree that people with mental retardation make up approximately 2.5 percent to 3 percent of the total population. Mental retardation is approximately 1.5 times more common in boys than in girls (Silka and Hauser, 1997; Crane, 2002).

In India, out of the 21,906,769 disabled people, 2,263,821 are people with mental retardation according to the census of India 2001. According to the survey conducted by the National Sample Survey Organisation (NSSO) during 58th round (July-December 2002), estimated number of mentally retarded persons in the country was 9.95 lakh. However, there is no evidence to show that the number of people with mental retardation is increasing.

According to NSSO's sample Survey 1991, there are around 20 million physical disabilities, 6 million multiple disabilities, 30 million mental retardation, 3 million cerebral palsy and 2 million Autism in the world. The same survey reported that three per cent of Indian children have developed mental delays often associated with mental retardation and several non-official studies have also suggested that 2 to 2.5 per cent children have mental retardation. Mental retardation cuts across the lines of racial, ethnic, educational, social and economic backgrounds.

#### **2.4.7 Causes**

Mental retardation can be caused by any condition, which impairs development of the brain before birth, during birth or in the childhood years. As many as 50 percent of people with mental retardation have been found to possess more than one causal factor. Several hundred causes have been discovered, but in about one-third of the people affected, the cause remains unknown. When the mentally retarded are classified according to the cause of their deficiency, the basic division is into

Unexplained, Endogenous (hereditary) and Exogenous (environmental). Unexplained category is the largest. Some research has determined that in 75 percent of children with mild mental retardation the cause is unknown.

#### **2.4.7.1 Genetic conditions**

The field of genetics has important implications for people with mental retardation. More than 500 genetic diseases are associated with mental retardation. Most identifiable causes of severe mental retardation (defined as an IQ of 50 or less) originate from genetic disorders. Up to 60 percent of severe mental retardation can be attributed to genetic causes making it the most common cause in cases of severe mental retardation (Taylor, et al. 1995). A recent study by Spinath et al. (2004) has found out a substantial genetic influence on mild mental impairment in early childhood.

There are basically two major types of genetic conditions that can lead to mental retardation: inherited and chromosomal aberration. Two of the most common genetically transmitted forms of mental retardation include Down syndrome (a chromosomal disorder) and Fragile X syndrome (a single-gene disorder)(Taylor et al., 1995).

In the inherited type, the child usually inherits a specific condition that can cause or be associated with mental retardation. There are three common types or modes of inheritance: dominant, recessive and X-linked (or sex-linked). Dominant inheritance occurs when one parent has a dominant, disease-causing gene which causes abnormalities even if coupled with a healthy gene from the other parent. Dominant inheritance means that each child has a 50 percent chance of inheriting the

disease-causing gene. Examples of dominant inheritance associated with mental retardation are tuberous sclerosis and neurofibromatosis. Recessive inheritance occurs when both parents carry a disease-causing gene but outwardly show no signs of disease. Parents of children with recessive conditions are called "carriers" since each parent carries one copy of a disease gene. They show no symptoms of having a disease gene and remain unaware of having the gene until having an affected child. When parents who are carriers give birth, each child has a 25 percent chance of inheriting both disease genes and being affected. Each child also has a 25 percent chance of inheriting two healthy genes and not being affected, and a 50 percent chance of being a carrier of the disorder, like their parents. Examples of disorders, which are inherited recessively and are also associated with mental retardation, include Phenylketonuria (PKU), Galactosemia, Hurler syndrome, and Tay-Sachs disease (Kaplan and Saddock, 1988; Taylor et al., 1995).

X-linked or sex-linked inheritance affects those genes located on the X chromosome and can be either X-linked recessive or X-linked dominant. The X-linked recessive disorder, which is much more common compared to X-linked dominant inheritance, is referred to as a sex-linked disorder since it involves genes located on the X chromosome. Some examples of X-linked inheritance associated with mental retardation include Fragile X syndrome, Hunter syndrome, Lesch-Nyhan syndrome and Duchenne muscular dystrophy (Clarke, 1984; Batshaw, 1997).

Chromosome abnormalities are the most common known cause of MR, occurring in 4-28% of all cases. In the chromosomal aberrations, mental retardation is not inherited; rather, the child's chromosomes have somehow been adversely affected, resulting in a condition associated with mental retardation. Chromosomal disorders

happen sporadically and are caused by too many or too few chromosomes, or by a change in structure of a chromosome. In most chromosomal disorders, each of the parent's genes is normal. However, during cell division an error in separation, recombination or distribution of chromosomes occurs. The most common type of mental retardation resulting from a chromosomal aberration is Down syndrome. It occurs in about 1 in 800 new born babies (Girimaji et.al., 2001:25). Examples of chromosomal disorders include Down syndrome, Klinefelter's syndrome, Turner's syndrome, Triplo X syndrome, Trisomy 13, Trisomy 18 and Cri Du Chat syndrome (RCI, 2001; Khalifa and Struthers, 2002).

#### **2.4.7.2 Environmental conditions**

A number of environmental factors, especially those damage and interfere with the growth and maturation of the brain can lead to mental retardation. These factors can be seen before, during or after the birth of the child. People with mild mental retardation are more likely to have the condition due to environmental factors, such as nutritional state, personal health habits, socioeconomic level, access to health care and exposure to pollutants and chemicals, rather than acquiring the condition genetically.

##### **(i) Preconceptional factors**

Include factors before a woman conceives. History of infertility, repeated abortions in the mother, and maternal age at conception are some of the factors, which can lead to mental retardation. In a study Chapman et al. (2002) have found out that older maternal age is associated with increased risk of mental retardation.

##### **(ii) Prenatal factors**

Mental retardation can result when the baby does not develop inside the mother properly. For example, there may be a problem with the way the baby's cells divide as it grows. Infections in the mother, such as rubella, syphilis, toxoplasmosis, cytomegalovirus, and tuberculosis, especially during the first three months of pregnancy can damage the developing brain of the fetus. Pregnant women who are infected with HIV may pass the virus to their child, leading to future neurological damage. Use of substances such as alcohol (Foetal Alcohol Syndrome), nicotine, and cocaine by the pregnant mother can also cause mental retardation. Recent research has implicated smoking in increasing the risk of mental retardation. Exposure to other harmful chemicals such as pollutants, heavy metals, abortifacients, and harmful medications such as thalidomide, phenytoin, warfarin sodium in early pregnancy can result in mental retardation.

Inadequate intake of iodine leads to insufficient production of thyroid hormones, which play a vital role in the process of early growth and development of most organs, especially the brain. The neurological outcome of iodine deficiency varies from minimal brain function to a syndrome of severe mental retardation. A meta-analysis of 19 studies has demonstrated that, on an average, children living in iodine deficient areas have an intelligence quotient (IQ) 13.5 points lower than children living in iodine sufficient areas (Bleichrodt and Born, 1994).

Folic acid deficiency may also cause the normal development of unborn babies. Severe malnutrition, radiation, or unknown conditions affecting implantation and embryogenesis during pregnancy are the other risks factors may cause mental retardation. Rh incompatibility between the maternal and foetal blood may result in the newborn child being jaundiced and mental deficiency is a possible accompaniment. There is also an evidence that mother-child blood incompatibility in

the classical major blood groupings (A,B, and O) may also be a factor in causing some cases of mental deficiency (Kaplan and Saddock, 1988; Carson and Butcher, 1992; Taylor et al., 1995) .

#### (iii) Perinatal factors

Any birth condition of unusual stress may injure the infant's brain, and can cause mental retardation. Even though there are a number of birth conditions, prematurity and low birth weight predict serious problems more often than any other conditions. Other risk factors include birth asphyxia, birth anoxia, traumatic birth injury, placental dysfunction, malpositioning of the foetus, toxemia, haemorrhage, severe jaundice, excessive coiling of umbilical cord around the neck of the foetus, medicines administered to the mother such as anaesthetics and pain killers, or other complications may still damage the infants' brain at birth.

#### (iv) Postnatal factors

An important cause of mental retardation after birth is brain infections caused by bacteria or viruses. If this infection is severe, there may be irreparable brain damage leading to mental retardation. Commonly found brain infections in the new born are tuberculosis, Japanese encephalitis, and bacterial meningitis. Head injuries due to accidents can damage the brain and lead to mental retardation. Lead, mercury and other environmental toxins can cause irreversible damage to the brain and nervous system. Severe and prolonged malnutrition during the first years of the developmental stage of the child can cause permanent damage to the brain.

Research suggests that Poverty and cultural deprivation can also serve as a cause of mental retardation as children from deprived backgrounds suffer from malnutrition, disease-producing conditions, inadequate medical care and environmental health hazards. Children from poor families are also deprived of many

common cultural and day-to-day experiences or lack of early opportunities for intellectual growth.

The above section gives an understanding on the nature of mental retardation. Now, let me point out some of the prevailing intervention systems of the population with mental retardation.

#### **2.4.8 Interventions**

A number of intervention strategies are used in the care and management of people with mental retardation. Care and treatment of the retarded in the past were mainly custodial. More recently, however, efforts have been directed toward improved medical treatment of organic and psychiatric conditions, behavior modification programs, parent education, special schooling, vocational training, sheltered workshops, and therapies like psychotherapy, group therapy, physiotherapy, speech therapy, music therapy, art therapy, and yoga therapy. Many retarded persons have proved capable of becoming nearly independent and productive members of society, although in most cases specialized training and continuing guidance services are necessary to aid adjustment. The most commonly used intervention programs are briefly discussed below:

##### **2.4.8.1 Education**

Beginning with Itard's work in the late 1700s and early 1800s, attention was focused on educating individuals with mental retardation. Presently education is the most commonly used intervention for children with mental retardation. Earlier special education was the major concern, but the later thinkers and educationists pointed out the need for integrated education, inclusive education, and other elementary

education. Apart from this, the Government policies also compel parents to educate their children with mental retardation. Hence, educational intervention has become the major type of rehabilitation for children with mental retardation. The education of children with mental retardation implies a systematic sequence of specialized teaching, which includes assessment, methodology, curriculum, and goal planning (Crane, 2002). All of these aspects of the system are essential to the intellectual and maturational growth of the retarded child and also to maximize the child's potential.

Special education represents the conjunction of two distinct but related components: the instruction of students with special needs and the use of special instruction. Thus the essence of special education appears to be defined by instruction matched to the particular needs manifested by the individual student (Kavale and Forness, 1999). Since the 1970's, an ecological approach has influenced the field of special education as well as psychology, inspiring research and interventions. The ecological approach to special education emphasizes the importance of understanding the surrounding conditions including people and their interaction with the child in a learning environment (Trepanier, 2005), which is very effective for children with mental retardation.

The integrated education of the disabled persons is a relatively new trend in the normalization movement of the handicapped persons. With the adoption of principles of normalization, integration, and mainstreaming, plus the movement towards full inclusion, along with a developing database supporting these principles, it has become quite obvious that separate educational environments may not be necessary for most students with mental retardation, especially those requiring less intensive supports. The integration process is featured with several aspects. The first indicator refers to the reduction of physical distance between the mentally retarded

persons and the rest of the community. It should be accompanied by the reduction of social distance, which implies social interaction among the mentally retarded and the rest accompanied by sharing of facilities in the environment. Finally, these activities culminate in social integration, which implies their acceptance in the community and allocation of citizenship roles appropriate to their level of functioning.

Cooperative teaching<sup>5</sup> between special and general education teachers is now being used to serve students with disabilities in general education classrooms. Trent et al., (2003) observed that cooperative teaching is a potentially efficacious approach for serving students more effectively in inclusive settings and for facilitating increased communication and sharing among teachers.

Though educational interventions are the mostly used interventions, there are issues related to this. The most common among them are: related with assessment, labelling, legal issues, financial issues, and instruction issues (Aloia and Macmillan, 1983; Hastings, 1994; Ysseldyke et al., 1998). The issues discussed above call for a more supporting education system with the retarded individuals. Effective educational practice depends upon interdisciplinary collaboration that emerges from the recognition of the multiplicity of influences on today's education, and from one that values and respects the efforts of all the stakeholders involved. Hence, it is very important that there should be learning beyond the school system

#### **2.4.8.2 Psychotherapeutic Intervention**

The effectiveness of psychotherapy has been a controversial issue among mental health professionals for many years (Prout & Nowak-Drabik, 2003). Only in 1940s and 1950s psychotherapists started considering children with mental retardation as suitable candidates for psychotherapy. Publications as late as the 1940s typically

---

<sup>5</sup> In cooperative teaching, general and special educators teach students with and without disabilities in inclusive classrooms.

implied that psychotherapy were neither feasible nor profitable for the mentally retarded. Probably no more than two-dozen papers can be found in the literature of the 1930's and 1940's (Robinson & Robinson, 1965). In a recent article, Lynch (2004) has elucidated that though empirical studies lack, demographic trends and changes within the field of mental retardation have broadened the range of problem areas that psychotherapy can address, including addressing aging-related needs, assisting with transition to community living, addressing increased exposure to the "freedoms and dangers of society," and treating individuals with severe or profound mental retardation.

Persons with mental retardation are referred for and seek out psychotherapy for a wide variety of reasons. The major goals of psychotherapy with the retarded are IQ change, emotional or behavioural adjustment, achieving a realistic self-appraisal, and milieu or (environmental) modification. Studies have shown that psychotherapy with individuals with mental retardation is often effective in improving coping abilities or relieving symptoms of psychopathology (Gaedt, 1995).

The most commonly used psychotherapeutic techniques in the field of mental retardation are behavioural interventions based on learning theories. A number of studies support this by specifying about the different techniques, which include: differential reinforcement, token economies, prompting, punishment, time out, and over correction, progressive muscle relaxation, systematic desensitisation, differential reinforcement, extinction – flooding, implosive therapy, participant modelling, behavioural rehearsal, self – management, self – reinforcement, and various cognitive – behavioural approaches such as problem – solving training, assertiveness training, self – instructional training, and social skills training (Peck 1977; Rickard et al., 1984; Whitman, 1990; Nezu and Nezu, 1994; Benson and Havercamp, 1999; Gates et al.,

2001). Behavioural interventions have in many ways succeeded in improving the independence and quality of life of individuals with developmental disabilities. Behavioural treatments have the potential to teach new behaviours previously thought beyond the capability of individuals with mental retardation.

Group therapy is also an effective, often underestimated, treatment modality for people with mental retardation and mental illness. Studies have described the positive effects of group psychotherapy with people with mental retardation (Pfadt, 1991, cited by Thomasulo, 1995). Psychoanalytic psychotherapy and cognitive therapy are also reported to be effective with people with mental retardation (Childester and Menninger (1936, cited by Robinson and Robinson, 1965). Cognitive therapy has been found to be effective in the treatment of obsessive-compulsive disorder for people with mental retardation (Nixon and Singer; 1993; Reiss, 1999; Dagnan et al., 2000).

Researchers have also stressed that in the field of psychotherapy, many general books resources on counselling and psychotherapy do not discuss issues related to persons with developmental disabilities (Prout and Drabik, 2003). Butz et al. (2000) based on a literature review observed that the literature on psychotherapy for people who have mental retardation dates back at least 30 years, and in some cases arguably 60 years, and therefore it is not a new area of inquiry. They also identified that recent contributions in this area have been promising, though historically the research has been lacking.

One of the chief difficulties in evaluating the feasibility of psychotherapy with mental defectives is that the criteria for the diagnosis of cases so labelled either are not stated or are restricted to an intelligence test score.

### **2.4.8.3 Psychopharmacology**

Persons with developmental disabilities who display aberrant behaviour, such as self-injury and aggression, often are prescribed psychotropic medications (McAdam et al., 2002). According to Rinck (1998, cited by McAdam et al., 2002), the combined results of several surveys show that approximately 25% to 50% of adults with mental retardation who live in institutions and 25% to 40% of adults with mental retardation who live in community-based settings receive one or more medications targeting aberrant behaviour. Mentally retarded children frequently develop emotional and behavioural difficulties requiring psychiatric treatment. These children's limited cognitive and social capacities require modified psychiatric treatment modalities based on the children's level of intelligence. Occasionally, psychotropic medication can help remove or modify certain target behavioural symptoms, such as hyperactive and impulsive behaviour, anxiety, or depression.

Studies on the prevalence of psychiatric symptomatology in people with different severity of mental retardation have yielded somewhat inconsistent results. Reiss (1988, cited by Holden and Gitlesen, 2004) found virtually no difference in overall prevalence for adults with mild and severe mental retardation, whereas Borthwick-Duffy (1994) found a higher prevalence in people with mild mental retardation. Borthwick-Duffy (1994) reported that numerous research studies have examined the prevalence of psychiatric disorders among people with mental retardation, and a wide range of rates have been reported. In a recent study, Holden & Gitlesen (2004) have found out a higher prevalence of most individual symptoms, and symptom disorders, in participants with moderate mental retardation compared with participants with severe and profound retardation. Differences between participants with severe and profound mental retardation were considerably less.

Frequently used psychopharmacological drugs with people with mental retardation are: antipsychotics, Antidepressants, Anxiolytics and Sedatives, Stimulants, Mood Stabilizer, and Opiate Blockers (Andrulonis, 1982; Reiss, 1999). The use of psychotropic medications has its risks, variously called adverse reactions or side effects. Therefore excessive use of these drugs is not advisable.

#### **2.4.8.4 Home and Community based services**

The home and community based services have provided the opportunity for people with mental retardation to live in smaller, less-regulated community homes (Crane, 2002). The most common activities focussed on home and community based services, include family centred programmes (Guralnick, 1999), and community based rehabilitation programmes.

Feldman et al. (2002) evaluated the effectiveness of positive behavioral intervention for persons with developmental disabilities who displayed severe self-injurious, aggressive, and disruptive behaviours. The multicomponent model included a comprehensive assessment of biomedical and environmental factors, stimulus control, and behavioural function. The intervention package was derived from the assessment findings and included antecedent-and reinforcement – based strategies and mediator training. Using a multiple baseline design across participants and pre-post measures of social validity and quality of life, the researchers found significant decreases in problem behaviour and increases in replacement skills in the 20 participants (17 children and 3 adults). Gains were sustained in the 14 participants who received follow-up observations up to 3 years after treatment. Caregivers reported noticeable improvements in the participants' behaviour and quality of life. Caregivers were very satisfied with the interventions and rated them as highly acceptable, effective, and non-intrusive. The findings provided support for the field-

effectiveness of functional assessment-driven, mediator-implemented, community positive behavioural intervention for persons with developmental disabilities.

In another study, Bird et al. (1998) studied the effect of an environment-emphasizing network of mental health and developmental disabilities services on ten individuals with mental retardation and psychiatric disorders who failed in their community placements due to aggression, property destruction and suicidal ideation. The focus of programming was the application of psychiatric rehabilitation principles and environmental behaviour support strategies. Components of the treatment model included goal-setting, comprehensive case management, social skills training, positive reinforcement, crisis intervention, competency-based skills teaching, medication monitoring, data-based outcome measurement, and community-living arrangements. Results showed that, all individuals demonstrated significant reductions in targeted behaviours, maintained extended placement within the community without emergency hospitalisations, developed effective and adaptive social skills, secured job placement, and reported satisfaction with their quality of life.

Home and community based programmes are of much concern in the intervention field of people with mental retardation.

#### **2.4.8.5 Other Interventions**

Other interventions include occupational therapy, physiotherapy, speech and communication therapy, recreational therapy, play therapy, yoga therapy, art therapy, dance therapy, music therapy, positive behaviour support, and social work. The intervention for people with mental retardation can be effective if it is done in a multidisciplinary team of professionals.

Are these above-mentioned therapies effective enough? Do they take into consideration the everyday lived experience of the mentally retarded children? This

research, by examining the relationship needs, and the relevance of relationship to the different therapies argues that meeting relationship needs could have great therapeutic value.

## **2.5 Relationships in mental retardation**

Very little is known or written about the relationships needs of people with mental retardation. This is due to the neglect of the researchers towards the relationships need in the research realm of mental retardation. There is less information available on social relationships among people with developmental disabilities, although this is an area about which parents and carers are often most concerned. The available literature on the relationships of people with mental retardation laid a heavy emphasis on the pattern and effectiveness of friendships.

### **2.5.1 Friendships in people with mental retardation**

The general relationship of people with MR is a controversial issue. The general view is that people with MR are lonely and lack friends (Richardson & Ritchie, 1989; Wall, 1998; Moore and Carey, 2005). A major reason found out by the researchers is that people with MR lacks the necessary skills for developing relationships; another explanation is that people with MR themselves are not confident of their skills to develop relationships. A third argument is that their ability to develop relationship is limited due to lack of relationship opportunities. Lets look at the major studies on these.

It is generally recognised that people with mental retardation may lack the social skill, which enable us to make and maintain friendships. Wall (1998) emphasise that people with mental retardation may lack the social skill necessary to develop friendships. However, Luftig (1989) observed that people with mental retardation were less critical of their own social competence despite higher levels of loneliness

than a control group, suggesting that they lacked understanding of the importance of such skills. In a study on the friendship skills of people with mental retardation, Richardson and Ritchie (1989) found that the lives of those who were severely shy and lacking in confidence were characterised by an absence of any close friends and little companionship other than that provided by relatives or carers. Conversely, those who had developed a belief in themselves and confidence to relate to others were much more likely to have developed some important relationships and to have a greater variety of social connections and activities. Firth and Rapley (1990) suggest that low expectations of others often lead to people with mental retardation being denied the opportunities and risks which enable others to learn about relationships as they are growing up.

Many people with MR spend much of their leisure time in solitary pursuits, such as watching television (McConkey & McGinley, 1990). Poverty, which affects many people with MR, may restrict the use of leisure facilities and social opportunities (Garve & Kroese, 1991). According to them, it creates transport difficulties and inhibits niceties, such as buying a round in a pub. Firth & Rapley (1990) suggest that the low expectation of others often lead to people with MR being denied the opportunities and risks which enable others to learn about relationships as they are growing up.

Wall (1998) suggests that people with mental retardation are possibly more likely to have experienced poor attachment to their parents, which results in poor relationship in these children. The inappropriate friendliness, clinging behaviour and obsessional relationships, which some people with MR display, can all be seen as indicative of poor attachment (Clegg & Lansdall-Welfare, 1995). In a meta-analytic study, Van Ijzendoorn et al (1992) showed that children with a developmental delay

and with autism were significantly more likely than children from normative samples to be classified as insecure (especially avoidant). Vaughan et al (1994) were among the first to find an overrepresentation of disorganized attachment among children with Down syndrome. They have warned that this over representation could be a result of developmental delays as well as the consequences of relational risk factors.

Thus research has consistently shown that people with mental retardation to be lonely and lack friends. However, researchers have also pointed out that people with mental retardation do not so much lack handicapped friends though they lack non-handicapped friends. In Atkinson's (1986) study on friendships of people with mental retardation, persons who had handicapped friends were twice the number of persons who had non-handicapped friends. In a comparative study of pre-school aged children with mild delays and typically developing chronological-age matched children, Guralnick et al (1996) found that pre-school aged children with delays form only a limited number of reciprocal friendships. They also exhibit more limited linkages across school and community settings are formed as part of their peer social networks (Guralnick, 1997). In another study, Guralnick et al (1996) found that preschool-age children with mild developmental delays were less successful in gaining a positive response to their social bids and fewer directive interactions initiated during play.

### **2.5.2 Types of friendships in mental retardation**

Guralnick et al. (1996) defined two types of friendships among children with developmental disabilities: unilateral and reciprocal. *Unilateral friendships* (ie, friendship identified by only one dyad member) were defined when 33% of the child's total positive social interactions occurred with a specific comparison. *Reciprocal friendships* were defined when a specific comparison and engaged in at least 33% of positive social interaction back towards the target child after an

initiation. The authors in their study found high proportions of unilateral friendships for preschoolers with developmental disabilities. They also found fewer reciprocal friendships in the group with developmental delays than in the typical group or a group of children with communication disorders.

From the study of Guralnick et al. (1996), it was observed that the type of disability, a child has may affect friendship formation. Thus in the above study children with communication disorders had more reciprocal friendship than did those with mental retardation.

One of the outstanding studies on friendships of people with mental retardation who live independently, was done by Atkinson (1986). She distinguished three sets of relationships based on their origins: (i) people assigned to the person in some kind of professional capacity, termed '*formal supporters*'; (ii) people acquired by life circumstances, including relatives and handicapped friends, termed '*informal supporters*' and (iii) people 'engaged' by the handicapped person, termed '*competent others*', comprising non-handicapped friends, neighbours and acquaintances.

### **2.5.3 Pattern of friendships in mental retardation**

The patterns of friendships among people with mental retardation vary depending on the etiology of mental retardation. Kasari and Sigman (1996) emphasise that children with different etiologies of mental retardation may vary aspects of sociability that affect friendship development. Children with Down syndrome are perceived by others as pleasant and cheerful (Cuckle and Wilson, 2002). Such sociable behaviour may facilitate friendship development.

The nature of importance of close relationships among people with mental retardation depends on three functions of social supports- *intimacy, company and practical help* (Richardson and Ritchie, 1989). The interview with people with mental

retardation found an uneven pattern in these social functions. While people generally had an appropriate amount of practical help, a sense of rapport or intimacy with another person was often missing. Company fell somewhere in between, with most people having a potential source of company, although not always at the appropriate time or of the chosen kind. They emphasise the role of friendships in providing intimacy and close companionship. Many people not only lack such support but saw this as a major gap in their lives.

#### **2.5.4 Effectiveness of having a close friend**

Knox and Hickson (2001) argue that the experience of friendships has long been recognized as an important element in a satisfying lifestyle for people with mental retardation. According to them the presence of meaningful friendship is an essential element of their well being.

Researchers have shown that people with MR desire for deeper relationships due to a variety of reasons. The major one is the problems attached to stigma. They find real difficulty to face problems in coping with the stigma associated to their condition. In a study, Jahoda et al (1988) found that many people with MR are well aware of this stigma and make positive effort to overcome it. Therefore, studies have shown that they would like to engage in friendships with non-handicapped individuals, because this seems to enhance their social status and thereby reducing the stigma.

In a study Field (1996) observed the effect of close friendship on expressive behaviour among handicapped children. In an earlier study on normal preschool children who had close friends, the same author had found out that they were more verbal and facially expressive, more likely to take turns directing and submitting

during play interactions, more likely to engage in fantasy play, and less likely to merely watch the activities of their peers. Thus, in the study with handicapped children the authors hypothesised more expressive behaviour among handicapped children who had close friends. In the study, they selected 16 handicapped children; seven of them had close friends. The classroom observational report revealed that children who had close friends were more assertive in initiating, leading, and terminating play interactions than the children without close friends. Greater assertiveness was also suggested by more frequent hugging other children or taking toys. They were also more verbal, showed more affective displays, both positive and negative. The children who did not have friends spent more time wandering around and watching the other children. In both studies, four dimensions emerged for those children who had close friends: assertiveness, vocal activity, affective expressivity, and extraversion. The generally lower frequency of expressive behaviors among the handicapped children suggests a lower level of social skills in general.

### Relationship interventions

One of the important models to develop relationship skills in disabled children is the one developed by Gutstein and Sheely (2002). This relationship intervention model focuses on the social and emotional development activities for Asperger syndrome, autism, PDD and NLD. According to them, since disabled children lack relationship fundamentals, they need to be trained in them before helping them to develop friendship. Therefore they call their model as Relationship Development Intervention (RDI). To induce curiosity in the child towards his social world is the prime focus of the therapists here. This means introducing new things to see, hear and touch. These relationship skills, which are nurtured through therapeutic intervention,

are portable and generalizable. The reason they say is that anyone who knows how to be a real good friend can know how to be a good son, brother, father, etc. According to them the skills develop together.

The skill development occurs in three stages: In their model the development of relationship skills occurs in three levels: In level one the child is the center of the attention. In this, it occurs in a tightly controlled situation. The reason they say is that there is no meaning in letting the desired person leads the way. In level two the therapist actively participates with the child and makes the child co regulates the activity. In level three the different challenges are taught in-group of two. The effect of RDI occurs socially, emotionally and cognitively.

Although the above studies focus on the positive aspects of relationships, one must bear in mind that there can be detrimental effects for not having a close relationship among children with mental retardation. Researchers have suggested that in families where parents have found it difficult to bond with the baby with mental retardation, more stress and more behaviour difficulties are reported (Buckley, 2002).

Thus, a review of the studies on friendships and close relationships among people with mental retardation reveal that most of the studies focus on the perspective of the researcher in identifying friendships, which lack the perspective of the people with mental retardation. More over, the studies show an over emphasis on the skills of people with mental retardation in developing friendships.

## **2.6 Demography and service in India for Mental retardation**

In India, there are 100 million people are with some disability, according to the RCI (2003). Of this 100 million, 12 million are children with special needs in the 6-14 years age group. According to the Rehabilitation Council of India's (RCI, 2003)

statistics, three per cent of the children below 14 years of age suffer from some form of mental retardation. However, there are very few centres in India, dedicated to helping mentally retarded persons. Most of them cater to mild cases, who can move about on their own, take care of their basic necessities, and can go to the toilet when they need to. All together, only 12 million disabled children attend education in India. To meet the educational requirements of children with special needs the country has round about 3200 registered special schools, of which 800 are specifically for children with mental retardation.

The current situation of trained teachers in India is that not more than 3,500 professionals are trained every year and in spite of the efforts of RCI, the growth in the number of training institutions is not matched to the demand (RCI, 2003). There are only 41 training centres in India which offer Diploma in Special Education (Mental Retardation) DSE(MR), the most common formal training programme for special education teachers for mental retardation in India. These courses are limited to 20 participants and the teachers trained per year are not in accordance with the demands of the country.

Apart from these, the number of special schools in rural India is very limited and the children can never come to the cities and do their education. Though there are different policies for the education of the children with mental retardation, especially the advocacy programmes on inclusion and integrated education, practically very few of these policies meet the educational needs of children with mental retardation. Therefore the condition of majority of the children with mental retardation is not very feasible for a full time education in our country.

However, there are a number of programmes to facilitate the education of the disabled children in our country. In pre-independence India, the country had a few

special schools for children with intellectual impairment run by non-Government organizations, a few mentally retarded persons admitted to mental hospitals and many stayed at home. India has come a long way since Independence in the area of disability rehabilitation. An important turning point has been the National Policy on Education (1986).

The District Primary Education Programme (DPEP) is another major step towards universalization of primary education wherein children with special needs are also included. A number of districts are implementing the programme. Inclusive education being the concept world over, the DPEP aims at including the children at primary level (up to Class V) with suitable teacher preparation, infrastructure facilities and aids and appliances. In addition, there are over 1,100 special schools run by NGOs with Government support.

There are few centres in India, dedicated to helping disabled persons. There are lots of Government grants in India to support the rehabilitation of the disabled people. According to Individuals with Disabilities Education Act (IDEA), children with disabilities should be integrated to public schools where they can interact with non-disabled peers. This scheme of integrated education is in effect in India since 1974 and is sponsored by the Central Government. The Government also funds the schools for normal children who implement this programme by admitting the handicapped children. However, integration of children with mild and borderline mental retardation receives technical assistance but not financial assistance (NIMH, 1999).

Besides, sporadic attempts for home-based and community based rehabilitation programmes can be seen in some states of India. Awareness programmes designed to educate common people about mental retardation can also be

observed. However, a few technologically advanced computerised education system for the mentally retarded children can be found in metropolitan cities.

## **2.7 Rationale of the study**

The above review has shown two important things. First, there is a heavy emphasis on diagnosis, classification, and therapy-based solutions for children with mental retardation. Second, the relationship need of the disabled child is least cared in structured settings, where therapy is the center. Rather than child-oriented, a therapist's oriented approach could be seen in the nature of interventions. Since the children with mental retardation are characterized by their deficits, the interventions need to be designed to compensate these deficits. Therefore, the therapists set targets so as to develop the particular skill, which is deficient in the child, and he strives to achieve his goals. But, in this juncture the emotional side of the child with mental retardation is completely neglected.

Same pattern also is observed in the research. The research on mentally retarded children focus on diagnosis, classification, and skill training rather than the relationships and other everyday-lived experience of the children. This deficit model needs to be challenged. In the process, study will be bridging the gap of therapy-oriented interventions and every-day lived experience of children in institutional contexts.

The second reason for this study was the lacuna observed in approaches, which focus intensive interactions and relationships. Therefore, a study which focuses on these two aspects become significant to compensate the deficiency occurred in the field.

Finally, there are hardly any studies, which have adopted a qualitative grounded theory approach to study children with mental retardation in their special educational set up. Such a study can bring out important issues and concepts that are often neglected, and sometimes challenge the strongly held views.

*Chapter 3*  
***Methodology***

## Methods

*“Tell me and I will forget; show me and I may remember; involve me and I will understand” (A Chinese proverb)*

This chapter describes the design of the study, detailed explanation of the stages of the study, sample selection procedures, data collection tools, methods of data analysis and limitations of the study. The chapter ends by detailing some of the ethical dilemmas faced during the study, and how the researcher dealt with them.

### 3.1 Research design

The concepts of intimate relationship and emotional well-being are the most important theoretical constructs of this study. The design of the study was qualitative case study, using grounded theory approach. Grounded theory approach, through an iterative process between data and emerging concepts (Glaser and Strauss, 1967), allows the researcher to arrive at theoretical formulations ‘grounded’ on data using inductive method.

According to Denzin and Lincoln (2003) the word qualitative implies an emphasis on the qualities of entities and on processes and meanings that are not experimentally examined, measured (if measured at all) in terms of quantity, amount, intensity, or frequency. Qualitative researchers stress the socially constructed nature of reality, the intimate relationship between the researcher and what is studied, and the situational constraints that shape inquiry (Banister et al., 1998; Denzin and Lincoln, 2003; Bryman, 2004). Denzin and Lincoln (2003) state that ‘a complex, interconnected family of terms, concepts, and assumptions surround the term qualitative research’ (p.3). According to them, this complex, and at times contradictory, family has arisen because qualitative research is informed by a variety of intellectual traditions. Bryman (2004) has classified these traditions as the three

major considerations of qualitative research: (a) the theoretical orientation is inductive; (b) the epistemological orientation is interpretivism; and (c) the ontological orientation is constructionism.

Most qualitative researchers treat theory as something, which emerges out of the collection and analysis of data, or analytic induction. 'Grounded theory' is found to be the most useful approach to the systematic generation of theory from qualitative data. A consensus among researchers could be seen in following grounded theory approach to the analysis of qualitative data (Pidgeon & Henwood, 1996; McLeod, 2001; Travers, 2001; Bryman, 2004). Glaser & Strauss (1967) originally used the term 'grounded theory' to refer to theory that is generated in the course of the close inspection and analysis of qualitative data. This idea is now a central tenet of naturalistic research. According to them, theoretical sampling is the process of data collection for generating theory whereby the analyst jointly collects, codes, and analyses his data and decides what data to collect next and where to find them, in order to develop his theory as it emerges. It refers to the sampling, not just of people; but also of settings and events. In grounded theory, the data collection, observing, interviewing, collecting documents, carry on until the theoretical saturation is achieved. As obvious, qualitative researcher is not primarily concerned with the generalizability and testing of the theory. Rather, their primary concern is developing a theory grounded on data, which could be tested later applying them to different situations and large data sets. Therefore, qualitative researchers could afford to focus on few cases in detail to understand the processes in total.

Another agreement among qualitative researchers is on its epistemological orientation. Majority of them consider it as interpretivism, which has rejected the practices and norms of positivism. Interpretivists share a view that the subject matter

of the social sciences – people and their institutions – is fundamentally different from that of the natural sciences. Hence, the study of the social world requires a different logic of research procedure, one that reflects the distinctiveness of humans as against natural order (Banister et al., 1998; Bryman, 2004).

The third factor is about the ontological orientation. Constructionism is an ontological position that asserts that social phenomena and their meanings are continually being accomplished by social actors. It implies that social phenomena and categories are not only produced through social interaction but that they are in constant state of revision. Knowledge of the world is intentionally constituted through a person's lived experience (Bryman, 2004).

Qualitative researches use variety of methods for data collection such as ethnography; participant observation; qualitative interviewing; focus group; discourse analysis; and textual analysis. However, a general agreement can be seen among qualitative researchers, as they employ multiple methods in their approach. According to qualitative researchers, the main steps in qualitative researches are: (i) general research questions; (ii) selecting relevant sites and subjects; (iii) collection of relevant data; (iv) interpretation of data; (v) conceptual and theoretical work; (v a) tighter specification of the research questions; (v b) collection of further data; (vi) writing up findings/conclusions. (Banister et al., 1998; McLeod, 2001; Silverman, 2001; Travers, 2001; Bryman, 2004). However, this dialogue with data is never-ending process in qualitative research since the theory is continually being built.

Therefore, the researcher approached the research question in two stages: the first stage of the study was *exploratory* and the second stage was *case focused*.

### 3.2 Exploratory stage

The objective of the exploratory stage was to get comprehensive knowledge of children with mental retardation, their educational pattern in a segregated setting, and the effects of this education, especially on the mental health of the students. The researcher had experience in the field of special education for the mentally retarded started in 1999 when she had done her M.Phil study on occupational stress of special educators. Following that, she started teaching psychology for the trainees of DSE(MR)<sup>1</sup> course. Hence she had prior experiences in the field of mental retardation and special education. However, her working experiences with children with mental retardation were limited, as she couldn't interact with them as an involved researcher. Therefore, in the exploratory stage she sought out for the study on children with mental retardation, their educational pattern, the nature of their learning, and the corresponding behavioural changes, especially from their special school set-up.

For this purpose, the researcher visited four special schools for students with mental retardation. Comparisons of the schools are given in the table 3.1.

Nazreth and Shamza were from Kerala, but Sadhana and Aksha were from Karnataka<sup>2</sup>. Schools Sadhana, Nazreth, and Aksha come under the registered schools of RCI, and they followed the syllabus and pattern recommended by the NIMH. Of these, Nazreth, and Aksha run teacher-training programmes<sup>3</sup>. Though Shamza also followed the syllabus recommended by the NIMH, the infrastructure in the school was not a promising one. All the four schools followed a structured pattern in their approach. However, Sadhana was more flexible and gave more freedom to the students.

---

<sup>1</sup>Diploma in Special Education (Mental Retardation), the training programme for Special education teachers set forth by RCI and conducted by NIMH. The programme is of one year duration.

<sup>2</sup> The major reason behind extending the study to schools in Karnataka was accessibility of these schools for the researcher since she was teaching in Karnataka.

<sup>3</sup> DSE(MR), and other short-term courses, for the trainers of children with mental retardation.

The researcher started her exploratory work in Nazreth, where she had done her study on special educators. She visited the school 14 – 16 times during working days, over a period of four months. After a gap of a short period, she visited Shamza consecutively on eight working days. Her next visit was to Aksha, where she spent a total of 10 working days with students in diverse settings, over a period of three months. And the last one in the exploratory stage was Sadhana, where she made 10 visits. During her visit, the researcher interacted with the students, as much as she could<sup>4</sup>, by joining in their activities. Apart from this, she had personal informal discussions with teaching and non-teaching staffs, and parents. She also talked to large parental groups thrice during her exploratory stage. Hence the exploratory stage was spread around a period of one year in different special schools. However, as it happens in the qualitative research, the exploration continued through out the study.

**Table 3.1 Comparison of schools visited during exploratory stage**

Names of the Schools	Number of Students			Number of Full time staffs				Nature of the school	
	MR	Others <sup>5</sup>	Total	Teachers Trained		Carers	Others <sup>6</sup>		Total
				Yes	No				
Sadhana	45	20	65	4	5	4	6	19	Day school
Nazreth	168	39	207	12	8	8	6	34	Residential + Day
Shamza	17	3	20	1	1	1	0	3	Day school
Aksha	261	36	297	18	9	8	12	47	Day school

<sup>4</sup> The researcher's freedom to move around in the student group was restricted, especially in Aksha, depending on the policies of the school.

<sup>5</sup> 'Others' include students who are not diagnosed as mentally retarded, which include students with autism, cerebral palsy, and physical handicap, but there are no characteristics of mental retardation.

<sup>6</sup> 'Others' include school principals, other professionals like physiotherapist, speech therapist, or occupational therapists, office staffs, and bus drivers.

### **3.2.1 Emerging ideas from the exploratory study**

The important observations and insights emerged during the exploratory stage helped the researcher to focus on the key issues. They are: (i) the special educational services gave much emphasis to the limitations, especially the physical and social skill deficits, of the students with mental retardation, (ii) since the interventions were focussed on meeting the purpose for which it was designed, there was no adequate emotional support for the students, (iii) due to the high teacher-student ratio, the individual attention received by the students was too limited, (iii) negative reactions due to teacher stress could leave negative emotions in students, (iv) the dominant role of the staff created unhappiness among students, (v) the anxious and stressed parents failed to provide sufficient care, love, and affection, (vi) the overall pattern in the schools were not sufficient to meet the emotional needs of the students with mental retardation, (vi) the students with mental retardation were in need of more emotional support, intimate relationships and happiness.

As a result of this preliminary exploration, a number of questions emerged: (i) can intimate relationship with someone be helpful to meet the emotional needs for the students with mental retardation? (ii) is it possible to make an intimate relationship with children with mental retardation? (iii) what are the necessary steps in the process of developing an intimate relationship with a child with mental retardation? (iv) what could be the possible obstacles during this process? (v) do the children with mental retardation really enjoy being in an intimate relationship? (vi) how far does it affect the well being of these children?

Therefore at the end of the exploratory stage, the researcher had focussed more on the possibilities of developing an in depth relationship with students of mental retardation. The explorations revealed that the level of support required by

each student was an essential element in the development of a relationship. This led to the next stage of enquiry.

### **3.3 Case focussed stage**

The key research strategy evolved was to spend long periods of time with students with mental retardation in their school setting. The researcher was immersed in one selected special school for about 10 months, interacted with the participants in a deeper level, made regular observations of the behaviour of the participants in that setting, listened to and engaged in conversations, interviewed relevant people around, collected documents about the participants, developed a deeper level understanding of the group in which the participants were involved, and wrote detailed account daily. Hence the aim of the research was to understand the life and problems of children through developing an in-depth relationship with them. The method was to interact with them in all their activities with empathic and non-critical attitude.

#### **3.3.1 Sample selection procedure**

##### **3.3.1.1 Selection of the setting**

The researcher in this phase selected Sadhana School as the setting for the study. The rationales behind selecting this particular school were: (i) Sadhana was the only school interested in a long-term case study approach. In the other schools the situation was not convenient for a long-term study by selecting few cases; (ii) this was the only school that allowed the researcher to move around freely in different settings of the school; (iii) the student strength in the school was neither too large, nor too small; hence the researcher could interact on one to one basis; (iv) the researcher could establish a strong rapport with the approval of the school principal, teachers, and care takers during the exploratory stage; (v) the school climate in Sadhana was matching in all respects to the research questions; (vi) and finally, Sadhana was

situated next to the researcher's own workplace, hence the journey to the setting was quite easy.

The detailed description about the research setting is given below:

### Sadhana Special School

Sadhana was situated at the centre of Mangalore city, established in the year 1993. The school followed the syllabus and pattern prescribed by the NIMH. As explained earlier, the approach of Sadhana was comparatively flexible than other schools. It was more like a care centre for children with diverse special needs including mental retardation, cerebral palsy, autism, orthopaedic handicap, and learning disability. The major objective of the school was to provide necessary support and training to children with special needs. This privately managed school does not charge the students for its services.

### Students

The school consisted of 65<sup>7</sup> students with a variety of special needs, aged four to 31 years. However, majority were between 6-20 years. The various special needs included mental retardation, cerebral palsy, autism, orthopaedic handicap, and learning disability. Of which majority, 45-50, were of mental retardation. The severity level of the students varied from mild to severe. Majority of the students were from lower class families, and few were from middle class families. They lived in and around Mangalore.

### Staff

There are nine teaching staff, four carers (aayas), one physiotherapist, a visiting homeopathy doctor (once a week), and a speech therapist (twice a week) to care the students. Apart from this, Sadhana has a principal, a vice principal, one clerk,

---

<sup>7</sup> This was the average number of students in the academic year. However, due to drop out and new admission there could be variations up to 2-3.

and two van drivers. The school has other visiting staff for helping the students in craft works, and other vocational activities. Apart from this, trainees of social work, speech therapy, physiotherapy, and few medical students come for internship or clinical training to Sadhana and contribute their part in taking care of the children.

### Routine of the school

Majority of the students come by school bus. The school bus picks up the students from their house, and reaches the school by 9.20. By 9.30, the school becomes alive. The first activity of the students, and whoever is present in the school is to come and assemble in the hall for the Morning Prayer, which usually starts with a song, followed by a small informal talk by the principal, or one of the teachers. After the prayer, the students, with the supervision of their teachers, go to their classes. Normally the class teacher gathers her students and takes them to the respective classes. Hence, by 10.00 they are settled in their classrooms. The class sessions continue for one hour and then there is a snack break for 15 minutes. To serve the snacks, the students are made to sit in two rows on the floor, one facing the other, in the corridor. Generally biscuits or chocolates are distributed to the children. By 11.15 the students go back to their classrooms and they engage in the particular activity of their class. The lunchtime is at 12.30, starting with younger children, followed by others. By 1.00-1.15, all the students and teachers finish their lunch and gather in a hall for entertainment until 2.00 pm. Generally, they could spread around, with the general sitting arrangement of boys on one side facing girls on the other side. Normally music is kept for the students to dance. There are some students who dance spontaneously as soon as the music is put on. By 2.00, they have to go back to their classrooms. Three of the afternoons, the teachers make them engage in some classroom activities, and the other two days, they are allowed to play games, like

cricket, ball throwing and running. These games take place in the long corridor. Generally, parents are allowed to pick their children after 2.00. However, majority stay back till the school ends at 3.00. The school bus takes the children to their homes and leaves them with their parents. Majority of the teachers accompany children in the school bus.

### Uniform

The uniform of the students are check black and red shirt, and black skirt for girls and black trousers for boys. The students have to come in their uniform for four days. On Fridays they are allowed to wear the dress of their interest.

### Academic programmes

Sadhana has various activities for the benefit of students. The activities consist of academic learning, pre-vocational training, vocational training, early childhood education, respite care, and training for children with cerebral palsy, National Open School, parental programmes, teachers meetings, and sports and cultural programmes, which are discussed below.

#### (i) Academic Learning

The school provided specialized academic training for children with mild mental retardation, and children with learning disability. The school had only one academic class, with seven students, and a teacher. The teaching and learning sessions took place on a regular basis in this class, individually. The syllabus followed was that of regular schools. Two of them were doing the second-class, one the third-class, and the rest were doing their first-class. The activities in the class included basic writing, reading, doing maths, once a week drawing, painting, and group singing. Of the seven students, five of them were children with mental retardation, and one was with ADHD, and one was a learning disabled child who had done his normal schooling up

to 4<sup>th</sup> standard. Apart from this, there was a special individual academic session to a student with mild mental retardation, who was in the vocational class.

(ii) Early childhood education

The early childhood education classes were categorised into three in accordance with the needs of the students. The classes were (1) early childhood education – one, (2) early childhood education – two, and (3) early childhood education – three. All these classes were specifically for children up to 12 years old. Of these, the early education - one was specifically for young children with autism, but not affected by mental retardation. The age range of the students varied from 4-10 in class one and the total strength of the students in the class were four. Early childhood education – two was the general class where students were made to sit on admission in the school. The age range of the students in this class was 4-9 years old and the number of students was five. Generally in the second year of the admission the children from class – two get promoted to early education three. The age range of the students in class three was 9-12 and the total number was six. Teaching was mainly done through different play activities in these three classes. Children benefited from group and individual games, as these were encouraged. However, the activities involve developing the writing skills by teaching the basic letters, and digits, especially in class three.

(iii) Pre-vocational class

The prevocational unit of Sadhana consisted of seven students. Though it was heterogeneous group, majority were students with mental retardation. The major activities of the classes included paper cutting, folding, gluing, cover making, drawing and flower making. Apart from this, students were allowed to do drawing on the board, playing form boards, writing or scribbling, singing, especially group singing.

Generally the class started with some singing, and then went on to some vocational activity. For the activities, the students were made to sit in a circle around the teacher, and the teacher prepared them to participate in the activities. The major training in the prevocational class was to prepare the students for vocational class.

#### (iv) Vocational classes

Sadhana had vocational classes for adolescents and adults, who did not benefit from academic learning. These classes consisted of students from the age group of 12 years and above, up to 31 years old. Students with different degrees of mental retardation, and associated conditions were the pupils of this class. Hence the vocational groups were heterogeneous<sup>8</sup> groups. This class provided focus on craft works, painting, and other vocational activities. Since the group was heterogeneous with typical characteristics, the activities usually ended up in some fights. A sum of 22-25 students belonged to the vocational section of Sadhana, with an average of seven in each class.

#### (v) Classes for children with Cerebral Palsy

Sadhana provided special training for children with cerebral palsy. There were 12 children with cerebral palsy in Sadhana. Two teachers were there for this group, and the physiotherapist looked after them quite often. The activities focused on the development of muscle tone, and other necessary self-help skills to each of the students. Singing and other entertainment programmes were part of the group activity.

#### (vi) National Open School

Sadhana conducted Open school programmes for two of the students in the school. The syllabus followed by them was similar to the mainstream syllabus. They had exams and the questions were a simplified version of the mainstream syllabi.

---

<sup>8</sup> It is a common characteristic in the vocational classes, throughout the special education field.

#### (vii) Skill training sessions

Sadhana offered skill-training programmes for the students individually depending on the strengths and weaknesses of each student. The most common skill development programmes in the school was physiotherapy, which was followed by speech and language therapy, and occupational therapy. Apart from these, each of the teachers worked on the IEP, to achieve the particular targets set for the student. In addition to that students were given opportunity to wash plates, clean the floor and toilets, and keep the class tidy.

#### (vi) Parental programmes

Parental meetings in small groups were conducted once in a week, and the meetings in large groups once in two months. The meetings provided ample opportunities for the parents to express themselves. Small group meetings with the class teacher were more effective, as the parents and teachers could discuss the issues and developments about each student. It was compulsory<sup>9</sup> for the parents to meet the class teacher once in a month. Thus, the meetings between the class teacher and the parents occurred once in a month. The parental meetings were very effective in setting the targets for each student.

#### (vii) Sports and cultural programmes

Sadhana had specific programmes on Independence Day, Christmas, and other festivals which gave the students a chance for performing their skills. All the students were encouraged and trained to participate in these programmes. The anniversaries on the last day of each academic year evaluate the performance of the students. Prior to the anniversaries there were various sports and cultural competitions held for the students, and most of them participated in it. At the anniversary celebrations each

---

<sup>9</sup> This did not happen always, as most of the parents were working and they found it difficult to come to the school. However, the frequency of the parents coming to Sadhana was comparatively more to other schools.

student was given some gifts irrespective of their participations in the activities. Parents and other family members were invited for these programmes. Such programmes made the students as well as the family members happy. Apart from this the students participated in the intercollegiate sports and cultural competitions. Few of the selected students were sent outside for the competitions. One of the interesting competitions in which all the students were trained, was the Special Olympics for disabled children.

#### (viii) Special facilities

The other facilities in Sadhana School included necessary medical help, important accessories for selected students, uniform allowance, transport allowance (school bus), and snacks.

#### **3.3.1.2 Case Selection**

Eleven students from Sadhana School were selected purposively for in-depth analysis in this study. The criterion for the selection was based on the intensity of needed support (Luckasson et al., 2002) required by the participants. The researcher had looked out for students who needed the minimal level of support in their daily school functioning with least associated conditions. The rationale behind this was the fact that the presence of a carer most of the time would interfere with the freedom of the researcher in the interactions with the participants. With this purpose the researcher met the principal and she recommended 20 students, who matched the criteria. Later, the researcher visited each class and interacted with the students, learned more about these 20 students. In addition to that the researcher discussed about the functioning of these students with the teachers and carers. Meanwhile, she had looked through the school records to gather more information about these students. Hence, by the end of the second week, the researcher selected eleven

participants for the study including nine from the list of 20 students the principal had recommended. Of which four were of mild mental retardation and seven of moderate mental retardation. The table 3.2 gives the characteristics of the sample. At the time of data collection, the age range of the sample varied from 7 years to 16 years. Of the participants, seven were boys and four were girls<sup>10</sup>.

---

<sup>10</sup> Mental retardation is approximately 1.5 times more common in boys than in girls. In Sadhana school there were 36 boys and 29 girls.

**Table 3. 2 Characteristics of the participants**

<b>Names</b>	<b>Age</b>	<b>Sex</b>	<b>Nature &amp; Level of MR</b>	<b>Intensity of support needed</b>	<b>Education category</b>	<b>Family background</b>
Faizal	13	M	Moderate Down syndrome	Intermittent	Pre-Vocational	Low SES, both parents are daily wage workers, 12 <sup>th</sup> of 12 children
Nithin	8	M	Mild Mental Retardation	Limited	Academic	Low SES, both parents are daily wage workers, 1 <sup>st</sup> of 2 children
Radhika	11	F	Mild Down syndrome	Limited	Pre-Vocational	Lower middle SES, father is a goldsmith, single parent mother passed away, 4 <sup>th</sup> of 4 children
Rahul	14	M	Moderate Mental retardation	Intermittent	Academic	Low SES, fast food at night for the father, mother is a house wife, comes from a joint family of 10 members, 2 <sup>nd</sup> of 3 children
Seema	10	F	Moderate Down syndrome	Intermittent	Academic	Low SES, mother does fish selling, single parent father died, 2 <sup>nd</sup> of 2 children
Naveen	16	M	Moderate Mental Retardation	Intermittent	Pre-Vocational	Low SES, both parents are daily wage workers, 3 <sup>rd</sup> of 4 children
Bhavya	8	F	Moderate Down syndrome	Intermittent	Early childhood education 2	Upper SES, both parents are in white collar jobs, 2 <sup>nd</sup> of 2 children
Rajeev	14	M	Moderate Mental Retardation	Intermittent	Vocational	Low SES, both parents are daily wage workers, 2 <sup>nd</sup> of 3 children
Navaz	15	M	Mild Mental Retardation	Limited	Pre-Vocational special academic sessions	Moderate SES, father is in gulf, mother house wife, 2 <sup>nd</sup> of 3 children
Vinaya	8	F	Moderate Down syndrome	Intermittent	Academic	Middle SES, both parents are bank employees, single child
Stanley	12	M	Mild Mental retardation	Limited	Academic	Moderate SES, father is a shop keeper, mother house wife, 2 <sup>nd</sup> of 2 children

### **3.3.2 Sources of data**

The other sources of data were participant observation, interview, psychological testing, and secondary data.

#### **3.3.2.1 Participant observation**

The primary method for data collection was participant observation, extended for a period of 10 months, from 2<sup>nd</sup> June 2003 to 1<sup>st</sup> April 2004, in Sadhana School. The methods used were taking part in their activities, observing them, talking to them, spending time with them, listening them, and playing with them (see McLeod, 2001 for usefulness of these techniques in qualitative researches in the context of psychotherapy).

The major situational contexts in which these methods worked out were: the classroom activities, including academic, early childhood education, pre vocational, vocational, and Open school; the snack and lunch time activities; the entertainment in the assembly hall during lunch break; the games in the corridor; the fun in the researcher's room; the journey in the school bus; the family meeting at the participant's house; the physiotherapy sessions; the cultural competitions and other cultural programmes in and out of the school; and the sports and games competitions in and out of the school ground. The rapport was established by taking part in the group activities of the participants. After the first month of interaction, the researcher started interacting individually also. Hence the data was the result of active collaboration between the researcher and the participants. Lets see this in detail.

### **3.3.2.1.1 The process of developing relationships**

Initiating, developing, and maintaining a close relationship with children with mental retardation is the major phase of the present research work. Building a relationship has two important functions in the study. It is in itself, a major objective of the study. Further it is the method utilized for understanding the life and problems of children with mental retardation.

Unconditional positive regard and total acceptance were the major guiding principles of the researcher. It was attempted to avoid punishments, negative remarks, evaluations and comparisons, control, forcing children to do something they don't like, and allowing children to move freely. The leading role was always given to the child.

Interactions with children can be classified into two – interactions in group situations and one-to-one interactions. Though both occurred in all the phases, initial sessions were predominantly of the first type while later sessions were of the second type.

### **3.3.2.1.2 Interactions in group situations**

During the initial phase of case-focussed stage, the researcher interacted with them in their groups, as one among them without any professional distance. This approach helped the researcher to gain the approval and acceptance of the participants. The researcher's constant interactions in the group helped her to act in accordance with the behaviours of the participants, i.e., to produce behaviours more similar with the participants. The researcher interacted with them in their language, in their actions, and in their interests, which formed the basis for intimate relationship.

The first two months of the study was carried out primarily in groups. During this period, the researcher interacted with the participants in different group contexts.

The researcher intensively interacted with the participants in their group activities and gradually constructed an emotional-bond with each of the participants. The researcher actively participated in almost all the activities of children in the school contexts including class room learning, play, leisure time activities, lunch, travel in the bus, prayer, celebrations etc.

These interactions helped the researcher to gain a place among the participants. The group interactions were effective in reducing the distance between the researcher and the participants, and providing a firm relationship between both. The participants enjoyed the company of a non-disabled person (Atkinson, 1986), who cares for them. Throughout the interactions, the researcher responded quickly to the needs of the participants, so that the researcher could keep the interactions positive and enjoyable for both the researcher and the participants.

#### **3.3.2.1.3 Individual interaction**

The focus of the individual interactions was to recognize the needs of each of the participants, and to increase the intimacy of the relationship between the researcher and the participants. One-to-one interaction is the most accepted strategy to be worked with children with mental retardation. The individual interactions facilitated the bond formed between the researcher and the participants through group interactions.

The researcher started interacting individually after two months of interaction. During this period, the researcher interacted with each of the participants by providing special attention to the needs of each of the participants. The individual interactions were able to compensate the limitations of group interactions by making the bond much stronger. In the initial phase of individual interaction, the researcher had to take initiative to bring them into the room, but within a week they started approaching the

researcher in her room. They could come and go whenever they liked, and could stay back as long as they required. They were allowed to move around freely, without any restriction. Throughout her interactions, the researcher allowed them to take the leading role, and she was following them. Researchers who have studied intensive interactions with children with mental retardation have specified that it is important for the children to take the lead roles, for the better results (Taylor & Taylor, 1998).

The close and warm individual interactions with each of the participants produced major effects on the process of developing intimate relationships. Most of the participants in the study had experienced relationship issues. Some of them through their behavioural response have expressed the desire to involve in a good friendship. Therefore, the individual care and attention became significant in the process of developing close relationship with them. The individual interactions made them more happy and enthusiastic, which was expressed through their behaviour. The participants gradually formed a strong emotional bond with the researcher. This type of one-to-one interaction helped the process to become stronger and deep.

Thus, throughout the study, whether it was group or individual, the researcher allowed the participants to take the lead, and enjoyed following them. This helped the participants to experience more freedom, which resulted in increased happiness. The researcher treated the actions and expressions of the participants as communications to her and encouraged them in many fields where they have been criticised and punished by others.

The researcher would like to state that she was successful in developing a close relationship with all the 11 participants. The level of intimacy and the nature of relationship may vary. The nature of the relationship was determined by the needs and

peculiarities of each child. Further, all of them used to enjoy the relationship in their own way.

#### **3.3.2.1.4 Observations regarding relationship building**

Based on the experience of the researcher, some specific observations can be made regarding the process of building a relationship with a child with mental retardation. The insights emerged from the experiences can be summarised as useful strategies: i) interactions with pleasant facial expression – importance of smiling and eye contact, (ii) open and free communication, (iii) responding to the needs of the participants, (iv) listening to them, (v) playing with them, (vi) the use of physical contact, (vii) developing relationships with significant people – father, mother, and siblings, (viii) the continuous and long interactions, (ix) providing individual attention, (x) providing emotional support.

The data produced by participant observation were recorded in the form of field notes. The researcher systematically made the notes of important changes observed in the behaviour of the participants. At the end of each day detailed report about the cases were written down. The deeper level interactions with each of the participants sustained over a period of time helped the researcher to obtain the reliability of data by comparing and ‘pattern matching’ the information from various sources and dimensions (King et al., 1994) related to a child.

#### **3.3.2.2 Systematic case history tracking**

Each of the participant’s case histories was systematically tracked by collecting information from multiple sources. The school records provided the starting point for this. The missing and important elements were then collected from teachers, parents, and siblings using a case Performa (Appendix 1). Important topics in the case Performa included demographic details, parental history, birth and early milestone

development, family history, personal history including education, behavioural patterns of skills, play, leisure, sexual orientation, creative ability, habits, unwanted behaviours. Most of this information provided were tried to be matched by the researcher through her personal observation. Additional enquiries to parents or teachers were made when there was mismatch between the information provided and the observation by the researcher.

Towards the end of the study, the parents, teachers, and carers were also requested to comment on the changes, if any, they had observed in the behaviour of children.

### **3.3.2.3 Interviews**

Two types of interviews were conducted with the persons associated with the case children to collect data. Semi-structured interviews, were conducted with parents<sup>11</sup>, teachers, carers and other professionals.

The parents, principals, teachers, and carers were interviewed on topics of perception of relationship with the children, encouragement to the children, patterns of punishment, methods of punishment, perception on child's involvement in skill development programme, emotions and feelings generated in teachers, parents, carers while providing skill development or caring, stress experienced in providing care and support. Especially in the initial stages of the study, this information was useful to understand the determinants of developing an intimate relationship with children with mental retardation in an institutional set up.

The researcher observed that in semi-structured and unstructured interviews the respondents became conscious at times, which blocked the spontaneous flow of information. The respondents tended to provide stereotypical socially biased

---

<sup>11</sup> The researcher could establish a rapport with the parents while their visit to school. On many occasions, the principal had asked the parents to meet the researcher, which made the task much more easier.

information on various occasions. Therefore, apart from semi-structured interviews, casual conversations were also used for generating more information, clarification, and gaps that researcher encountered in the study. Thus, more emphasis was given to casual conversations, which provided crucial information. Therefore, the major part of interview data was from the causal talks occurred between the researcher and the significant people of the participant's life.

While semi-structured interviews were recorded simultaneously at the time of interviewing, casual conversations had to be recorded at the end of the day.

#### **3.3.2.4 Secondary data**

The secondary documents available in the school relevant to the study were taken as sources of information.

##### Medical records

Medical records were used to find out about the nature of delivery, birth weight, and the conditions of the mother during pregnancy, early milestones of development, complications during pregnancy, medications taken by the mother during pregnancy, medications immediately after childbirth and the illness of the mother during pregnancy, and the illness of the child during development and all the previous medical history. However, the medical records were not available for all the participants.

##### Psychological records

The psychological records contain the IQ assessments and Vineland Social Maturity Scale done in the school. These were used to identify the level of mental retardation.

##### Educational records

The educational records were helpful to some extent, in finding out the

educational history of the participants. The researcher could not find homogeneity in the records kept in the school as some children had more information, while some others missed much vital information. Hence, the interview conducted for parents were considered more reliable in the history-taking path. Apart from these, the Behavioural Assessment Scales for Indian Children with Mental Retardation (BASIC-MR) done in the school for each of the participants was noted down to get a clear picture of the developments occurred from the date of joining in the school. This was helpful to get a better understanding of the skills and deficits of the participants.

### **3.4 Data processing and analysis**

As it is obvious from the methods of data collection narrated above, four types of data sets were obtained at the end of fieldwork period: (i) field notes from participant observation and casual conversations, (ii) transcribed interviews, and (iii) secondary data.

The data were electronically processed by keying it into 'Nvivo' software, which enhanced researcher's ability to conduct analysis on large qualitative data sets. Though this took a considerable time, it gave good familiarisation with the data by the time analysis had begun. Coding was done in Nvivo at two stages. In the first stage only the names of the students were coded, and documents were created for each student. In the second stage, free codes were generated for each document, and codes were created. Then they were reclassified under themes according to the focus of the research. Here concepts began to be emerged and by using the grounded theory approach further data analysis was done to compare the cases and observations. Further recoding was done once again going through all the material. The process of recoding went on until the completion of the written work, because some re-

structuring of the existing themes was necessary as the writing progressed (Glaser and Strauss, 1967). The codes developed are given in Appendix (2).

### **3.5 Limitations of the Study**

The major limitation was related to the case study approach. Case study approach used to be criticised by the statisticians for its methodological problem of 'degree of freedom' since there are few observations. However, it has been convincingly refuted by Campbell (1975), King et al. (1994), Bennett and George (2004) primarily on the grounds: a) case study researcher conducts 'pattern matching' with a number of dimensions of the case with the expectations and predictions of the theory; b) Case study researcher does not aggregate variables like statisticians, rather variables are treated qualitatively with relevant dimensions; c) researcher observes various steps of validity while searching causal paths and at each step the magnitude and signs are assessed to provide sufficient 'degree of freedom'.

However, King et al. (1994) points out case studies suffering from a different type of problem called 'infinite regress' since there is 'infinity of causal steps between any two links in the chain of causal mechanism' (86). Therefore, it is the researcher's ability to discipline the research focus and to examine only the necessary links, which provides a solution to this problem. However, there are no satisfactory solutions to the criticisms of establishing uninterrupted causal paths and choosing one causal mechanism while more than more causal mechanisms exist (Achen and Snidal, 1989), by case study researchers. The generalisability of the study is limited as the study was on a small sample of children with mental retardation

The participants for the study were students who needed limited support, which prevents the applicability of the method to students who need extensive, and pervasive support.

The study is time consuming and needs a lot of effort from the part of the researcher, which in fact a limitation with researchers who wants to finish their data collection in a short period. At the same time, a period of ten months is in fact short for a research, which is focussing on developing intimate relationships with children with mental retardation. Because, some of the relationships take longer time to bloom. The results would have been more supporting, if the study were more extended.

Since the research setting was the school, an overall interaction away from the school was not possible with the participants. Even though it was in the school setting, the researcher could not interact with the participants in all the school working days. The meeting was intermittent.

### **3.6 Ethical consideration**

Since the study was in the educational set up, the participants for the study were selected with the consent of the school authorities. The privacy of the participants, their families, and the school had been respected throughout the period. Since the study involved in developing in-depth relationship with each of the participants, care was taken not to affect the participants once the study gets over. Considering this, the frequency of the meetings was reduced in the final stage of the study. And the researcher stopped his study on 1<sup>st</sup> April, with the anniversary celebrations of the school, and then the school closed for two months vacation. Another consideration in the study was the researcher was very careful that providing individual attention to the participants should not affect the other students. Therefore, she has interacted with all the students at some points, so as to make them unaware of her target in the school.

*Chapter 4*  
***Results and Discussion***

# **Evolving relationships with persons who have mental retardation**

*“Every relationship is unique in at least some respects” (Hinde, 1995)*

## **Introduction**

This chapter is organised into four sections. The first section gives the detailed analysis of the cases studied. The second section discusses the general relationship pattern of children with mental retardation in their family and school drawing evidences from the individual analysis. The emotional and social conflicts in relationships are discussed in the third section. The fourth section talks about the dyadic relationship formed between the participants and the researcher. The chapter ends with highlighting some of the important findings based on the analysis.

## **Section 1**

### **4.1 Individual analysis of the pattern of relationship development**

The pattern followed in presenting the cases here is as follows: First the major argument of each case is given. Case report with a brief account of developmental features follows this. Then the relationships in the family, relationship in the school, general behaviour pattern, child's pattern of relationship building with the researcher, the detailed case analysis and the implications of case analysis are discussed.

Since relationships evolve over time (Hinde, 1995), for the better understanding of this gradual process of relationship, the time period in the present study has been divided into three phases: (i) the first four months are taken as the initial phase (1-4 months); (ii) the second three months are considered as the second phase (5-7 months); and the last three months as the third phase (8-10 months). Given that it is impossible to look into each and every minute details in the interactions

(Hinde, 1995), the study has used some of the remarkable elements to look at the gradual process of relationship development.

#### **4.1.1 Challenging behaviour as a mechanism for developing relationship: Faizal**

Research has indicated a close association between maternal sensitivity and attachment security among children with DS (Atkinson, et al, 1999). Studies have also shown that children with DS have an over representation of disorganized attachment (Van Ijzendoorn, et al, 1992; Vaughan et al, 1994). To a great extent, the consequences of insecure attachments in people with MR are challenging behaviours (Clegg & Sheard, 2002). The behavioral model<sup>1</sup> suggests that challenging behaviors are used to serve social functions, such as ‘attention seeking’ (Car & Durand, 1985).

Faizal was a 13-year-old boy with DS. He was known as a ‘problem boy’ because of his challenging behaviors and was prone to punishments. Faizal’s challenging behaviors were increased as a consequence of punishments. The punishments acted as reinforcements for Faizal. In reality, Faizal used his challenging behaviors to serve some ‘social functions’, i.e., a mechanism to develop relationship with the social world. However, a close dyadic relationship could bring down Faizal’s challenging behaviors. Through the case of Faizal, I argue that it is possible to decrease challenging behaviors by establishing attachment security with an intimate close relationship.

#### **Case report**

Faizal is a 13-year-old boy with moderate mental retardation (Down syndrome) in the diagnostic records of the school. However, his physical appearance was that of an eight-year-old boy. The obstetric report said that Faizal was born out of a full term normal delivery, but without birth cry. The pain was induced through an

---

<sup>1</sup> The dominant casual and treatment model for challenging behaviour is derived from behavioural theory.

injection at the time of delivery. Although the prenatal period was normal, Faizal's mother was on drips for few days immediately after the delivery. The developmental records reported that his milestones were delayed. Faizal has problems with his speech even now. Though he speaks few words, it lacks clarity. Early medical records accounted that he had epilepsy during his childhood and was under medication. Faizal did not have any special services until he was sent to special education at the age of 10. The educational records reported that because of the request of the community workers, his parents started sending him to school. School accounts from this period described him as 'hyperactive problem child'.

Faizal is the 12<sup>th</sup> and last child of his parents of Muslim origin. He has six brothers and five sisters. Faizal is the third disabled child in the family, one sister (ES3) is physically handicapped and another one (ES5) is sensory impaired. Five of his siblings (three brothers and two sisters) are married and four of them live in separate houses. Now there are 12 members living together in Faizal's family (The family tree is given in Appendix-3). Faizal's parents and siblings (except those with disability) are daily wageworkers. His father does fishing and his mother does Beedi making. While most of his brothers pursued the father's occupation, his sisters did Beedi making. They took turns among themselves to look after Faizal and his disabled siblings.

Faizal's relationships with the family members were recorded based on the interviews and casual conversations with his class teacher, mother and his elder sisters (ES2 and ES4). ES2 reported that he was not given any extra care in the early days. His mother said that she went for work to meet the financial needs of the family. She added that there was no problem from Faizal in the early years as he was simply lying down. His mother also reported that most of the time Faizal's elder sisters (ES2 and

ES4) took care of Faizal while she went for work. ES2 said they did not have much difficulty to look him after until he started walking at the age of three. Mainly ES2 took care of Faizal until she got married four years back and now ES4 has the major responsibility. The teacher also supported ES2's role by saying that Faizal likes ES2 more than anyone at home. However, according to the teacher, Faizal is not looked after well at home. Both ES2 and ES4 reported that Faizal likes to participate in household activities and other works.

The mother, teachers and his sisters said that Faizal exhibited behaviours like biting others, hitting others, kicking others, snatching things from others, poking others with his finger and occasional self-injurious behaviour. My observation also supported the same. Faizal's behaviour was considered as stress inducing among the family members as observed from the class teacher's and ES2's report. His sister said that he never sits quietly and one person cannot manage him. Therefore, they took measures to control his behaviour. Faizal got slaps from one or more people at home on a daily basis. One-day his class teacher said, "Faizal goes to the neighbours' houses and streets if he is free at home. So, when they all go for work they lock him inside or tie him in the veranda". She also said, "I also do the same thing. At times he needs to be tied up. Then only he learns". When asked the teacher said to me that his parents are happy about the school doing anything to him. My observation also supported the teacher's report regarding the treatments Faizal received from his family members and in the school. One occasion, I saw Faizal was slapped by his father in the school (explained in chapter 1 page 2). On several occasions in the initial phase of the study, I found Faizal tied to the grill of the window of his class.

Faizal was in the pre-vocational class from his admission and now this is his third year in the same class. His classmates are Radhika, Naveen, Navaz, Hari (NPS)

and Lesley (NPS). The teacher's report and my observations revealed that Faizal was very keen on participating in all the classroom activities, though most of the time it ended up in some fights with his classmates. He was the one who took more effort to put on the music in the school and initiate dancing. In the classroom, he grabbed things for the daily vocational activity and seated himself alone, so that nobody could disturb him. Faizal was crazy about paper and pencil. He enjoyed scribbling in the books or papers. He did everything, which could bring satisfaction to him, reacted to everything, which were obstacles for his happiness. However, his enjoyment could produce problems to others involved. One of the common problems occurs in the class is Faizal's snatching book from Radhika. Therefore, several times he had to get beatings from Radhika and her friends (explained in section 4.1.3). Another interesting activity of Faizal is going to different classes and grab things of his interest. A general behavior from Faizal at lunchtime is grabbing the meals of students who sit next to him and putting in his plate. Therefore, not only in the class, but also in the school Faizal didn't have any friends. The teachers reported that Faizal never obeyed the teachers. Therefore, he received innumerable scolding and beatings from the teachers and carers. 'Faizal and his punishments' were generally an event for enjoyment in the school. Almost all the students in the school, especially his classmates expressed their happiness by laughing and clapping their hands whenever Faizal was punished. Most of the time, Faizal too laughed with them. He came to be known as a 'problem boy' in the school.

#### Relationship with the researcher

Faizal was tied to the grill of the classroom window (coincidental), when we met each other for the first time. The next day, he was found to be actively participating with the teacher and other classmates for cover making. He did not show

any signs of acquaintance to me. After some time, he grabbed some papers and gum and went and sat in a safe place, where nobody could disturb him. However, his behaviour in the following day was unusual. He came and sat next to me with all his materials for cover making and asked me through his gestures to join him. From then on we started interacting. Faizal came to me as his own as if he has been interacting with me for a long time. In our relationships, Faizal was much faster than me to move the friendship forward. He was there in the school to welcome me everyday, even from the second week of my study either with a hug or smile. However, Faizal exhibited behavioural problems with me too, especially in the initial phase. Faizal's inclination towards pen and paper made him to snatch my bag on a number of occasions. He pulled the notebooks and pen, ripped my books, scribbled on it in spite of the shouting from the teacher. On other few occasions, he injured me with his fingertips. There was no doubt that Faizal was exhibiting problem behaviours. However, Faizal expressed his inclination to be with me but not disturbed by anyone. Some days as soon as he sees me he pulled me to his classroom or my room so that he could play with me alone. On some other days, when Faizal sees me with other students in the morning, he would go and stand near the door of my room. He would enter into the room with me and close the door behind us. Thus there was ample opportunities for us to play together, talk to each other, laugh at each other, and fight with each other. Our dyadic relationship moved forward with higher concern to each other. Few occasions, I made him free from the tied up situations with the permission of the teacher and expressed my care towards him. On one time he showed me the marks on his wrists after freeing him. The marks were caused as a result of tying him up to the grill.

The responsiveness in Faizal's behaviour in the relationship could be evident in the following incidences. One day, I reached the school during the assembly in the hall and stood at the back of the hall. As soon as Faizal saw me, he came to me and stood next to me. This was against the assembly rule of the school. Therefore, the teacher of another class beat him. Faizal hugged me and stayed there without moving. In another event, one day Faizal shut the classroom window and the teacher asked him to open the window. Even though she asked him several times, he did not open the window. Finally, I asked him to open the window. Without any delay he went and opened it. The teacher was surprised to see Faizal obeying me and she said, "This is extra ordinary, he never obeys anyone".

Towards the end of the study, Faizal could empathise with me in my distress. The following incidents show the intensity of his relationships. One day, I skidded in his classroom in front of everyone and got hurt. Faizal's reaction was very quick to my fall. He rushed to me, helped me to get up and massaged my knees. Later he gave me a kiss as well. Another day, Samad (NPS) from the academic class came to Faizal's class for playing. While playing, he smacked a table unknowingly and it hit me terribly. While all the students were watching, Faizal rushed to me. He massaged me and looked at my face after massaging as if to make sure that I'm all right. Later he followed Samad and gave a hit to him. This was an astonishing behaviour from Faizal, reported by even the teachers who saw the incident. In the last phase of the study, his behaviour even with some of the classmates has changed significantly. For example, his behaviour of snatching things from Radhika, grabbing food items from other students etc was vanished. My observation and the opinion of the teachers and the carers was that Faizal had calmed down towards the last part of the study.

Throughout the study, Faizal tried to pull me towards him in a situation where others did not disturb him.

### Discussion

The nature and style of Faizal's challenging behaviors had the function of seeking attention from the outside world. This indicates that he had used his challenging behaviors as a tool to develop relationships. This is clearly evident from the various events of punishments occurred in Faizal's life at school. Faizal enjoyed receiving punishments, especially the slaps from teachers and carers. This was expressed from his laughing with other students while he was being punished. It was very clear that punishments never had the intended effect on him, but it affected him in the reverse sense. Rather than the reduction of his problems, infact it strengthened his problem behaviors. It looked punishments had the function of positive reinforcements in him. The chain of challenging behaviors and punishments continued and mutually reinforced. Although his problem behaviors brought punishments to him, it acted as a way of bringing happiness to him by maintaining relationship with the society. Therefore, he never gave up problem behaviors though he had been given severe punishment for the same.

Faizal's tendency to seek attention from the people around seem to have occurred as a result of an insecure attachment in his early years. Being born in a poor large family of 12 children, Faizal was deprived of a sensitive interaction (Bowlby, 1969), which was necessary for infant-mother attachment, from his own mother. From the mother's and ES2's report, it was observed that Faizal to a large extent was taken care by his elder sisters, while the mother went for work to meet the needs of the family. The mother's strive to meet the basic needs seemed to have thwarted the need for love and care between Faizal and mother. His condition of mental retardation

never seemed to have produced an alarming state in the parents. This may be due to the fact that he was born as the third child with disability in the family. It is likely that by the time of his birth, the parents would have had accepted the status of having a child with disability. Therefore, rather than worrying about the condition of mental retardation, they worried about the extent of food and services they could provide to their children. This lack of sensitive interaction between Faizal and his mother might have resulted in an insecure attachment in Faizal (Atkinson, et al, 1999). As the previous researches show this insecure attachment would have led to the challenging behaviors in Faizal.

Faizal's close relationship with me and the effect it brought support the previous findings: (i) the challenging behaviors were as a result of an insecure attachment (Clegg & Sheard, 2002); (ii) he used his challenging behaviors to develop and maintain relationships (Car & Durand, 1985). When the relationships between us were raised to a close intimacy level, the challenging behaviours in Faizal reduced. In the initial phase of the study, the challenging behaviours exhibited by Faizal were capable enough to irritate me. However, when he was shown care and sensitivity, he responded positively by expressing concern in return. The trust developed in the relationship between us was so powerful that he did not have to exhibit some challenging behaviours to maintain the dyadic relationship formed between us. This is clearly observed from the reduction of his challenging behaviour with me even towards the end of the first phase of the study. The dyadic relationship formed between Faizal and me was through mutual exchanges. We learned about each other at the first instance and acted according to the needs of each other in the second instance. The verbal and non-verbal exchanges were capable enough to learn about each other (Duck, 1986). Faizal responded positively to all the behaviours expressed

to him. His responsiveness could be observed from the different behaviours he expressed in the relationship building process. For example, coming to my room, obeying me, helping me in my trouble, and fighting with the one who troubled me. In the last part of the study, Faizal could empathise with me in my distress. This is well observed from his behaviour in two different situations where I was being hurt. He expressed his concern towards me just like any normal developing individual. It could be observed that he coordinated all his activities step by step. This needed a lot of cognition and sensitive thinking. This behaviour of Faizal would never let anyone to feel that Faizal was a child with MR. This behaviour of Faizal was also against the usual conviction that people with MR are low in relationships and lack the ability to involve in close relationships (Richardson & Ritchie, 1988). Faizal being a child with moderate MR can perform all these is a crucial element for researchers who argue that people with MR are due to low relationship skills. When we both could engage in such an empathic relationship, the behaviour difficulties in Faizal came down. His behaviours in the school, especially in his own class, and with me were changed.

A remarkable element observed in our relationship was Faizal's tendency to remain in the dyadic relationship. Faizal was not comfortable when we both were in the groups. He wanted the relationships to be remained in the dyadic level. His tendency to be remained in the dyadic relationship seemed to have originated from his lack of early intimate relationship in the family. However, through an interactional approach (Schneider-Rosen & Rothbaum, 1993) Faizal could engage in a close relationship. Here it could be assumed that Faizal's relationship with me were able enough to provide secure feelings in him, may be a security of attachment. As far as Faizal is concerned, the interactions would have had the style/effect of maternal sensitivity and the resultant secure attachment (Van IJzendoorn, 1995). As happens in

children, Faizal's tendency to keep the relationship in the dyadic level was a clear expression of his inclination to involve in a close relationship with his mother. When he could establish an attachment relationship, the problems were reduced. It seemed that when he was given adequate attention, the problem behaviours lost its function. From this, it could be assumed that the dyadic relationship between Faizal and me could produce the function of attachment security in Faizal. This is well observed from his spending time in my room by wandering around. His frequent kissing and hugging were reflections of his happiness (Robison, 2000) in this situation. The findings of this study are in line with Amado's (1993) findings that the inappropriate behaviors in people with mental retardation decreased dramatically when they acquired a friend.

#### **4.1.2 Unrealistic expectation of the significant adults poses emotional insecurity:**

##### **Nithin**

In special schools students in the academic session are prone to unrealistic expectation of the parents and the teachers. Although studies have conducted to identify stigmatisation among people with mild mental retardation (Jahoda, et al., 1988), a lacuna could be observed to identify the issues among students who are in the academic classes of special school. Most of the time, the expectation of the significant people stand as a powerful source of stress for children with mental retardation in the academic classes of special school.

Nithin was an eight-year-old boy with mild mental retardation. Since he was moved from mainstream school to special school, his academic performance was slightly above his disabled peers. However, his mother and his class teacher interpreted his performance as laziness and they provided rigorous academic training at home and in school. He was expected to perform a level equal to his non-disabled

peers. Nithin reacted to this by developing selective stuttering to his mother and teacher. He responded intensely in the new dyadic relationship. Through the case of Nithin, I argue that the unrealistic expectations of the significant people are a reason for emotional insecurity in children with mental retardation.

### Case report

The diagnostic reports of the school accounted that Nithin is an eight-year-old boy with mild mental retardation. He was born out of a caesarean birth without birth cry at the eight month. The prenatal complications reported were that of no foetal movement and the recurrent pelvis pain of the mother. The prenatal scanning also accounted for lack of breathing in the baby. There is no history of mental retardation in the family and the cause of Nithin's condition is unknown. The developmental records reported that there was a global delay in his development. He sat at one year, walked at three years, and spoke his first word at three and a half years old. Nithin started his Anganvadi education at the age of four, two years later he was moved to a mainstream school. A year later he was transferred from mainstream to special education in the research school. Nithin is in the academic class now. His academic skills include basic reading, writing and math. He is doing class 2 of the mainstream syllabus in his academic class. His classmates are Seema, Vinaya, Stanley, Rahul, Vinod (NPS) and Samad (NPS). He underwent homeopathic treatment for few months in the research school.

Nithin is the eldest son of his parents from a low socio economic status Hindu family. The family comprised of his father, mother and younger sister (the family tree is given in Appendix-3). The income of the family is from the daily wage works of his parents. While his father was a coolie, his mother was a home maid. Nithin's relationships with the family members were identified through interviews and casual

conversations with his mother and class teacher. His mother reported that Nithin did not like his younger sister and kept a hostile attitude towards her. The class teacher also reported the same. According to the mother, Nithin has good relationships with both parents. During the interview it was observed Nithin's mother was overly anxious about Nithin's condition. Both mother and teacher reported that Nithin had all the abilities to study, but he was lazy to study. After his transfer to the special school, the parents arranged a tuition for him at home in the evenings from 7.30 – 9.00. Therefore, the mother herself reported that Nithin received very little time to interact in the evenings. The mother also reported that she never allowed Nithin to do something at home, but provided him all the opportunity to study.

At school Nithin was a gloomy boy, who hardly smiled or laughed. His face was always tight, never relaxed and looked at others with doubtful eyes. The teachers report and my observations revealed that he took long to do his academic activities. In the opinion of the teacher, this was due to his laziness and she shouted him for the same. An important observation during the academic sessions was that of Nithin looking at the teacher with fearful eyes. His face was always filled with fear while interacting with the teacher. Sometimes he looked panic and nervous. My observations also revealed that when questions were asked, most of the time he did not answer. It looked his fear prevented him from answering. The response of the teacher was to make him stand for quite sometime or ask him to write on the blackboard, especially the maths calculations. If at all he made some mistakes, he was beaten up in front of everybody. My observations revealed that he burst into tears most of the days. Although the teacher stopped seeing his tears, she continued the same pattern in the following days.

Nithin kept himself away from all the social interactions in the school. However, he observed everything intensely. Since he was new to the school environment, his behavior reflected that he had problems in getting adjusted with his new disabled peer group. May be he was in a dilemma to accept the new label put on him. Even with compulsion he was not ready to join in the group activities. Although he was a gloomy boy, he reacted to situations where he has been hurt. His mother also reported that he gets angry quite fast. His general behaviour, actions and eyes gave the impression that he fears something. He never participated in the dance at the hall.

#### Relationship with the researcher

When I met Nithin for the first time, he was standing in the academic class. Later I realized that he was making efforts to answer the questions raised by the teacher. The teacher was found to be demanding quick response from him, but he was very slow. Later on, when I sat in his class, he was observed as looking at me. However, he did not make an attempt to come and talk to me. Although he was watching me from a distance, it seemed he did not have the courage to come and talk to me. However, his long gaze gave me the impression that he was interested in me. When he was talked to for the first time, he was not ready to respond in the first instance. The teacher replied on behalf of him. He continued the same behavior of looking but not talking for few days. However, my active involvement in his class seemed to have created a familiarity by loosening the strangeness of the situation in him. Gradually he started smiling, coming and answering my questions. It took nearly a month for Nithin to approach me freely. Later on we played together in his class, in my room, travelled together in the school bus, sat together and played in the hall, worked together for his maths and other writing, and talked quite a lot about his family and previous school. Among the participants he was very consistent to sit next

to me for leisure activities. Another remarkable event in the first phase was his desire to link his mother with me.

NB 4968

Our relationship became even stronger in the second phase of the study. Nithin's interactions with his classmates and other peers in the school also have changed. He joined the classmates for various activities. Along with our interaction, his familiarity with the school was also an important element for this general change in his behaviour. However, an embarrassing element occurred in the last part of the second phase. One day his class teacher said to me that Nithin developed stuttering. This was new information and a new behaviour in him. The most important aspect of his stuttering was that he stuttered only in front of the teacher and the mother. Except these two, he was fine in front of everyone and hardly anyone noticed his stuttering. My subsequent observations revealed that he stuttered in the dyadic interactions with his class teacher (teacher-Nithin), mother (mother-Nithin) and stuttered in the presence of this triad (teacher-Nithin-mother) as well. I have also observed that the immediate responses of the mother and the teacher were of shouting him and making him to repeat the phrase until tears come into his eyes. From then on reducing his stuttering was also an objective of the study. A close look at Nithin's stuttering revealed that the emphasis on the academic skills and the insensitive interactions from the significant people were the root cause of his stuttering. As a first step, the teacher, the mother and I worked together various strategies to help him overcome this issue. The group discussion had pointed out the need for an encouraging, supportive attitude from the people who work with him. The new approach from the significant people helped Nithin to reduce his stuttering in the last phase of the study. Along with my observation, the teacher and the mother supported the same. The mother specifically came and said to me that the new sensitive interactions helped Nithin quite a lot.

Although Nithin did not undergo speech therapy for his stuttering, the school doctor provided some homeopathic medicines. None, even the doctor himself, accounted this as the reason for his change in stuttering.

Although Nithin had problems in his relationships with the class teacher and the mother, the relationship with me brought remarkable changes in him. At the personal level, he expressed himself more verbally and behaviourally. One day he said to me that the tuition teacher beat him with her stick if he didn't know the answer. Another distinguishing element in the study was that of his friendships with Stanley. The formation of this dyad was basically through the activities linked with me. They both many times worked together to bring me to their group, for example, lunchtime, to the hall, to the school bus, and to their class. He has many times literally involved in some fighting with his classmates to sit next to me in the hall. Towards the last part of the study, Nithin's behaviour with me reflected that he considered he was my best friend. When Rajeev fed me with his lunch (see section 4.1.8), Nithin's face was filled with mixed emotions of sadness and happiness. The sadness may be that he considered me as his best friend and he could not provide me lunch. On the other hand, he was happy that he could also do the same thing and he came with a handful of rice. Nithin's behaviour with me reflected that he was happy and content in the interactions with me. His behaviour also reflected that he wanted to develop more social relationships, especially with his peers. His actions together with Stanley were a clear indication of this desire of Nithin. Thus, the relationship with the researcher helped Nithin to re-establish his emotional security and develop more social relationships.

## Discussion

Nithin's stuttering was a clear indication of the distress he had in his relationships (Hinde, 1995), may be with the teacher and the mother. Since Nithin was transferred from mainstream school to special school, he could perform a level slightly higher than his disabled peers in the special school. The mother and the teacher saw this as equal to his non-disabled peers and attributed 'laziness' to this state. Therefore, they both expected a competency level equal to his non-disabled peers. Both mother and teacher worked together to find some measures to improve his performance. The mother arranged a tuition for him at home in the evenings, whereas the teacher used some punishments to make him the best. This unrealistic expectation of these two significant people put him under real pressure and he reacted to this by exhibiting stuttering to their demands.

Nithin's transfer from the mainstream to the special school disturbed his parents, especially his mother. This was reflected through their 'over expectations' from him in the form of a tuition at home. The expectations of the parents were that of making him up to the level of his non-disabled counterparts. This was unrealistic to his condition of mental retardation. However, they arranged tuition for him in the evenings at home from 7.30 – 9.00 on weekdays. Since he was the best student in the school, the situation in the school was also the same. He had to experience the over expectation of the teacher in the form of shouting and beating. Generally, it was observed that the academic classes in the special schools put a heavy emphasis on the academic skills of children with mental retardation. Nithin was no different from this. In the case of Nithin, the mother's expectation was an added factor for more pressure on him from the teacher. Nithin who was likely to be happy in the prolonged infancy stage with the mother, did not like the idea of the mother breaking the agreement to

make him independent. The close observation of Nithin's life revealed the very fact that he was suffering from the pressures put on him by the parents and teachers.

A 'frustrated' Nithin did not know how to deal with the dissatisfaction he experienced, which was reflected on his face. It was observed that Nithin never developed a coping mechanism to release the enormous tensions he experienced. He could not relate to his peers and elders. He could not even relate to the social activities of the school or the home. This was evident from him not participating in the school activities. Thus, all the mechanisms through which he could release his tensions possibly failed in Nithin. There was nothing to counteract his issues. Therefore, he reacted to this by developing a new behaviour, 'stuttering'. He was more afraid of the consequences of his responses and developed stuttering. The immediate responses of the mother and the teacher were of shouting him and making him to repeat the phrase until tears come into his eyes. This in fact aggravated the condition of Nithin.

During this ten months time, two faces of Nithin's behaviour could be observed. The initial period was filled with his passivity and lack of social interaction, whereas towards the last part of the study he was active and socially interacting. Although he was resisting in the beginning, his long gaze was a reflection of his interest in the stranger. His interest and my effort made us to develop a bond between each other. His responsiveness in the various stages was indications of his attachment with me. Along with the direct behavioural changes with me, his overall social interaction and activity level was also increased. Towards the last part of the study, the changes expressed in Nithin were remarkable in the dyadic relationship. For example, his proximity seeking behaviour, considering him as my best friend, sitting next to me wherever possible and so on were reflections of his attachment with me. Apart from this, he could develop different dyadic (with Stanley) and group

relationship (circle formed around me after lunch, explained in section 4.4.3.4) through the dyadic relationship with me.

However, the pressure on him regarding the academic programmes still continued in the same way. The attachment relationship formed with me was of no help to him to overcome the disagreement he had with his teacher and mother on the academic skills. This was evident from Nithin's development of selective stuttering (to mother and to teacher) in the second phase of the study. Although I did not have a focus on decreasing any unusual behaviour in the children, I had to work with the teacher and the mother in the case of Nithin's stuttering. The major reason for this was due to my observation about the kind of interaction Nithin received from his teacher and mother while he stuttered. The shouting from both teacher and mother was so hard that tears came to his eyes often. Therefore, the need for sensitive interactions with Nithin had to bring during the study. Sensitive interaction and non-critical attitude from the teacher and the mother helped him to reduce his stuttering in a month. This study points out the need for sensitive interaction in special schools and the drawback of special education for children who are mildly retarded.

#### **4.1.3 Loss of attachment figure is a reason for loneliness: Radhika**

In view of the fact that attachment relationships are long lasting (Ainsworth, 1989), the unexpected loss of an attachment figure results in emotional reactions in children (Bowlby, 1979). The experience of separation habitually initiates defensive processes, which lead to yearning for the lost person and reproach for desertion both becoming unconscious in infants and young children (Bowlby, 1979). Since attachment relationship cannot replace the other (Ainsworth, 1989), the emotional reaction at the loss of an attachment figure persists unless an adequate coping strategy is found. Research has suggested that people with mental retardation do grieve at the

loss of loved ones (Schwabenland, 1997/1998). However, most of the time the feelings, which are evoked by loss, come to be linked to someone's mental retardation rather than to their losses and the losses go unrecognized (Schwabenland, 1997/1998).

Radhika was an 11-year-old girl with DS. She lost her mother at five years of age. Radhika's complementary behaviors of activity and passivity reflected her complex emotions likely to be the consequences of the loss of her mother. Although she was apprehensive in developing a new attachment relationship, her behaviors indicated that she achieved attachment security in the relationship. She was keen on to stick to the dyadic relationship and expressed her distress while the dyadic interactions rose to group level. After the death of her mother, may be this was for the first time she was engaged in another sensitive interaction capable of fostering her life long dependence. Through this case, I argue that the loss of attachment figure has serious emotional reactions even in children with mental retardation.

### Case report

Radhika is an 11-year-old girl with mild mental retardation according to the diagnostic records of the school. The medical records reported that although she was born of Down syndrome, she had birth cry just like any other normal childbirth. However, the developmental records accounted that her sensory and motor developments were delayed. She attained walking at 30 months. Even now Radhika's speech is not clear and she is hard of hearing. There is no history of mental retardation in Radhika's family. Radhika started her education at five in a mainstream nursery nearby. A year later she was moved to a special school and from there a year later she was moved to the research school at seven. She was in the academic session from then until she expressed an interest to sit in the pre-vocational class last year. This is her second year in the vocational class. Her classmates are Faizal, Naveen, Navaz, Lesley

(NPS) and Hari (NPS). Radhiak's academic skills include basic reading, writing and math. She undergoes speech therapy in the school.

Radhika comes from a Hindu family and her father is a goldsmith. She lost her mother as a result of jaundice at five. She has three elder sisters (the family tree is given in Appendix 3), two of them are studying and the eldest one is doing clerical work. Her father and sisters look after her with great concern. Radhika's relationship with the family members was revealed through the interviews and casual conversations with her father, eldest sister (ES1) and the class teacher. Both her father and elder sister said that the mother looked after Radhika until her death. Her father stressed that because Radhika was a disabled child, her mother had extra care. One of the important points about Radhika's behaviour at home was that of her sitting alone for long periods (40-60 minutes) reported by both father and her sister. None of them could not recollect about the origin of this behaviour in Radhika. They also said about Radhika's active side of doing all the household activities. She often engaged in washing clothes, cleaning the dishes, sweeping the house, and so on. Since she was a disabled, motherless child they never allowed her to take part in the household activities. She protested to this by sitting outside (generally at the backyard of the house) alone for long periods (60-90 minutes). Her father reported that she was very stubborn and he attributed this to her condition of mental retardation and the absence of the mother. One day he said, he takes good care of her, but he can't replace the mother. However, after the death of the mother, the father was her primary caretaker. More often than not he came to the school to pick her in the evenings and my observation revealed that she followed him as an obedient child.

Radhika's contradictory behaviour of activity and passivity was observed at school too. The teacher reported that Radhika is most of the time moody and she

doesn't like to be interfered and her normal response was that of sitting alone without talking to anyone. Although she was in the pre-vocational class, she was encouraged to bring her books and does her writing. Apart from the other activities of the class, she spent time in writing according to her pace. Radhika never had a smile on her face and she looked at people with a questioning eye. While all her classmates sat on the floor, she preferred to make use of the table and chairs put at one corner of the classroom. She was very reluctant to participate in the vocational activities of the class. By virtue of her academic skills, she was not forced to participate in it. However, whenever, she was asked to join the group, she stooped her head down to the table to avoid the situation. Normally she remained in the same position for a considerable amount of time. During this period, she seemed to be unaware of what happened in the class. This behaviour usually followed by her opening the book and scribbling something or the other in it. However, she made sure that she would not be disturbed again. It was observed that in the middle of her work, she puts her head on the table seemed to be taking rest or thinking of something. The teacher's report and my observation revealed that Radhika did not have any special affection towards any of his classmates, elders or even youngsters in the school. This apathy of Radhika was observed in her interactions with the teachers too. Radhika never initiated to talk to any of the teachers not even to her class teacher, carers or other professionals in the school. She was observed to be more defensive in the presence of these significant elders of the school.

Radhika imitated the class teacher, carers and elder students in the school. In the class, she gathered students from her class around her table, showed them how to write or did some performance activities. She made them copy down words or numbers on her book or sometimes on the black board. She scolded them for making

mistakes or for not concentrating. She had a long ruler kept in her bag and occasionally she made use of it as a stick. Since Faizal was crazy about books and grabbed books from Radhika (explained in section 4.1.1) she copied the class teacher to beat Fazial with her ruler. From the beginning, one of the striking behaviours in Radhika was that of holding her bag almost always. The major reason for this was to save the bag from Faizal as observed from the classroom interpersonal interaction. She was so smart that she occasionally encouraged Hari and Naveen to work against Fazial. This triad (Hari-Naveen-Radhika) in the class and another triad (Seema-Vinaya-Radhika) at the lunchtime were Radhika's friends. Later on Bhavya also joined the lunchtime group. At lunchtime, she imitated the carers and the older students. She often helped the younger students to open their lunch box, sit in front of the plate properly, wash their hands before and after lunch, and wash their plates. These behaviours she copied down from the carers. Although she was not allowed to clean and mop the floor after lunch, she joined the older students with it. The carers scolded her for doing it. Her reaction was to stop the activity, go to the common room and stay alone by resting her head on her knee. However, the next day she joined for the same activity. Despite the fact that she was of underage for cleaning the hall, she was enthusiastic, happy and sincere to do the activity. Apart from this, her activity side included her sports and dance. She was a good cricket player and enjoyed cricket at the corridor with her schoolmates. Although she participated in the group dance for Independence Day, she never participated in the lunch break dance at the hall.

#### Relationship with the researcher

Radhika's relationship with me was a slow process. When I saw Radhika for the first time she was sitting on her usual chair at the corner. Although she had a notebook in her hand, she was surrounded by few of her classmates. She completely

ignored me for the first few days. Although she accidentally helped me in cover making one day, she remained resistant in the relationship building process. Once I made sure that she never takes any initiation to develop a friendship, I approached her at the table during the initial phase of the study. She looked at me, but never smiled in this interaction. On my request she showed me her book and read for me (the names in the book). Later on as the interactions increased, she showed me her book by pointing out something or the other in the book of her own. Frequent interactions led to familiarity between us. During the first phase of the relationship, we played cricket and form boards together, talked about her family, cooperated with her to clean the lunch hall, and so on. She was happy and enthusiastic to come to me and spend time with me. A general behaviour observed in this phase was that of her unhappiness while I played with other children, especially with Faizal. She never looked at me until I called out her name. Some days she didn't respond, but on other days she was happy to respond.

A remarkable element in our relationship was that of Radhika expressing her desire to be with me in my room in the second phase of the study. Whenever, I asked she came with me to my room, but she was not ready to go back to her class. Radhika was happy to spend as much time as she could with me. Sometimes it extended up to 80-90 minutes. She smiled, laughed, talked, played and walked around in my room freely. While walking in the room, most of the time she was found to be humming. The same behaviour continued until the last part of the study. Towards the third phase, this behaviour of Radhika was present even within her class. A noticeable event in the second phase of the study was that of her reactions while I met her father and sister. Unlike other participants, she kept a distance from us, however she keenly observed the situation. This was her response throughout the study period while I met

her father or sister. As far as the mutual interactions are concerned, she joined me many times with all her equipments and asked me to play with her. By the end of the second phase she realized that I spent time with other students in the school and she patiently waited for her turn. An astonishing factor in the last part of the second phase was that of Radhika keeping her bag with me while she was engaged in some activities. Although the teachers occasionally made fun of her bag, they considered this behaviour of Radhika as a remarkable change in the interactions with me because she never gave her bag to anyone else. Although Radhika was more keen on sticking to the dyadic relationship, a considerable lot of changes observed in her behaviour even with the classmates. The foremost was that of her change in the approach towards Faizal. Sometimes she accommodated him in their group by providing a paper or pencil to him. The class teacher and others considered this as a change in her. Although Radhika accommodated with other children in the group, she was happier to be in the dyadic relationship formed with me.

### Discussion

Radhika's personality comprised of two complementary behaviours. Radhika was passive and unhappy on one side, but she was active and happy on the other side. While her passive side was evidenced from her sitting alone for long periods (60-90 minutes), her active side reflected through her enthusiasm in imitating the elders. These contradicting behaviours in Radhika were a reflection of the conflicts she had been undergoing. A possible explanation of this complementary behaviour in Radhika was the loss of her mother when she was five years old. Presumably, the sudden death of the mother at such a young age left emotional implications (Bowlby, 1979)<sup>2</sup> on her.

---

<sup>2</sup> According to Bowlby (1979), human beings have a propensity to make strong affectional bonds to particular others. There will be strong emotional reactions when these bonds are threatened or broken. In his studies, Bowlby (1979) was specifically concerned about the loss of mother figure during the period between about six months and six years of age.

Just like any other child, the separation from her mother at a young age most probably has resulted in a longing for the mother and the expectation of a possible recovery (Bowlby, 1979). Probably she had waited for the reunion with her mother through a normal defensive process of sitting alone. Since the recovery did not happen she would possibly have accelerated the defensive process of sitting alone (Bowlby, 1979) and eventually which has become a part of her character.

Radhika's behaviour indicated that sitting alone was the common form of her defence. This was what we saw in her responses to the family members, teachers, and carers while asking her to stop the activities at home and school respectively. Since she did not respond while sitting alone, none of the significant people tried to get her out from the situation. May be she saw a future perspective on this behaviour of the significant people and reinforced this defensive process at the face of anything unpleasant to her. May be she expected an approach filled with warmth and care, possibly reflecting her mother's interactions, from the significant people to come out of the situation. However, when the social relations were not up to her expectations (Perlman & Peplan, 1981), presumably she continued the same style of sitting alone. As mentioned earlier, eventually this has become a characteristic of her and might have led to loneliness in her.

Radhika's loneliness was reflected throughout her activities. Her self-absorbed behaviour while all the children in the class participated in the vocational activity; her non-responsiveness and apathy in social interactions were indications of her loneliness (Jones, et al., 1985). It was likely that she could not find an effective mechanism to come out of it by engaging in a strong relationship, may be something similar to her relationship with the mother. Therefore, she seemed to have developed

an active part in her to cope with her loneliness (Duck, 1986)<sup>3</sup>. Thus the imitating behaviour in Radhika had specific connotations. This helped her in two ways: On one side, this helped her to cope up with her loneliness, whereas on the other side she could maintain her relationship with the social world. We have seen that Radhika enjoyed the opportunity to imitate the elders both at home and in school. However, she was denied the opportunities to imitate the significant elders on the grounds that she was 'special' and 'young' at home and school respectively. Radhika's imitating behaviour had an indirect implication too. As evidenced from the above discussion, Radhika was not allowed to do the activities of her interest, i.e., the activities of the elders, at home and at school. This appeared to have resulted in some kind of rivalry in Radhika towards the elders. Presumably she saw the elders as someone with more power. Therefore, it was likely that she tried to resolve the rivalry by internalising the role of elders. As in any normal developing individual she used imitating as a mechanism for that. By imitating the elders, probably she experienced more recognition among her classmates and younger children in the school. In fact Radhika's behaviour reflected both power and dependence in the relationship.

A reflection of the mixed emotions of Radhika was observed in our dyadic interactions too. She was non responsive when I met her for the first time. However, when she was approached strategically according to her needs, she responded to me with the same level of intensity even in the first phase of the study. Towards the second phase, she was more active than me in our dyadic relationships. This was a remarkable change in her. In the last part of the study, the intensity of our dyadic relationship could be observed while Radhika kept her bag with me. This was a clear indication of the emotional security and trust she developed on me. Radhika's

---

<sup>3</sup> Typical styles of coping with loneliness are to engage in 'busy-busy' activities, solitary hobbies, jogging alone, or taking some vigorous exercises (Duck, 1986).

intensity in the relationship was also evidenced through her behavioural changes in our interactions. She did not try to imitate anybody, while she was with me. From this it was evident that she was not lonely while she was with me. This also implies that she missed an attachment relationship in her life. Apparently, none of the other relationships in her life could substitute the attachment relationship she lost at the age of five (Ainsworth, 1989). More over, the significant people considered her behaviour as stubbornness resulted from the condition of mental retardation (Schwabenland, 1997/1998). The family members or the school were incapable of identifying the emotional reactions of Radhika resulted in the absence of an attachment relationship (Bowlby, 1979).

Radhika was keen on limiting herself in the dyadic relationship with me. Although she enjoyed being in various groups (lunch time group, lunch break group, classroom group) with me, she never took an initiation to involve others in our dyadic relationships. Few of the incidences to support this are: Radhika did not show any sign of interest while I met her father and sister, even though it was in the second phase of the study; she hardly asked me to sit with her while either she or me was in a group, whereas she stayed with me for long periods (80-90 minutes) whenever we were alone. On some occasions she said, “no” when she was asked to go to her class. Her desire to stick to the dyadic relationship was an indication of the attachment security she received in the relationship. May be this was for the first time, she received maternal level warmth and care to protect her life long dependence in a relationship after the death of her mother.

Radhika’s case gives implications for the needs of the family members and the school to identify the emotional needs of children with mental retardation. This also gives implications for future researchers to specifically look for attachment

relationships in the lives of children with mental retardation. A third implication is the importance of identifying the unusual behaviours in children with mental retardation before putting them as a condition resulting from mental retardation.

#### **4.1.4 My aspiration to develop 'we-self': Rahul**

Achieving 'we-self' is an indispensable process for a growing child to integrate into the joint family system. In traditional Indian Hindu joint families children are prepared for a joint family life rather than an independent life (Kakar, 1978), fostering the development of group ego or 'we-self' (Roland, 1988). Therefore, attachment security of the offspring is ensured through the development of we-self and the resultant close intimacy relationship with the family members (Roland, 2002). Grandmothers contribute as equally as the mother to childcare in traditional Indian Hindu joint families (Kurtz, 1992). Therefore, the rejection from the grandmother poses serious emotional implications for a developing child.

Rahul was a 13-year-old boy with mental retardation. His grandmother interpreted this as 'Karma' and refrained from childcare. This was in contrast to the expected support of the grandmother to care the disabled child in joint families (Peshawaria, *et al* 1995). However, his life and activities indicated the way the interpersonal chemistry in the family through rejection has become a source of aspiration for his life. He was hardworking and determined to finish his tasks. Although he abstained from initiating social relationships, he was capable of leading a dyadic relationship to different levels. Through this case, I argue that Rahul's behaviours were a reflection of his aspiration to establish an identity in the family, may be a 'we-self'.

## Case report

Rahul is a 13-year-old boy with moderate mental retardation according to the diagnostic reports of the school. Although the delivery was normal, he was born at the eight month. Therefore, he was kept in the incubator for 10 days. Rahul was born without a birth cry. Apart from the low foetal movement, the pregnancy period was normal. There is no history of mental retardation in the family and the cause of Rahul's condition is unknown. The developmental records reported that his speech and motor development were delayed. He sat at the age of one and walked at three years. Even now Rahul has problems in walking, combined with poor muscle tone. Besides he lacks clarity in speech. The medical records show that Rahul had a fever at 1 1/2 years and he had his first epileptic seizure immediately afterwards. He was under medication until five. Rahul started his education in a mainstream nursery with normal developing children. However, he was transferred to another mainstream nursery a year later on the reason that his performance was slow. A year later he was transferred from here to special education in the research school at seven in the academic class. Rahul's academic skills include basic reading, writing and math. Rahul undergoes physiotherapy and speech therapy in the school.

Rahul is the second child of his parents in a traditional Hindu joint family<sup>4</sup>. The family consists of grandparents, granduncle, uncle, aunt, their daughter (his cousin), his parents, and two siblings – one elder brother and one younger sister (the family tree is given in Appendix-3). The family is originally from Andhra Pradesh settled long ago in Mangalore. Therefore, Rahul is a bilingual, speaking Kannada in

---

<sup>4</sup> Joint family is a multi-generational household living together, i.e., a father and his sons and dependents, or a set of brothers with their sons and dependents. The members live under one roof, eat food cooked at one hearth, hold property in common, share a common income, and participate in common family worship (Karve, 1953). Thus the network of members acts as a close-knit community.

the school and Telegu at home. The income of the family is from the business of all the members. Rahul's father runs a mobile tavern at night; uncle is a street cloth seller, and brother an electrician. The grandparents and granduncle also provide their share to the economy of the household by selling roasted peanuts. Rahul's mother and his aunt are housewives.

Rahul's relationships in the family were identified mainly through interviews and casual conversations with his mother and class teacher. During the interview his class teacher said, "Rahul doesn't like his grandmother. He always fights with her". His mother's response was almost similar, "They both don't like each other. If the grandmother shouts, he shouts back; if she beats, he tries to beat her back". She also added, "Rahul doesn't like anyone at home, except the father, mother and brother. His sister loves him, but he always fights with her. He likes his brother and they both go for cycling". On another occasion, she said, "The mother (her mother-in-law) doesn't like Rahul from his childhood. She says Rahul has got some curse on him (Karma<sup>5</sup>) and that's why he is like this. She doesn't like him playing with other children in the family". When Rahul was asked about his grandmother, his responses were smiling in the first phase of the study. Rahul's condition was a much-discussed issue in the family from its identification at the early age, reported by the mother. Rahul's mother added that his father and herself take care of Rahul. Since his father goes for work at night Rahul gets little opportunity to be with him. Rahul is more close to his mother according to her.

---

<sup>5</sup> The beliefs in the laws of Karma, is strong in traditional Indian Hindu families. 'Karma', literally means, 'deed' or 'act', and more broadly names the Universal principle of cause and effect. The doctrine of karma states that one's state in this life is the result of actions in past incarnations.

As the grandmother did not take any role in looking after Rahul, his chances of developing a close relationship in the family were minimal. During the interview, the mother reported that he had been neglected in the family circle by even his grandfather, granduncle and uncle. In the opinion of the mother, Rahul's uncle (a drunkard) is a harsh person and he beats Rahul if he sees Rahul during his drunken spells. Therefore, Rahul's parents were very protective of Rahul in the family, which resulted in the reduction of interaction with other family members. Rather than a close relationship, he developed some kind of aggression towards the other members, especially to his grandmother, drunkard uncle and sister. He reacted aggressively to the physical abuse of the grandmother and uncle. Rahul's mother justified the aggressive behaviour of Rahul by saying, "Rahul knows that his grandmother and uncle don't like him".

At school Rahul was very 'calm' and hardworking. The teachers report and my observations revealed that he did not have someone to be called as a 'friend' in the school. His classmates are Seema, Vinaya, Nithin, Stanley, Vinod (NPS) and Samad (NPS). The teachers had a very high opinion about Rahul because of his hardworking nature. He was a well-disciplined, hard working, obedient boy in the school, hardly punished by anyone. The class teacher was very supportive to his academic activities and quiet behaviour. As a result of his poor muscle tone and the resultant slowness, he was given more time for the completion of tasks. Though he took long, he never gave up, but worked with high determination, as if he had some specific aim to achieve. According to the class teacher Rahul was different from the other students in doing his academic works. He tried to finish his work sitting in his own place and never gets up unless he is been called. From the teacher's report it was observed that Rahul preferred to remain in his seat rather than interacting with other students. My

observations also supported this. Although Rahul did not take initiation to engage in relationship, he was found to be comfortable with a smile in different social situations, for example, lunch in the hall with everyone, entertainment at the common room, physiotherapy sessions, and travel in the school bus.

### Relationship with the researcher

Rahul's relationship with me was an extraordinary one. In our first meeting, he didn't show any signs of wanting to socialize until I reached him. While some of his classmates approached me (a comparison with other participants is given in section 4.4.2), he ignored me by concentrating in his writing. However, from his gestures it was clear that he was aware of the surroundings. But a deliberate avoidance could be observed in him. However, when I approached him, he responded well to the questions though his speech was not clear. Although he was comfortable in the interactions, he never took any initiation to come to me for the first two months. During this period, a noticeable point was whenever he was called, he responded well, for example to play, to write something together, to read, to do math, walk towards the lunch hall, to come to my room and so on. But he always waited for his turn. However, there was a change in his behavior in the second phase of the study. He started the interactions most of the time. A significant turn of our dyadic relationship was my meeting with his mother for the second time. Unlike at the first meeting, he came and sat next to his mother. The mother and I met quite frequently in the second phase. As the interactions increased between us, Rahul's mother said to me one day that he told her about me in the evenings. His mother also reported "Now Rahul has lots of things to say in the evenings, mostly about you". Many a times Rahul was the mediator between us to exchange information. Thus the dyadic relationship of Rahul

was becoming triadic towards the end of the second phase. Another incident also supports this change. In the last part of the study, one day as a surprise he took my phone number and in return wrote his number on a paper and gave to me. One evening his mother rang me and told that Rahul wants to talk to me. He just said, "Going for cycling, with my brother". Another significant gradual process could be observed in Rahul was his participation of his own around the group formed around me during lunch break (explained in section 4.4.3.4). Rahul initiated himself to join the group towards the last part of the study.

The continuous interactions between Rahul and I resulted in Rahul disclosing few of the events in his life. For example, in the initial phase of the study, when I asked him about his grandmother, he just smiled, did not say anything. But in the second phase of the study, one day he said she beats him. However, he didn't say anything more about it throughout the study. In another incident when he was asked about his dreams, he said to me that he dreams of driving a car always. His mother also told me that sometimes he said to her that he dreamt of driving a car. Although, there was a good relationship between us, his hardworking nature continued.

### Discussion

Rahul's condition as a child with mental retardation was a shocking event for the entire family members. His grandmother's interpretation of his mental retardation as 'Karma' could be originated from the strong traditional beliefs of the family (Gabel, 2004). Keeping Rahul away from her was obviously against the traditional grandmother-grandchild bond (Kurtz, 1992) found in Indian joint families. Thus, Rahul did not have an opportunity to go through the normal traditional joint family

process of 'separation-integration'<sup>6</sup> (Kurtz, 1992) in his early development. Rahul's mother could never hand over Rahul to her mother-in-law (Kurtz, 1992; Roland, 2002) because of his MR. Therefore, the possibility of developing a 'we-self' or 'ego of the whole' (Roland, 1988; 2002) was almost negligible in Rahul.

The lacuna in developing a close intimacy relationship in the family reflected in different facets in Rahul's life: active individual level, passive social level, and aggressive. The active side of Rahul was his academic hard work, cycling, and determination in completing tasks. It was likely that the rejection through interpersonal chemistry in the family (for example, protective parents, punishing grandmother and uncle, lack of opportunity to interact in the family circle) counteracted as motivation for him. His frequent dream of 'driving a car' also was an expression of his achievement motivation. Although he said, he dreamt many times of driving a car, there is a possibility that it could be his imagination resulted from his achievement motivation. Therefore, the active face of Rahul could be considered as a reflection of his basic step towards the achievement of a 'we-self'.

Rahul's lack of initiation to interact with someone was an indication of the passive side of Rahul. One aspect of this could be explained from the relationship perspective. It could be interpreted as because of the repeated rejections in social relationships (first in the family and then in the outside world, i.e., by transferring him

---

<sup>6</sup> Kurtz (1992) calls the bond between grandmother and grandchildren in traditional joint families as 'separation-integration' phase of early development. According to him, in the separation-integration phase the mother in the joint family pushes the child into the arms of the mother-in-law and making room for the child to integrate into the family. Kurtz (1992) again describe this action of the mother as her 'emotional non-responsiveness' to the child. However, Roland (2002) has criticized Kurtz' use of the term 'emotional non-responsiveness'. He argues that this is not a lack of empathic responsiveness but a different mode of child rearing in Indian families. The Hindu mother herself has a we-self, i.e., she has already formed a close intimacy relationships with her in-law-family, very much oriented toward her children becoming an integral part of the joint family (Roland, 2002). Roland (1988; 2002) argues that through this mode of child rearing, the individual becomes an integral part of the family and thus develops an 'ego of the whole'.

to three schools on the grounds that he is a child with MR) he voluntarily kept himself away from social activities (e.g., his behaviour in our first meetings, school games). May be the anticipated fear of rejection withheld him from social interaction and relationship building. The other explanation could be attributed to his low motor functioning resulting from mental retardation. Although Rahul was passive in initiating interactions, he expressed his desire to build up relationship through a number of incidences from his life. His readiness to go for physiotherapy sessions, expression of happiness when called for lunch, his smile when talked to during the lunch break and readiness to help when asked, were prominent examples of his desire to interact with the world.

His fighting with his grandmother, uncle and younger sister marked his aggressive face. It would be considered as the frustration resulted from the rejections in life led to some form of aggression. While there was direct reason for his aggression towards his grandmother and uncle, his aggression towards his sister was based on indirect reasons. From the mother's report his grandmother loved his sister the most in the family. Therefore, he may have found his sister as a threat standing between his grandmother and himself. Another possible explanation could be, as happens in any normal situation, that the birth of his sister reduced the mother's attention to him. This would possibly have made him see his sister as a rival taking away all his opportunity to develop relationships. However, his anger at the inability to develop relationship seems to have helped him to find out new ways to direct his relationship (Auhagen & Hinde, 1997) with the family members. A clear link between his active side and aggression in relationship could be observed here.

A reflection of the mixture of his passive and active aspects could be observed in his relationship with me too. In our first meeting, he was withdrawn to himself, by concentrating to his writings. Further interactions in the first two months resulted in almost similar experiences. He was always passive hesitant to take the lead in the relationships. More specifically, he was still with his individual behaviour. However, the positive signals (e.g., responding adequately to the various social stimuli, i.e., invitation to play, join in academics, talking about his family) expressed were a clear indication of his willingness to develop a dyadic relationship with me. After two months, the roles were reversed, i.e., Rahul started initiating our interactions and I was passive. He reciprocated well to the relationship needs of me. Thus through the interchange of experiences and behaviours, a dyadic relationship between Rahul and I was developed (Auhagen & Hinde, 1997).

However, Rahul's further behaviour in our relationship reflected that he was not content to limit himself in our dyadic relationship. This is well observed from the change in his behaviour while my meetings with his mother. In our first meeting, although Rahul saw us talking, he did not make any attempt to come to us. But from the second meeting onwards, he came without being invited and sat next to us. This was a clear reflection of his desire not only to have a link between his mother and myself but also to be an integral part of it. Another incident in the last part of the study also shows this desire of Rahul. He made his mother ring me one evening. The mother and myself talked first, then he came in the scene. By now, the dyadic relationship had taken the triadic form with Rahul as the active link. His mother's words, "Now Rahul has lots of things to say in the evenings, mostly about you" were also a clear reflection of the way Rahul acted as a third person (Auhagen, 1991, cited in Auhagen & Hinde, 1997) in developing a bond between his mother and I.

Rahul's desire to expand the dyadic relationship to a larger network of relationships was evidenced in his other interactions in the last part of the study. Although he was ready to join the informal group of participants who would gather around me during lunch break when he was invited, he was reluctant to come and sit on his own. However, this changed in the last period of the study as he came on his own, sat with the group and participated in the activities. Thus he expressed his inclination to be part of a wider group. Unlike some of the other participants (for example, Faizal and Radhika), he was not satisfied with just the dyadic relationship between him and I. On the other hand, he was making use of the dyadic relationship to develop wider relationships. However, he never gave up his active individual side, but coordinated it and the new relationships to move forward. Through this it could be assumed that he was making use of all the possibilities available to him to establish an identity in his family, may be the 'we-self'.

#### **4.1.5 Clinging behaviour is a reflection of attachment relationship: Seema**

Sucking, clinging, following, crying and smiling in the child-mother interaction are biologically based patterns of behaviour contributing to attachment and the subsequent survival of the child (Bowlby, 1969). Researchers in the field of mental retardation have suggested that people with mental retardation exhibit inappropriate friendliness, clinging behaviour and obsessional relationships (Clegg & Lansdall-Welfare, 1995; Wall, 1998). This is considered as a reflection of the poor attachment of people with mental retardation (Clegg & Lansdall-Welfare, 1995). However, our ability to relate to others is determined by our 'internal working models' of self and others, derived from our earliest relationships (Bowlby, 1973).

Therefore, clinging behaviour in a relationship may be a reflection of the attachment relationship of children with mental retardation.

Seema was a nine-year-old girl with Down syndrome. Since she was friendly, she had a comparatively higher social network in the school. She expressed her happiness in a relationship by clinging, proximity seeking, hugging and kissing to the persons involved. Although she was criticised for these behaviours, her behaviour reflected that she cling to those whom she had attachment relationship. She expressed the same clinging behaviour in the new dyadic relationship on reaching attachment security. Through this case, I argue that clinging and hugging behaviour in children with mental retardation may be a reflection of their happiness in the attachment relationship.

#### Case report

Seema is a nine-year-old girl with moderate mental retardation (Down syndrome) according to the diagnostic records of the school. The obstetric report revealed that she was born out of a full term normal delivery. However, birth cry was absent in her. There is no history of mental retardation in the family. The developmental records accounted that her speech and motor development were delayed. She sat at the age of one and started walking at three. She spoke her first words at three and a half years old. Seema did not undergo any special services until she started her education at five years in a mainstream nursery. However, she was transferred to the research school a year later as per the educational records. Seema is in the academic class now. On admission she was in the early intervention class and moved to the academic class a year later. Seema's academic abilities include, basic reading, writing and math. She is doing class 2 of the mainstream syllabus in her academic class. She has all the necessary self-help skills for personal care.

Seema comes from a low economic status family of three members. The family consists of her mother and one elder brother. She lost her father when she was six years old (the family tree is given in Appendix-3). The financial difficulties of the family have increased after the death of the father, reported by the mother. Seema's mother and brother are daily wageworkers who sell fish in the market. Her relationship with the family was identified through interviews and casual conversations with her mother and class teacher. According to her, Seema is very affectionate. She is close to both mother and brother. She said Seema and her brother are good friends. The teacher said that Seema is very active and helps her mother in the household activities at home. Seema accompanied her mother and brother occasionally to the market for fish selling.

At school, Seema is very active with a leadership quality. The teacher's report and my observation supported her active participation in all the school activities. Her classmates are Nithin, Vinaya, Stanley, Rahul, Vinod (NPS) and Samad (NPS). Although she doesn't have a special friend, she joins Vinaya most of the time. However, it was observed that rather than a strong dyadic relationship, she enjoyed socializing in the school. Seema could interact well with her disabled peers, youngsters, and even elders. Radhika and Vinaya are her lunchtime friends; later Bhavya too joined this group. While she expressed care and nurturance towards her youngsters, she participated in the activities of the elders. For example, she helped Vinaya in sitting next to her for lunch, opening her lunch box and most of the days encouraged her to finish her lunch. Although she was active in other activities in the school, the teacher complained that Seema is lazy and she doesn't do her academic work in the class. She added that Seema forgets whatever she learnt the previous day. The teacher also reported that Seema is good in everything, except her laziness in

academic works. She was one of the best students in the sports and games activities. She enjoyed music and dance, and participated in the cultural activities too. All these activities were of her interest and she excelled in these, but never in academics. In the midst of all the academic writing, she found time to interact with her classmates.

A distinct feature of the relationships of Seema was her hugging to people whom she was attached to. Seema's mother reported that Seema hugged and kissed her whenever she was asked to do something of her interest. At times, she hugged her even without any reason reported by the mother. My observations revealed that Seema played around the 'pallu' of her mother's sari while the mother was around in the school. Seema's hugging was observed in all her relationships. The teacher said that Seema hugged her too. Since it was not considered as an appropriate behavior, she was shouted for the same behavior. Therefore, Seema hardly tries to hug the teacher now. It was observed that Seema hugged some of the disabled elders in the school too. Although she expressed maternal care with some of the disabled youngsters in the school (especially Vinaya and Bhavya), she never found to be hugging or kissing them. The teacher also reported that Seema hugs only the elders, but not the youngsters. Another remarkable element observed in her hugging was that of her gender difference in it. Not only that she did not cling to her opposite sex peer group, she maintained a certain extend of distance from them.

#### Relationship with the researcher

Seema's relationship with me was encouraging from the beginning making all the other relationships easy. On our first meeting, she invited me with her charming smile. When I approached her she was too shy to look at me, however she was very good in responding to all the questions. The next day onwards she was very friendly in our interactions. In fact her friendliness made our interactions very smooth in few days. A remarkable event from Seema happened in our interaction was after the first

weekend of my study in the school. On my arrival on Monday to the academic class, most of the students looked at me with their questioning eye. But it was Seema who tackled the unfamiliarity of the other children. She greeted me and told the students that 'This is Leemakka'. When Seema initiated the situation, others started showing acquaintances. In the initial phase we both participated in a number of games together. Since Seema was very good in cricket and other games, it was fun to watch her and join her at times. Joining her in her activities of interest was a reinforcing factor for our relationship. An interesting event to express my concern towards her in this initial phase was to tell her about her birthday on the previous day and the importance of bringing chocolates to the school. Although she could not bring chocolates on her birthday (it was a Friday, 8<sup>th</sup> Aug, 2003), she brought the chocolates on Monday. However, she passed the information on Friday itself that she would bring chocolates on Monday. She was treated special on her birthday as we all sang birthday songs for her. Instead of Seema, I kissed her on her birthday and made her special. She was more clinging to me after this event. She approached me with something or the other to talk. She called me while having lunch to sit next her in her group. She looked for a place next to me most of the time in the hall, in the bus and for some common games. Typical was her finding place next to me in the hall. If at all she cannot find a place, she used all her tactics to move the children who sat next to me. Among the participants, Seema was the only one who did such strategies. In this phase, Seema was very supportive to whenever I expressed an interest to meet her mother. She worked as a messenger between us, which continued throughout the study. She was very keen on involving her mother in our dyadic relationship from the beginning.

Seema's relationship with me became even stronger in the second phase of the study. Seema hugged and kissed me whenever she was happy at this stage. She had typical styles of hugging. Sometimes she just came from back and put her arms around me, in spite of the shouting from the teacher. She has expressed her love and concern towards the researcher exactly the way the researcher has expressed it to her. In this phase, some or the other types of physical contacts she expressed in the interactions. For example, one day during the lunch break she just came and sat on my lap. This was considered as a problem behaviour or immature behaviour in the school. However, for me it was a reflection of her freedom and attachment in our dyadic relationship.

Seema's dyadic relationship with me grew much stronger in the third phase. Although we both could develop a good attachment relationship, Seema was keen on developing the dyadic to other levels. One day she told me that her mother would be coming to the school. Although Seema told me that her mother wanted to meet me, her mother said to me that she did not tell anything to Seema about meeting me. It was realized that Seema had decided to bring her mother to me. Apart from this, there are other situations also where she deliberately brought a third person in the relationships. Many times she called me to tell that Vinaya doesn't eat her lunch. There are other occasions where she has brought some or the other person to me by telling them that I have called them. Apart from the childhood mischievousness, this was an indication of her desire for larger networks of relationships. However, throughout the study, Seema's hugging and kissing continued.

### Discussion

From the above observations it is understood that the significant people considered Seema's clinging behavior as her typical characteristic. However, her

behaviors reflected that her clinging had special implications. This was infact an indication of her attachment with the others (Bowlby, 1969). She hugged and kissed those who expressed real concern and care to her, but she refrained from all physical contacts with people who do not show concern and care. Therefore, it might be well thought that her clinging to others was a reflection of her emotional security. More specifically, she could develop attachment relationship with people who could exhibit power within her expectations of dependence. Seema's clinging was not generalized to all the people with whom she interacted, but to only those with whom she had good relationships.

Seema's clinging behavior is evident more with the mother. This is clearly evident from her playing with the mother's 'pallu' while she was with her. This was like any other normal developing children of an age period around 3-4 years. Therefore, this could be considered as a reflection of her childlike clinging behavior with her mother. Seema's mother's responses also point out the fact that Seema hugged and kissed her whenever she was allowed to do something of her own interests. According to Seema's mother, after the death of the father, the relationship between the existing members in the family has become closer. From this, it could be understood that Seema's relationships with her mother and brother might have increased after the death of the father. Seema's attachment and dependency with the mother is clearly evident from Seema's behavior on her birthday. Seema's first response, while asking her to bring chocolates was to ask the mother about it. Seema did everything as the mother asked her to do. Even though she could not send it on her birthday, she was found to be a responsible mother to send the information with the child. This level of sensitive interaction is a clear indication of the attachment between Seema and her mother.

From the teacher's report it was well understood that Seema did cling to all the people close to her. However, the teacher's report also suggests that Seema was shouted for doing the same. Therefore, she hardly hugs the teacher or someone while the teacher was present. From this it is well understood that Seema's friendly behavior was not a reflection of inappropriate attachment, but was a reflection of appropriate attachment relationships. It was likely that Seema interpreted the close interactions with the teacher and the other elders as the same level of interactions with the mother. However, the major difference she might have observed was that of the mother encouraging the hugging and the teacher shouting for the same. More over, the teacher's emphasis on her doing the academic work was also a factor for her not continuing her clinging to the teacher. In the school, Seema had some special disabled elders who expressed concern towards her. At times, Seema went and hugged them as well. Although she was clinging to them, she never found to be clinging to her youngsters in the school. However, she expressed maternal concern towards her youngsters. This is well evident from her behavior with Vinaya at lunchtime. Seema's distinction between elders and younger ones is a clear reflection of her making use of the internal schema of attachment formed in the prolonged infancy stage. May be her internal working models helped her to generalize her attachment relationship with the mother to other interactions which has a maternal level interaction (Bowlby, 1973).

This was the major building block of our relationships too. Although she did not initiate on the first day with her verbal expression, she invited me with her smile. In this, even though Seema wanted to talk to the stranger, something prevented her. It seemed her interactions in the family and the interactions in the school made her to form a new schema before generalizing any new relationship. The attachment schema from the interactions with the mother kept her approaching any new relationship

positively, whereas her attachment schema with the teacher's interactions made her to be a bit hesitant in the interactions. However, in few days she realized that she is cared well in the new interactions. Her birthday celebration in the initial phase of the study was an added element to this. This was the major element in her clinging towards me. Thus in the first phase itself Seema expressed her happiness and concern through her hugging and kissing (Robison, 2000) with me. Each event of her happiness in our interaction was marked by Seema's some or the other way of physical contacts (Duck, 1986).

The intensity of Seema's clinging increased as the relationship become even stronger in the second phase. This was clearly evidenced from her sitting on my lap during the lunch break in the hall. She expressed her freedom in interacting with me by sitting on my lap. Although Seema hugged and kissed the people whom she attached to, she never found to be sitting on the lap of someone. May be her closeness with me provided her the emotional dependence she had at home with her mother. Another reason for this could be she has seen that some of the other participants (for example, Faizal, Bhavya) sat on my lap at times. In the third phase of the study, there was no remarkable change occurred in the intensity of our dyadic relationship, but the changes occurred was in Seema's personal life. The most important element was that of her expressiveness in integrating more people to the relationship framework. This is well evident from her telling me that her mother wanted to meet me during her visit to the school. From the mother's response it was well understood that Seema was the one who wanted her mother to meet me, but not the mother. This expresses Seema's confidence in the relationship formed with me. She seemed to have considered our relationship as one of the important ones and observed the importance to maintain even the relationship formed with her mother. Although her mother and I did not ask

for a meeting, Seema found the necessity of a strong triadic relationship among us. Seema's desire for making use of this relationship to form larger network was also evident in her calling and showing me that Vinaya was not eating her lunch. Here not only that Vinaya didn't eat her lunch, but also Seema possibly observed that linking me with them was more practical than linking others in this case. Her desire for larger networks of relationships was evident from her content of talking as well. She talked and invited more people to the relationship framework. This was not because she did not enjoy the dyadic relationship, but because she observed the need for larger networks.

The case of Seema is indications of the attachment relationship of people with mental retardation to significant others. This case is against the findings of the studies, which stress that the clinging behavior in people with mental retardation is a reflection of their inappropriate attachment. Through this case, I argue that the clinging behavior in children with mental retardation may also be a reflection of their attachment relationship with the significant others.

#### **4.1.6 Interpersonal chemistry through 'Shyness': Naveen**

Shyness is a cause for lack of close relationships in people with mental retardation (Richardson & Ritchie, 1989). Shyness revolves around problems with interpersonal communication (Kelly, 1982). Deficient communication skills, anxiety about communication and simple avoidance of communication are the causes of shyness (Kelly, 1982). Therefore, a central problem for many shy people is their unwillingness to communicate (Kelly, 1982) and interact in social situations (Duck, 1986), especially with strangers (Burgoon & Koper, 1984). Although shy people feel negative towards others, they feel positive if they engage in some close relationships (Burgoon & Koper, 1984).

Naveen was a 16-year old boy with moderate mental retardation. His 'shyness' in socialization was a distinctive element in him. He lacked eye-to-eye contact and was poor in communication too. This was a reason for Naveen being neglected in the school. Although he refrained from socializing with the service providers, he interacted well with the peers in the social situations. When he was given attention and care in the dyadic relationship, he was able to develop an attachment relationship. The emotional dependence he could experience in the relationship helped him to achieve functional independence (eye contact in the dyadic relationship) without any skill training.

### Case report

Naveen is a 16-year-old adolescent boy with moderate mental retardation. Although the delivery was normal, he did not have birth cry and had poor sucking reflex. There is no history of mental retardation in the family and the cause of Naveen's condition is unknown. The developmental records reported that his speech and motor developments were delayed. Although he could achieve basic motor skills, he still lacks speech. According to the parental reports, he did not show any signs of speech until he was five years old. Although his speech was impaired, there is no record of him undergoing some speech therapy. The educational records reported that Naveen started his education in a mainstream nursery with normal developing children at the age of five. However, he was transferred to special education in the research school a year later. Naveen undergoes physiotherapy in the school. Although Naveen was in his adolescent stage chronologically, his behaviour reflected that of a child in his middle childhood stage.

His parents are practising Hindus and are daily wageworkers. Naveen has an elder brother, elder sister and a younger brother (the family tree is given in Appendix-

3). While his elder siblings are looking for some daily wage work, his younger brother is studying. Naveen's relationship in the family was identified mainly through interviews and casual conversations with his mother and class teacher. His mother reported that he is friendly with his elder siblings, but he doesn't like his younger brother. She added that there is no reason for him to dislike his younger brother. According to the mother, Naveen likes her more than the father. Although both parents went for work, his mother was the one who came to school for all programmes and meetings, reported by the class teacher. His mother said that Naveen was a calm boy at home, except his fighting with younger brother. Naveen participated in the activities of the household with his parents and siblings.

Naveen is in the pre-vocational class now. On his admission in the school, the school had two classrooms and he was in the early intervention class. Three years later when the school was expanded he was moved to the pre-vocational class. He was in the same class for the past six years but under different teachers. He is under the present teacher for the past two years. His classmates are Navaz, Radhika, Faizal, Hari (NPS) and Lesley (NPS). Of them, Hari and Lesley are his friends. They always sat together, but hardly communicated to each other. Radhika was also his friend to go against Faizal. Naveen had all the self-help skills and good comprehension, but he lacked speech and eye-to-eye contact. Unlike speech and hearing impaired, he never developed any sign language for communication. Therefore, he was considered as one with poor communication skills. A remarkable behaviour in him was his 'shyness'.

Naveen's mother, teachers and carers reported that Naveen was extremely shy. Although his parents and teachers reported that he had it long before, none of them remember its origin. At home, he was shy with strangers and visitors. The teachers report and my observation at school revealed that he was shy in front of all the staffs.

He was shy everywhere, whenever he encountered some significant people. His typical response was a smile with eyes half closed, and bend his head down. By seeing this, everyone called out his name as if to make sure that they saw him. He responded to this by smiling more and putting his head bit more down. Though he bent his head, he observed if the person has gone or not. However, he never raised his head unless he was sure that the person was engaged in some other activity. Another typical response of Naveen was that whenever the teachers, carers or any other professionals or any strangers came to the class, he moved to the back of the class never providing an opportunity for them to have a face to face view. Naveen found to be inactive while some strangers or any of the service providers present in the situation. This behaviour of Naveen most of the time made the significant people to call out his name, but more than that he was neglected in the social activities due to this.

Although he was shy to perform in the presence of the teachers, carers and other professionals in the school, he was very active in himself and with his peer groups. He participated in all the classroom vocational activities. Although he did not respond, his ability to comprehend things in one instruction was an amazing factor. He was fond of playing form boards, putting designs, and drawing the basic geometric designs. He was very enthusiastic to participate in the dance. However, he stopped it whenever a teacher or any other service provider came to the hall. Although he abstained from social interaction in the presence of service providers, he was very active with his peer group.

#### Relationship with the researcher

When I met Naveen for the first time he was sitting in the group formed by Radhika (explained in section 4.1.3). He gave a smile when he was introduced to me

by his teacher, but didn't raise his chin. He was too shy to look at me. His shyness increased whenever his name was called out. This behaviour was predominant in him in the initial phase of developing a relationship. Throughout the study, I deliberately called Naveen numerous times so as to develop interaction with him. He was joined for his play in the class several times in this stage. Form board was one of his favourite activities in the class. He was very quick compared to his classmates in doing form boards. While playing, he waited for his name to be called out and responded with the same behaviour of smiling and bending the head. However, may be due to the frequent interactions, he started showing positive signals in the interactions. We talked about different things, about his family, friends, and the different colours. I talked to him verbally and he responded behaviourally. When I asked the name of his mother, he articulated clearly. However, he couldn't articulate the names of his other family members.

As the interactions increased our playing together was more fun, especially in the second phase. At whatever time, he saw me he brought some or the other kind of play material to join him, but never looked at my eyes. His style of asking me to join him for playing was by sitting next to me and placing the materials in such a way that both of us could play. Every time he waited for his name to be called out. The same response of smiling and bending the head occurred over and over. However, in between he raised his face as if he was doing some exercise for the neck. One day as a surprise he came in search of me outside my room. The walls of the classes in the school are half glassed and therefore we both saw each other right away. His response was smiling and running back to his class. When I followed him, he was ready with the form boards. Another day, he brought his mother to me from downstairs and

intensely observed our conversation. One of the significant events in this stage was he dancing in the hall in my presence, but withdrew while the teachers or carers came.

The relationship between Naveen and myself went smooth. We were eager to respond to the needs of each other. A remarkable event occurred in the initial stages of the third phase was his development of eye contact with me. Although he could not sustain it longer, he looked into the eyes quite often in the last part of the study. Initially smiling by lifting the face, this was followed by looking into the eyes and finally keeping eye contact, though he could not sustain it for a long period. This was definitely a gradual process in him. The teachers were surprised to see him looking at my face. However, he behaved as the same with everyone else. On the annual day, after the celebration we went apart for vacation.

### Discussion

Naveen's shyness had a specific purpose for him irrespective of its origin. He was communicating his desires and difficulties in the relationships through his shyness. On one side he was expressing his unhappiness in the relationships and on the other side, through this he was expressing his desire to involve in social relationships. However, the significant people failed to understand his communications and interpreted his shyness as something due to poor communication and social skills. Therefore, he was neglected in most of the social activities in the school. By virtue of his self-help skills he was independent at home and school to do his personal care. This also turned a reason for the disregard of others, especially service providers to him. This neglect in the school seemed to have resulted in a severe threat to his emotional dependence.

The uncertainty in the reports of the parents about the origin of Naveen's shyness reflected that this was not a characteristic of his adolescent age. This would

be considered as the outcome of a gradual process, otherwise the significant people would have noted the origin of this. Therefore it is reasonable to think that Naveen's shyness originated as a result of his poor interpersonal communication skills (Kelly, 1982). Presumably, the anxiety about communication abstained him from interacting with others (Kelly, 1982). It was likely that his poor speech development was a reason for him not to communicate. May be later on this resulted in shyness in the interactions. Apart from his communication difficulties there were other possible factors, which kept him away from the social world of significant people in the school. Because he was proficient in self-help skills, he was not given any skill training in the school and his quiet behaviour never brought the need for any behaviour modification programmes either. Therefore, his chances of interacting with the service providers were limited. In this situation, he seemed to have developed his shyness.

Naveen's shyness was selective to people. He was shy to almost all the significant elders in the school. Naveen was very shy whenever he realized that someone was observing him. In the absence of significant elders he was never shy or withdrew from his activities. An example of this would be his withdrawal from the dance in the hall, if any of the teachers came to the hall. From this, it is reasonable to assume that his shyness had two functions. On one side, through this he expressed his difficulties in the interactions with people, and on the other side, this was his desire to involve in social relationships. May be his emotional dependence was threatened due to his poor communication skills and the resultant shyness.

Naveen possibly found 'shyness' as the best means to develop relationship with the outside world. Whenever, he understood the presence of someone, he brought a smile on his face and withdrew himself from the activity. In this way, infact

he was drawing the attention of the others more to him. Just by seeing his withdrawal, everyone called him again, to participate in the activity. Over time he learned that this is the only activity, through which he could catch the attention of the people around him. Calling out his name acted as reinforcement for him to repeat the activity. This is well observed from his contingent behaviour of raising his head on the departure of others. In due course he learned that this is going to be effective as long as someone provides attention to him. This can also be explained by looking at his subsequent search for the person as soon as he leaves or diverts his attention. Once the person has taken his attention from him, he learned that the chances of any interaction don't exist, so also the chances of building up a relationship. His behaviour of waiting till the last moment, i.e., remaining in the same style until the person diverts his attention, was a clear indication of his desire to engage in a social relationship.

The gradual development of his relationship with me also proves that he used 'shyness' as a mechanism to develop relationship. In the initial stage of interaction, he never looked into my eyes whenever we interacted. His strangeness of the situation and the stranger without any relationship were major barriers at this stage. However, his readiness to interact with me reduced the distance between us. By virtue of his comprehending ability, talking to him was easy though he did not reply verbally. His non-verbal communications were powerful in continuing our interaction. This is against a notion about people with mental retardation that they cannot engage in useful activity. His changes in behaviour in the initial phase were a reflection of the trust he was developing on me.

The intensity of the relationship between Naveen and myself has increased in the second phase of the study. The attachment relationship with me seemed to have resulted in reducing his shyness with me. This is clearly observed from his dancing

while in my presence, but he refused to dance or withdrew from the situation if the teachers or carers came in the scene. Thus it is a clear indication that his shyness was his way of building up relationship. This was also evidenced from his diminished shyness in the dyadic relationship with me. Once the relationship was built up his shyness came down and he was free to perform in my presence. His coming to my room in search of me was another reflection of his relationship with me and the reduction of shyness in him. No eye contact in his case was definitely a barrier in developing relationship. But the chances of developing relationship in spite of his poor eye contact increased due to his smiling. Smiling is the basic step in developing a relationship. In the third stage, the attachment relationship he could develop with me resulted in emerging eye contact in him. Infact the emotional security he obtained in the relationship resulted in developing a functional skill. Although nothing was done to develop the functional skill, the emotional dependence he achieved in the relationship helped him even with a functional skill.

The present case raises the importance of simple behaviours or sometimes known as unusual behaviours or deficit behaviours in building up relationships in children with mental retardation. Through the case of Naveen, I argue that shyness can also be behaviour for developing social relationships. Although a shy person has negative attitude towards others, this becomes positive when relationships are formed. Being shy, they get satisfaction by being noticed by the people around. Another implication of this case is that, non-verbal communication is very effective in developing relationships with mental retardation. Language impairment or speech impairment can never be a barrier in developing relationship between two individuals. Here, I argue that even though people with mental retardation have poor communication skills, the need for friendships and close relationships are strong in

them and they are capable of developing close relationships. The only thing required is we need to understand their communications.

#### **4.1.7 Relationship through other skills: Bhavya**

People with special talents or skills become popular in the society very soon. The superiority in the skills makes people popular in the social world. Having a relationship with such an individual is many a times the dreams of many of us. This 'acquired recognition' is the primary factor for developing new relationships and maintaining their existing ones. The recognition and the internal working models of attachment security formed in the earlier relationship (Bowlby, 1973) at home are capable of providing confidence to approach any social contexts. Sometimes this popularity could also be the reason for taking things for granted from the people around.

Bhavya was an eight-year-old girl with moderate mental retardation. She was a talented dancer in the school. The recognition from the skills and the attachment security at home helped her to over power among her disabled peers in the school. She took the lead role in all her social relationships. Although she was initiating in the dyadic relationship, she was more comfortable when it developed to wider network. Through this case, I argue that attachment security and self-confidence are two important conditions for developing social relationships in children with mental retardation.

#### Case report

Bhavya was a girl with moderate mental retardation (Down syndrome) in the diagnostic records of the school. The prenatal records accounted that her mother was 36 years old when she conceived Bhavya. Apart from two ordinary fevers, the mother was healthy throughout the pregnancy period. The obstetric records reported that

Bhavya had a caesarean birth at the eighth month with birth cry. From the developmental records it was clear that all her milestones were delayed. She sat at nine months, walked at one year and seven months and spoke her first words at two years old. Bhavya started her education at five in a mainstream English medium nursery. A year later she was moved to the research school. She is in the early intervention class-2 (detailed in chapter 3, page 71). Although she is the second oldest student of her class, due to her small size she looked the youngest. Her general behaviour reflected that of a child in the phallic stage.

Bhavya comes from a family of well-educated and employed parents. The family consists of her parents and one elder brother (the family tree is given in Appendix-3). Her father was a medical representative and mother was a Lecturer in Commerce. Bhavya's relationship in the family was revealed the interviews and casual conversations with her father and the class teacher. According to the father Bhavya has very good attachment with all the family members. His father came to the school daily to pick her up in the evenings. When asked he said to me that because his job was flexible he could come to the school at any time, but it was not possible with the mother due to her job. She was very active at home. Since she was good in dancing, the family members provided extra care for her to practise it at home.

At school also Bhavya was very active. She participated in all the classroom activities and moved around freely. She enjoyed the company of older students of other classes than her own classmates and she liked to be cuddled by them. She sat on their lap quite often at leisure time. Her lunchtime friends in the beginning of the study were few of her classmates, but later she joined the triad of Vinaya-Seema-Radhika. Bhavya has good verbal and non-verbal communication skills, which makes her easy to move around. Sometimes she found to be resting her chin on her wrists

even while she sits on someone's lap. However, a remarkable skill possessed by Bhavya was her dancing skills.

A talented 'dancer' was Bhavya in the school. She was an unavoidable student for the cultural and social activities of the school. Whenever, there was some program in the school, Bhavya's dance was a fixed event. She was good in singing too. As soon as she finishes her lunch, she comes to the common room to dance and make others dance. By the time everyone comes to the hall, she gets tired and would have landed onto the lap of someone. However, she would come to dance at least twice for a one-hour lunch break. Her general pattern was dance for sometime, take rest, and again dance. Sometimes, someone would request her to dance again. As long as the music was put, Bhavya used her fingers rhythmically even though she takes rest. She had a special taste for music as well. Because of her ability to dance, she was popular in the school. One of the remarkable things observed in her was her standing in front of the mirror (on a cupboard) in the corridor. She tilts her head and touches her hair while looking at the mirror.

#### Relationship with the researcher

My first encounter with Bhavya was an extraordinary one. She called me by making gestures with her hand and asked, "Why did you come?" Through her smile and question she made the situation very comfortable. Thus the establishment of rapport was very easy with Bhavya. Her behaviour was coupled with happiness and curiosity, aroused by the presence of a stranger. Rather than me initiating the situation, Bhavya initiated the interactions. During the initial phase of the study, much of the interactions between us were in her classroom and lunch break. She was always joined for her classroom activities like cushion passing, picture seeing, design matching and group singing. She took the lead roles in most of the activities. During

this period, a grand Independence Day celebration was conducted in the school and the preparations for the same went for two fortnights. She was the leader of the dance programme and was given the responsibility to gather the group members. She was more active whenever she saw viewers to see her dance. I was present for the dance several times, and she was very happy to receive encouragements for her dance. Watching her dance and talking about it was infact a moment of happiness for her. Although she initiated in our first meeting, the major reason for the development of a close relationship between us was to respond to her needs to be cuddled. From the initial phase of the study, she sat on my lap whenever she wanted. She was never asked to get up or do something else. This welcoming approach from me was also a reason for the smooth interactions between us.

A remarkable event in the second phase of the study was that Bhavya pulled me several times to dance with her in the hall. Her usual style was to sit on my lap for sometime and then asked me to come and dance with her. In this phase, for the Christmas celebrations, she asked me to come for the celebrations to see her dance. She was pleased to see me watching her dance and taking pictures. When I got the pictures later, she called everyone and showed them her pictures. She behaved as if she is someone really great. When her father came to pick her up in the following day, she asked me to give the pictures to her so that she could show it to her father. She was absolutely enthusiastic to see her pictures. During the last part of the study, Bhavya came and joined the lunchtime triad of Seema-Vinaya-Radhika. She did not ask me to join her but she came and sat with the group where I spend time. Although I sat with her at lunchtime, she herself took an initiation to come and sit with this group. In Bhavya's case the dyadic relationship did not bring any remarkable

behavioural change, apart from identifying her capabilities in developing relationships.

### Discussion

“The smile is the first form of ‘positive’ communication and it means ‘I feel good’”(Ziv, 1984, p. 27). This was the first impression anyone got from Bhavya. She invited people around her and gave them the very feeling that she is quite comfortable in herself and others. The major reason for this could be the recognition she received from her society. Unlike other children with mental retardation, she was not neglected anywhere. Nobody complained about her not writing or reading, but everyone praised her for her dance. Thus she herself felt that she is an important person. Here she didn’t have time to think that she was someone with some special needs and get sad. Her special taste for cultural activities, especially dance and music were an added advantage for her or more of a compensating type.

Bhavya never had any compulsion on her to do some activities in the school. This was basically due to her being in the early intervention class. By virtue of her sufficient self-help skills she was never under any systematic skill-training programme. As a result of all these she was comparatively free in her school life, and entirely different from other participants. At home, she had good relationship with the parents and the brother. Her clinging and kissing to the father gave a good feeling around the people. Thus her relationship in the school and at home was very comfortable. Due to her childlike size and behaviour, she could arouse the feeling of ‘to be cared’ among elders. Besides all these, the recognition she received through her dancing skill stood as a major step in building up relationships. Her skills brought her popularity in the school, and at home she was encouraged to do dance.

As happens generally, Bhavya's recognition among the students helped her to have new relationships. Because she was good in dancing many of the students were happy to dance with her. As the school encouraged dancing<sup>7</sup> after lunch, Bhavya was lucky to get opportunity to be performed in front of everyone. Therefore, building up recognition in the school was quite easy for her. As in any normal individual, to talk to and dance with Bhavya was considered a good thing by many of the students, especially girls. Thus, here Bhavya's recognition helped her to develop new relationships. Those who were already in friendship with Bhavya maintained the relationship. However, the interesting element in this relationship was Bhavya wanted to be cared and cuddled always. She never had any fear to sit on the lap of people whom she felt wanted to develop a relationship with her. Thus it could be seen that she was in fact making use of her skills through a complex process to develop relationships and thereby satisfying her needs. All these were possible due to her social security.

Bhavya was socially secured when I met her. Her first sign of seeing me is a clear indication of the security she had in front of the strangers. Her authority to call me and ask me on the situation was extra ordinary. Since she was comfortable with the others, she could relate very well to a stranger. In her case she was the one who took the first steps in our interactions, which was something different from the other children. In fact she invited me to her life and showed me how happy and comfortable she can be with a stranger. In our relationship, she longed for recognition from me too. This is well observed from her request to watch her dance. Her happiness of kissing while she was praised was a clear example of the desire of children with MR

---

<sup>7</sup> One of the major reasons for encouraging dancing in special schools is to develop the motor skills of students in an unstructured way.

to have recognition and a place in the society. In other words, it reflects their desire to play an important role in the society.

Bhavya was a child who enjoyed being cuddled by the elders. Her way of sitting on the lap of others was a clear expression of the safety and security she experienced in the presence of an elder. This kind of security was very crucial in her overall relationships. Majority of the children with MR lack this aspect. Bhavya enjoyed my company, which was evident in her frequent visits to my room and the tendency to sit on my lap. One important point to be noted here was that Bhavya never tried to sit on the lap of any of the teachers. She kept a distance from them in this matter, though she was comfortable with them. This could be a well example of her ability to differentiate relationships. In the case of Bhavya, though relationship occurred gradually, it could not go onto a further level.

Although she was very comfortable and interacting in our dyadic relationship, she never tried to limit it in a dyadic level. By virtue of her personality and social situations, she was looking for wider relationships. A clear example of this could be observed in her joining the lunchtime triadic group of Seema-Vinaya-Radhika. Rather than asking me to come and sit with her, she joined the group where I spend more time. This indicates her socialization skills and her desire to develop more social relationships.

Bhavya's case indicates the ability of children with mental retardation to develop social relationships on the first instance. The second implication of this case study is the way the internal working models of earlier attachment result in developing new relationships.

#### **4.1.8 Empathy in the relationship of an adolescent boy with mental retardation: Rajeev**

Empathy is the ability to respond to the distress of another person. Researchers have observed that people with mental retardation lack empathy and intimacy in the interactions (Zetlin & Murtaugh, 1988). The explanation for this lack of empathy is the relatively superficial friendships of people with mental retardation (Clegg & Standen, 1991). However, it is argued that people with mental retardation do express empathy in close relationships.

Rajeev was a 14-year-old boy with moderate mental retardation. He was comparatively sociable and happy at home and in school. He was an inviting boy in all the relationships. Rajeev reciprocated well in the relationships. When he developed an attachment relationship, he could empathize in the relationships. Through this case study, I argue that people with mental retardation express empathy and intimacy in interactions.

##### Case report

Rajeev is a 14-year-old boy with moderate mental retardation according to the diagnostic report of the school. The obstetric report said that he was born out of a full term normal delivery. However, the developmental records accounted that his milestones were delayed. He started walking at the age of three and a half years old. The medical reports said that he suffered from epileptic attacks and has been under medication from seven months of age. The educational history revealed that he started his education at eight in a special school and was transferred to the research school at the age of ten. On admission he was in the pre-vocational class until he expressed an interest to sit in the vocational unit a year ago. He has all the self-help skills for personal care. Rajeev comes from a low social economic status family of Hindu origin. His family comprised of his parents, elder sister, younger brother and a

younger sister (the family tree is given in Appendix-3). Rajeev's parents are daily wagers. His elder sister stopped her education in 8<sup>th</sup> class, while his youngsters are studying. There is no history of mental retardation in the family and the cause is unknown.

Rajeev's relationships with the family members identified through the interviews and casual conversations with his mother and his previous class teacher. According to his mother, Rajeev is very friendly and active at home. However, she reported that Rajeev fought with his youngsters, especially with his brother. The teacher also reported the same. Rajeev liked his elder sister, reported by the mother. The mother also reported that Rajeev likes her more than the father. She also said that she never allowed Rajeev to do any household work at home, even though he expressed an interest to do the same. Both mother and the teacher said that Rajeev maintained a good relationship with even the relatives and friends who came home.

At school Rajeev was a sociable and happy boy. He enjoyed socializing and making friends. The teacher said that Rajeev has more friends in the pre-vocational class than in the vocational unit. However she did not know the reasons for him choosing the vocational class. Rajeev's behaviour supported the teacher's account that Rajeev has more friends in the pre-vocational unit. Rajeev visited the pre-vocational class quite often to meet his friends. At lunchtime also, he sat with his friends of the pre-vocational unit on most of the days. However, he had good friendships with even his classmates in the vocational unit. Rajeev liked the teachers of both pre-vocational and vocational classes. Sometimes he said that he came to the pre-vocational class to meet the teacher and his friends. Rajeev's friendships were not within the two classes. He was very active to talk to the people around. An interesting observation about Rajeev's behaviour was his passion for colours. Rajeev initiated relationships by

referring to some colours. The most important mechanism used by him was Naming and identifying the colours was the major mechanism for Rajeev to develop social relationships. He generally started his conversations by pointing out the colours. He interacted well with people who could play with him by referring colours.

### Relationship with the researcher

Rajeev's interest in playing with colours was the major element in our interactions too. We met in the pre-vocational class during cover making for the first time. Although he was concentrating on his activity, he responded well to the questions of me. We did some paper folding and gluing together. The next day I greeted him in the morning at the corridor. He was quick in responding. In a week's time, we became friends and he said to his friends that I was his friend. We both visited each other's class. Whenever I visited him, he welcomed me to his class with increased enthusiasm. Some days he straightaway pointed out the colours of my dress or his dress. His general question was "Batte colour yavuthu?" (Which colour dress?). Thus in the initial phase of the study, through a number of plays involving variety of colours we developed a strong relationship between each other. Apart from playing with colours, we played cricket and other games in the corridor, travelled together in the school bus, sat together for lunch, danced together in the hall and so on. The second phase also moved ahead with such mutual exchanges. However, we had more verbal exchanges occurred in the second phase. As an example, one day he asked me about my house and enquired if I need to catch a bus to reach home.

A remarkable event occurred in the last part of the study was Rajeev expressing empathy towards me in my distress. One day during lunch, Rajeev asked me, 'Leemakka ootta bekka?' (Do you want lunch?). I said, 'Bekku' (yes, I do).

Suddenly, he took a handful of rice from his plate and asked me to open my mouth. He fed me like a responsible individual caring a helpless person. This incident expressed his real concern towards me. Both teachers and carers reported that this was for the first time he was doing such an activity. They added that he gave lunch because he liked me. Seeing this, the class teacher of the pre-vocational unit said to me that Rajeev liked me and that's why he has been coming to the pre-vocational unit frequently for the past few months. According to her, rather than meeting his friends, he came to meet me. For Rajeev, this was not a single detached event. Rajeev then asked his friends (Navaz, Hari, and Jeevan (NPS)) also to provide me lunch. The reason he told them that I didn't have lunch. Towards the last part of the study, the relationship between us was really strong. Although he could establish a strong dyadic relationship with me, he was not ready to limit himself in that. He even made use of the dyadic relationship to develop more friendships.

### Discussion

The behaviour of Rajeev throughout the study period expressed his inclination and happiness in the new dyadic relationship. The intensity of this was expressed in the last part of the study by a remarkable incident of empathy in the interaction. This was against the general notion about people with mental retardation that they are unable to empathise (Zetlin & Murtaugh, 1988) due to their inability to engage in strong friendships (Clegg & Standen, 1991). This incident and the subsequent incidences of empathy came out as a result of the attachment he developed in the new relationship.

Rajeev was a sociable boy at home and in school. By virtue of his relatively good relationship at home, he was considered as an emotionally secure boy. At school, since he was apparently fine with his skills and abilities, he was not given any

intensive services. More over, his personality style was to develop more social relationships. Therefore, he was comparatively happy in his school life. However, his behaviour reflected that he longed for more relationships. This was evidenced from his coming to the pre-vocational class even after his transfer to the vocational unit. His passion towards colours could be attributed as the major reason for his choice for the vocational class. This was observed through his behaviours. On few occasions, he dragged me to his class to see the paintings, and arts done by them. More than the beauty, he referred the colour of those objects. It was observed that in the vocational class, the major activities were painting and craft works. Of these, prevocational class did not have painting. Thus, it could be observed that his liking towards the colours made him to choose the vocational class. The most significant observation was that even though, he went for colours but he never dropped his earlier friendship. Therefore, it should be argued that Rajeev was very good in developing relationships.

Although Rajeev fought with his younger siblings, he behaved well at home. From the mother's report it was clear that Rajeev was emotionally secure at home. Maybe the positive schema of past relationship helped him to view each new relationship with a positive attitude. This was reflected in his relationship with me as well. Rajeev initiated relationships in majority of the situations. The most important mechanism used by him was 'naming and identifying the colours'. He generally started his conversations by pointing out the colours. He used colours to develop friendships. He interacted well with people who could play with him by referring colours. Colour was the major element in our interactions too. Rajeev named the colours of his dress, my dress, and all the possible things. He considered it as a wonderful play and derived satisfaction from it. Whenever we played, he enjoyed playing with various colours. Rajeev was friendly from the beginning. Although there

was not much emotional element in the initial phases, the frequent interactions grounded on 'colour' helped us to become closer. Once he could establish relationship with me, he was seeking proximity with me. His frequency in coming to the pre-vocational class was a clear indication of his interest in the new relationship. Apart from my observation, the teacher also reported that he frequently came to the class while I was present.

Rajeev's closeness in the dyadic relationship was well evidenced in his act to provide lunch to me in the last part of the study. The gradual development of the dyadic relationship was capable enough to bring out the innermost content of empathy in Rajeev. This was evidenced by providing lunch to me. This was a clear expression of his concern towards me. From the acquaintances and interactions, he knew that I never brought lunch to the school. This showed Rajeev's ability to empathise with me in my distress. Through this he expressed his concern and love towards me. This was against the typical notion of people with mental retardation that they are unable to empathise. The account of teachers and carers who saw the activity support the fact that Rajeev or any student in the school never done something with such empathy.

A remarkable observation in this event was that Rajeev did not consider feeding me as a single activity. He considered this as a joint activity. Thus, by making others also join in the activity, he expressed the most powerful skill of socialization and the ability to maintain social relationships. Through these incidents he was expressing an important emotion and an important skill underlying even in children with mental retardation. Thus, the life pattern of Rajeev was more of developing friendships and expressing his concern towards the friends with whom he was attached.

#### **4.1.9 Stigmatisation in people with mental retardation leads to close relationships with non-handicapped persons: Navaz**

People with mental retardation face problems in coping with the stigma associated with their condition (Richardson & Ritchie, 1989). Many people with mental retardation make positive effort to overcome the stigma (Jahoda, et al., 1988). Therefore, people with mental retardation engage in close relationships with non-handicapped individuals. This seems to enhance their social status and thereby reduce the stigma attached to their condition.

Navaz was a 13-year-old boy with mild mental retardation. He was moved from mainstream school to special education at the age of 11. The educational reports said that he was almost a submissive boy in the mainstream school, whereas he became more active on his transfer to special school. While he dominated among the peers, he developed friendships with most of the non-disabled persons in the school. Although he was resistant in the initial stages of the new dyadic relationship, he developed a close relationship without much delay. Through this case, I argue that sometimes the desire for people with mental retardation to engage in relationships with non-handicapped individuals is to overcome the stigma.

##### Case report

Navaz is a 13-year-old boy with mild mental retardation according to the diagnostic records of the school. Navaz had a full term normal birth, but the birth cry was absent in him. The developmental records reported that his milestones were delayed. He started walking at the age of two and talking at two and a half years old. Navaz started his education in a mainstream English medium school at the age of five years and continued his education in the same school up to 4<sup>th</sup> class at 11 years. Then he was moved to the research school at the same age. He started his education in

Sadhana School at the age of 11 years. Though he sat in the prevocational class, he was undergoing academic learning. The syllabus followed for him is that of the mainstream syllabus of 6th standard. Navaz' classmates are Faizal, Naveen, Hari (NPS), Lesley (NPS) and Radhika. His academic abilities include reading, writing, maths, and computer skills. Navaz could speak Kannada, Urdu, Tulu<sup>8</sup>, and English to a good level. Unlike the other children in the study, Navaz expressed few of the age appropriate characteristics, especially not talking to adolescent girls.

Navaz comes from a middle class family of traditional Muslim parents. His family comprised his father, mother, elder brother and younger brother. He is the second son of three children of his parents. Navaz' father has been working in Gulf for the past seventeen years and visited the family once a year for 45 days. His mother is a housewife. When the children were younger, his grand mother stayed with them to help his mother. Navaz' relationships with the family members were recorded based on the interviews and casual conversations with his mother and class teacher. According to his mother, Navaz likes his father more than the mother. She also said that Navaz always talks about his father. My observation also supported the same factor. His mother and class teacher reported that Navaz likes both his elder and younger brother. Navaz' mother was very protective according to the teacher. The teacher's conclusion about it was that since Navaz' father was away in Dubai his mother looks after everything. My observation revealed that Navaz' mother was very protective about him. She never allowed him to interact with others outside, or eat something from outside.

---

<sup>8</sup> Tulu is the mother tongue of ancient Mangalore. However, Kannada, the state language of Karnataka, is the official language of this region. Hence, the local people consider both languages equally important and they are good in the usage of both.

At school, Navaz was observed to be dominating the situations. In the class, he never participated in any of the vocational activities. One of the major reasons for this was that since he was given special academic training, he was most of the time asked to concentrate on it. Although he did not participate, he observed and enjoyed giving orders in the class. The teacher's report and my observations revealed to me that Navaz had some good friendships in the school with his own age peers. However, the peculiarities of these friendships were that Navaz controlled and led the situation. Most of the time, it was observed that his friends followed him. However, an astonishing behaviour in Navaz was that of his friendships with the non-disabled elders. He had very good communications and friendships with the teachers, carers and any trainees who came to the school. Quite a lot of trainees did not know to speak Kannada and most of the teachers and carers didn't know to speak English. The problem was that most of them found communication as a big problem. In such situations, Navaz was of much help to many as he could translate the basic things in different languages.

#### Relationship with the researcher

When I met Navaz for the first time, he was giving some orders to some of his classmates. While his classmates were sitting on the floor he was standing and walking outside quite often. He neglected me in the first meeting. He did not even look at me directly. However, both of us realized that we observed each other indirectly. In few days we became friends, although the major part of it was through the mutual gaze of each other. However, later on our verbal communications found to be more effective in our interactions. This was the key factor in developing our relationship to a different level. We both talked to each other about our family, especially about our parents and siblings, his previous school, and my college. Apart

from this one of the major contents of our conversation was his aspiration to join his father in Dubai. Navaz talked about his father more than anyone. He talked affectionately about his brothers, but talked very less about his mother. Our relationship in the initial phase had become so strong that he invited me to his house. I reached at the junction and as per his direction I waited for him there. When he was late to arrive, I rang up to his house and asked for him. His mother abruptly said to me, "I don't give phone calls to Navaz". And she also told me "I don't like if someone comes home to meet Navaz". However, Navaz' mother and I could develop a good relationship in the second phase of the study. This has infact helped the relationship between Navaz and me.

An important observation made during the second phase of the study was that how Navaz reacted to situations where I talked to other children. As an example, one day I spent some time with Faizal and later with Radhika. Navaz was observing me since I reached school and reacted to me harshly when I went to him. He asked me to go back home. He also told me that he did not like me and he liked only his teacher. When I sat next to him, he was even angrier. He said to me that he does not like me and kept on asking me to go back. This was a situation, where I too responded quickly and told him that I would be going back. But, when he realized that I was serious, he calmed down. Finally he asked me to come for lunch with him. Although Navaz was very keen on the relationship with me, he was observed to be keen even on the relationship with almost all the significant non-disabled adults in the school. In the last part of the study, Navaz invited me again to his house for his birthday. Although this time, the mother agreed, I couldn't make it. In the last part of the study, one day Navaz took my number and gave the number of his brother's new mobile number. Through this he expressed his desire to have a link between his brother and me. More

or less similar events could be observed in the friendship of some of Navaz' friends. Some of the friends of Navaz came and talked to me through Navaz. Some of them have even told me that Navaz said to them that he was the best friend of mine.

### Discussion

The stigmatisation in Navaz reflected through his change in behaviour on his admission to the special school. Navaz was a submissive and silent boy in the mainstream school, whereas he was dominating in the special school. May be in the mainstream school, owing to his condition, he seemed to have lacked the opportunity to initiate something or join in teamwork (Szivos, 1992). But when he came to the special school, by virtue of his skills (slightly higher than his disabled counterparts) he became superior to his peers. The sudden change in his behaviour as a result of the transfer from the mainstream to the special school reflects his inner conflicts in relating with his aspirations and the new world of relationships. Presumably, he observed the situations, especially the children with multiple disabilities, in the new school as a threatening one to his dreams and therefore he seemed to have adopted measures to overcome the new label put on him.

Navaz' dreams in life can be only be seen through his relationships with his father and brothers. Although his father was away in Dubai, his behaviours and his intimacy while talking about him reflected his attachments with the father. Rather than an attachment with a sensitive level physical interaction, it was based more on his imaginations. Possibly, the cultural and traditional beliefs of providing importance to the male members in the Muslim family are added reasons for this aspiration in Navaz. His mother's explanation about his relationships that he liked his father and brothers more than her is an indication of this. It seemed his siblings and he was brought up with the aspiration to join the father after their studies. The interviews

with the mother revealed that each one was waiting for their turn to join him. Navaz was also not exempted from this according to his perspective. At this stage, the sudden change from the mainstream to special school seemed to have resulted inner conflicts in him about his capability and identity. Therefore, it was necessary for him to adopt some measures to overcome the stigma the transfer of schools brought with.

The stigmatisation experienced by Navaz could be observed through two aspects of his behaviour. On the one hand, Navaz tried to develop relationships with all the non-disabled elders in the school, but on the other hand, he exhibited superiority over his disabled counterparts. This superiority feeling of Navaz was reflected in his behaviour throughout. Apart from his own subjective experience of the difference from the disabled peer group, there were other factors in the special school made Navaz dominant among his peer group. The major one was his command over language. Since he was in a mainstream English medium school he could speak English and which was considered as an outstanding factor in the special school. Quite often, he played the role of a translator to many in the school. Although none in the school expressively reinforced him for his proficiency in handling different languages, this brought him an unknown recognition among his peers and others in the school. For example, he was selected as the emcee for the Independence Day program. This recognition most of the time put him in the leading position among his friends. In a sense, the transfer from mainstream to special education helped him to boost up his self-concept a lot. He exhibited this ego-boost up in all his field of interactions in the special school. This ego-boost up and the resultant superiority over the disabled peers reflected his unwillingness to accept his status as one with a disability.

A second facet of his stigmatisation could be explained from his desire to have friendships with non-disabled elders. Navaz was very keen on developing friendships with teachers, carers, other professionals, trainees and all the non-disabled others in the school. He seemed to have considered himself different from his disabled counterparts. Therefore, presumably he looked for developing relationships with the non-disabled. By making friendship with them, he was in fact trying to overcome the negative effect of stigmatisation he was experiencing. More specifically, bonding with the non-disabled was a reflection of his denial of the new label put on him. Unlike any other children, his behaviour reflected that he considered bonding with any of these significant people important. Some or the other way he tried to catch the attention of any of these non-disabled person and reacted if he was not given attention up to his expectations.

This attention seeking behaviour was reflected in his interactions with me too. This was evident from our first meeting itself. His intense desire to bond with a new non-disabled person was evident through his deliberate avoidance of looking at me directly in the beginning of our relationship. Although he was resisting, it was not of the usual resistance experienced with the other children. The resistance he showed was not a spontaneous internal one. It seemed by not looking directly, but looking indirectly, by walking away from the group but seated in such a position that he could observe my activities, he was trying to draw my attention towards him. When he was provided with attention, it was easy to build up a relationship between us. Although he was very close in the relationship, our dyadic relationship was slightly different from all the other relationships. It was likely that rather than enjoying the friendship itself, Navaz seemed to have concentrated more on the recognition it could bring to him among his peers.

Navaz' desire to not to accept his condition was reflected in his invitation to me to his house. He invited me to his house just like any normal developing individual. However, he was not allowed to invite someone to his house and his mother denied me the entrance to home. From her explanation, it was observed that the family members saw Navaz as slightly different and therefore he had extra protection. However, Navaz' behaviour indicated that he hardly ever thought of this aspect, but considered himself just like his brothers. Through this he was trying to equate himself with that of other family members. More specifically, he seemed to have denied the label put on him. His desire to over come the stigmatisation was reflected clearly in the last part of the study too. By giving his brother's phone number, he tried to develop a link among three of us. Since Navaz considered his brother an ideal one, he wanted to relate with him always. In our relationship, he found the necessity to have a link among three of us, so that he would be free from the stigmatisation of being a different.

The implication of this case study is that children with mild mental retardation should be provided with the opportunity to mingle with their non-disabled peer group.

#### **4.1.10 Attachment relationships facilitate deficit services: Vinaya**

Researchers have suggested that the deficit based services fail to look at the emotional well being of people with mental retardation (Amado, 1993; Sheehy & Nind, 2005). These services are so therapist oriented that the freedom of the child is restricted in most of the situations. A heavy emphasis on the physical skill development is even capable of producing negative emotional responses in children with mental retardation.

Vinaya was an eight-year-old girl with Down syndrome. She was affected with numerous health related problems. Therefore, she was the victim of all the

services in the school. Vinaya developed a negative attitude towards the deficit focussed services and the service providers. The heavy emphasis on her deficits, health and academic skills prevented her from developing close relationships outside family. However, she could develop an attachment relationship when her emotional needs were given importance. She was capable enough to make use of the new attachment relationship to facilitate her condition in other deficit services. Through the case of Vinaya, I argue that an attachment relationship in the school may benefit the other services of children with mental retardation.

### Case report

Vinaya is an eight-year-old girl with moderate mental retardation (Down syndrome) in the diagnostic reports of the school. Although the delivery was normal, she was born without a birth cry. Apart from an ordinary fever for the mother at the fifth month, the prenatal period of Vinaya was smooth and normal. She did not have any postnatal complications or major illness until she had a severe fever at the age of six months. However, the medical records did not show any implication of this fever on her condition. There is no history of mental retardation in the family. The developmental records show that she had a global developmental delay. She sat at one year and stood without support at one and a half years old. However, Vinaya has problems with her speech, muscle tone, and vision. Besides she has other health problems consists of chronic cold and frequent vomiting. Vinaya started her education in the research school at four years of age. She was in the early childhood education – two. A year later she was admitted to the academic session with the prospectus that she would be able to read and write. This is her third year in the academic class and her academic skills include basic writing, reading and maths. Vinaya undergoes speech therapy, physiotherapy and other services in the services in the school.

Vinaya is the only one child of her parents in a Hindu family. Both parents are bank employees. Vinaya's relationships in the family were identified mainly through interviews and casual conversations with her father and class teacher. During the interview her father reported that she was born to them in the third year of their marriage and was much expected. However, immediately upon Vinaya's birth, the parents were informed of her condition. From the father's report, it was observed that both parents were shocked at the diagnosis. Her father and the teacher reported that Vinaya's mother had difficulty to accept the unusual condition of Vinaya in the early stages. However, she could synchronise with the reality without much delay. According to the father, Vinaya has good relationship with both her father and mother. Since both parents were working, Vinaya had a nanny at home to look after her reported by the father. She had good relationship with her nanny as well. Owing to her poor health conditions she was excessively protected at home.

Because Vinaya has numerous health related issues and skill deficits, she was the victim of all the services (this will be discussed more in section 4.3.2.1) at school. Whether it was physiotherapy, or speech therapy it was given to her without any failure. Vinaya on various occasions responded negatively to these situations. One day she said, "I don't like her... She creates pain in me... I don't want to play with her... She comes to stretch my legs". In this incident she was referring to the physiotherapist who made her to do stretching exercises. The behavioural expression of her dislike was frequent; sometimes she hid herself under the tables in the class so as not to encounter the physiotherapist. Besides the services in the school, most of the trainees who came to the school also approached Vinaya more than any other participants. Apart from the above-mentioned services, the heavy empathises on academic skills was also a problem for Vinaya. She was very slow in academic

activities. As usual the teacher perceived her slowness in terms of laziness and shouted her most of the time. Occasionally, teacher beat her for not doing the academic work up to her expectations. Vinaya sometimes hid herself under the table exactly the same way she did to hide from the physiotherapist. During the second phase of the study, one day the teacher beat Vinya for looking outside with a long ruler. Instantly, she said to the teacher, "I don't like you. You go out from the class". The precipitating factor in this incident was that the teacher had beaten her for not writing. The response was that of expressing her annoyance towards the approach of the class teacher, making her to write and read, something that she didn't like. Throughout the study, my observations revealed that there was no change in the behaviour of Vinaya towards these programs.

The teacher's report and my observations revealed that Vinaya did not have some specific relationship with teachers. It seemed the heavy emphasis on the academic skills and other deficit services kept Vinaya away from further interactions with the service providers in the school. She had almost similar behaviour with all the others in the school. However, Vinaya was friendly with Seema in her own class. Rather than Vinaya's approach Seema's approach seemed to have developed this relationship. Besides, Vinaya had lunchtime friendships with Seema and Radhika. Radhika and Seema helped Vinaya to wash her hand, to open the lunch box, sometimes to feed her and to wash the lunch box. Vinaya sat in the same place for the leisure activities at lunch break. Immediately after that she was sent home as her father came at 2.00. Therefore, she lacked the opportunity to interact with her peers.

#### Relationship with the researcher

Vinaya was the first participant with whom I interacted for the first time in Sadhana School. Though I sat next to her she paid no attention to me in the first

instance. However, I participated in her writing and mathematics, which helped Vinaya to familiarise with me. The second day also I sat next to her and joined in her writing. The third day when I entered into the class, Vinaya offered a position next to her. This was an important step in the process of developing a relationship between Vinaya and I. She invited me to develop a relationship with her. In the initial phase of relationship, the interactions occurred mainly in the classroom and in groups. During this period, I deliberately sat next to her in the hall and in the lunch hall. Although she smiled and expressed her happiness, she never dominated the situation in the first phase of the study.

In the second phase of the relationship one of the remarkable thing was that she introduced me to her father. Since I asked her many times about her father, one day when he came to pick her up, she told him that “This is Leemakka”. She was very happy to introduce me to her father. Whenever, she was taken to some therapy she started complaining to me and asked me to be with her throughout the therapy. Throughout the sessions she was smiling, looking, and talking to me, while she ignored the therapist. As mentioned earlier, she complained about the physiotherapist in the second phase of the study. She expressed her annoyance towards the class teacher also in front of me during this stage. One day she said to the class teacher, “I like Leemakka. I don’t like you”. A subsequent comment was observed in the third phase too. One day Vinaya said to me, “I like you. You be my teacher”.

Apart from the verbal expression, she kept her things with me from the second phase itself. She was happy to share her snacks or lunch with me. Lunchtime even while the carers feed her, she asked me to come and sit next to her. Towards the last part of the study, Vinaya was very close to me and asked me quite often to accompany her in the class, physiotherapy, lunch hall, and the dance hall. She was

very eager to take me for her physiotherapy more than anywhere. During this phase another noticeable observation that Vinaya kept her things with me, but never gave to anyone else. This was a clear expression of the trust she had developed with me.

### Discussion

Vinaya's life was filled with a number of support services. Everyone approached her with some or the other demands, which was most of the time against her wishes. Although the services could enhance her physical independence, it failed to provide enough emotional security to her. Since the services focus only on the target behaviours, there were very limited opportunities for Vinaya to develop good friendships with the service providers. The services were likely to lose her spontaneous rhythm. More over, she had to function in the framework developed by the significant people of her life. Therefore, Vinaya had a strong negative attitude towards the service providers and the deficit based services. Frustrated with the frequent exposure to these services, she reacted verbally and behaviourally in a number of occasions. Her responses were a clear evidence of her aversion towards the services and the service providers. Unlike other students, Vinaya's opportunity to interact in the school was limited mainly due to these services.

Since she had numerous health related issues, most of the time she was under some or the other services. Because of the heavy emphasis on services, she failed to develop close relationship with the service providers and the peers in the school. Vinaya's frustration towards these services was clearly expressed from her verbal reaction to the physiotherapist that she does not like her. Her dislike towards physiotherapy was evidenced in her tendency to hide under the table too. Presumably, she felt that the service provider may not be able to see her if she could hid herself under the table. This finding is in line with the findings of Schwabenland (1997/1998)

that people with mental retardation may choose not to be in when their support worker shows up. For Vinaya, everyone approached her with some or the other demands. She observed it as against her wishes as it took her freedom away. Therefore, it was possible that she developed a strong negative attitude towards the deficit-based services and the service providers. In this situation, she was denied of the opportunity to develop relationships.

There were other factors also in Vinaya's case to reduce her opportunity to interact with the social world. As usual being in the academic class, the pressure on her academic performance was higher. Therefore, the chances of interacting or playing with classmates were less. Apart from this, the teacher interpreted Vinaya's slowness in academic activities due to laziness. She was shouted frequently and beaten occasionally for the same. Therefore, Vinaya never developed a close relationship with the teacher. Rather she developed a rivalry towards the teacher. Vinaya avoided situations where she felt the teacher would shout her. At the extreme situations, she expressed her annoyance verbally and behaviourally. This was what we observed when Vinaya said to the teacher that she doesn't like her. Her behaviour in the academic classrooms was the reflections of the stress and frustration. Since her parents picked her in the early afternoon, she did not have any other chances to develop friendships through the afternoon games in the school. Therefore, she could not develop any thick friendship in the school. During lunch, Vinaya was very slow in eating. Therefore she was forced to finish her lunch with shouting from the carers. Some days, just to finish their work, the carers would feed her with a spoon, rather than feeding they just put everything into her mouth, and she had to swallow her lunch many times. Since this was not a friendly approach from the carers, Vinaya

appeared to be uncomfortable with it. Practically, this was another situation she possibly developed negative attitudes towards service providers.

The above mentioned relationship experiences possibly have developed a negative schema of relationship in relation to school as far as Vinaya was concerned. This may be the reason for her unfriendly attitude towards people who are in some authority in the school. Though I sat next to her on my first fieldwork day, this would have been the reason she didn't want to interact with me. She would possibly have expected some other constraints on her in the form of a stranger and just ignored being in the situation. However, the interactions made her clear that she wouldn't be taxed in any way, but would enjoy the relationship and she started interacting with me. By offering a chair next to her on the third day she showed me the green signals of friendships. Since I sat next to her on a chair one among them, she possibly could differentiate me from the teacher. Thus the first phase was filled with trying to get to know each other. Apart from the initial resistance, Vinaya's relationship with me was smooth. As the relationship progressed Vinaya expressed her desire to spend time with me. Vinaya's desire to involve in close relationship was observed through her lunchtime friendships too. Though she had self-help eating skills, she enjoyed being pampered by two older friends (Radhika and Seema). This was a clear indication of her desire to be in close relationship with the elders.

The second phase of the relationship was stronger by her behaviour of introducing me to her father. There was no one who asked her to do this, but she felt the need to link her father with me. Through this she was leading the dyadic relationship to a triadic level. This also an indication of her desires to involve in wider relationships. Vinaya's closeness with me could also be observed from her freedom in complaining about the teacher and the physiotherapists. She possibly saw the service

providers as people who impose something or the other on her. Presumably, Vinaya found the presence of me (someone whom she is attached to) would ease the situation. This may be the reason she took me to her physiotherapy sessions. This was a clear expression of her emotional security with me. Similar situations could be observed in the classroom and lunchtime. By asking me to sit next to her in the class and at the lunchtime, she possibly derived satisfaction even with support services.

My observations revealed to me the very fact that the development of an intimate relationship helped Vinaya in other services. This was very clear from her request to me to be with her for physiotherapy. The presence of someone with whom she had good relationship was capable enough to lessen the discomfort she experienced from this therapy. Her behavioural expressions were also an indication of her happiness in the contexts. She smiled at me, looked at me and talked to me, whereas she ignored the therapist. Thus I argue that along with other interventions, there should be interventions to enhance the emotional well being of the children with mental retardation.

Thus Vinaya's case is an example of the way the unconditional love and close relationship can benefit the deficit-based services.

#### **4.1.11 Interpersonal relationship through complaints: Stanley**

The minimized social interaction due to social insecurity (Jenkins, et al 1977)<sup>9</sup> may result in difficulties to develop social relationships. Socially insecure people use some safety behaviours or protective mechanisms to protect them from the threat in social situations. Most of the time, the safety behaviours in children with mental

---

<sup>9</sup> The concept of social insecurity has taken from Jenkins, et al (1977) study on the association between coronary-prone Type A behaviour and social insecurity. Social insecurity is explained as uncomfortable interpersonal relationships and a feeling of discomfort and awkwardness in groups. Socially insecure people have a preference for minimizing social interaction.

retardation, linked to someone's mental retardation rather than to their social insecurity and the social insecurity go unnoticed.

Stanley was a 12-year-old boy with mild mental retardation. He initiated conversations through his complaints. Therefore, he could not develop any friendships, but most of the time he was rejected. However, the nature of his complaints showed that he was using it as a mechanism to protect him from the insecurity he had in the social situations. The development of a close dyadic relationship provided him a temporary relief in some of the threatening social situations. However, since his problems related with the social situations he continued complaining to protect himself. Through this case, I argue that most of the time, the unusual behaviours in children with mental retardation is matter for laugh for the significant people.

#### Case history

Stanley is a 12-year-old boy with mild mental retardation in the diagnostic records of the school. The obstetric record said that he was born out of a full term normal delivery, but without birth cry. The prenatal records reported that his prenatal period was smooth. There is no history of mental retardation in the family and the cause is unknown. The developmental records reported that he had global developmental delay. He could walk at two years and could talk at two and a half years. Even though he attained all the developments, his speech is slurred most often. Stanley started his education in a mainstream nursery at five from the educational records. Two years later he was moved to the research school at seven. Since he was almost familiar with the alphabets he was put in the academic class from the beginning and now he is in his fifth year in the same class. His classmates are Nithin, Rahul, Seema, Vinaya, Vinod (NPS) and Samad (NPS). He is given training for class

three of mainstream syllabus. His academic skills include basic reading, writing, maths and basic computer skills. Stanley is the youngest child of his parents of Catholic origin. The family members are his father, mother and his elder brother (The family tree is given in Appendix-3). The income of the family is from the small business of his father. Stanley's mother is a housewife and his brother is a student of 9<sup>th</sup> class.

Stanley's relationships in the family were identified through the interviews and casual conversations of his mother and the teacher. According to the teacher, Stanley has good relationship with his parents and brother. She added that he helps his mother in the kitchen and likes to do the dishes. The mother also agreed that Stanley has good relationships with the parents and the brother. However, since his father is busy with his business, the mother said he is more attached to her. Both mother and the teacher reported that Stanley goes out to do the basic shopping. According to the teacher, Stanley is too smart to go out for shopping. She said that Stanley knows the different coins. Therefore occasionally she sends him to buy things from the close by grocery shop. When asked about Stanley's relationship with the neighbours, the mother said that he knows almost everyone out there. The mother said, at home, he comes and tells her most of the things. However, she reported that most of the time, it was some complaints about his health or something about the people whom he met. According to her, Stanley had typical mannerisms while talking and interacting. He shook his hands when asked to do something as if he is frightened of something.

Stanley's complaints and unending questions were a matter for laugh in the school. The teachers' report and my observations supported this factor. Although he interacted well with everyone in the class, the teacher's report and my observation found that Stanley did not have someone to be called as a 'friend' in the class, so also

in the school among the students. He did not initiate to develop friendship with someone specifically. But he approached everyone on time to time. The problem observed and reported in his talking were the nature of his complaints. His complaints and the way he asked questions had the pattern of nagging. Most of the time, the content was own health problems or something about other students or teachers or carers. This behaviour of Stanley irritated others, and therefore he was ignored most of the time, including the teachers and carers. Once his class teacher reported that, Stanley gets scolding from everyone for making complaints. She said to me that Stanley was lazy to do his academic work though he was a good student. According to her, Stanley made complaints in order to escape from the academic works in the class.

Although Stanley was not interested to be seen to develop a close dyadic friendship, he was observed to approach the class teacher or other teachers or carers for his things to be done. In spite of the class teacher's shouting he approached her with all his complaints frequently. He was observed to be secure in the presence of the teacher. This observation of mine was supported with the opinion of the school principal. One day during a casual conversation, the principal said to me that in the previous year Stanley had stopped coming to the school all of a sudden. How much ever, the parents and the teachers tried he was not ready to come to the school. Finally, he told that he would come to the school only if he was allowed to sit in 'Sasiakka's (class teacher) class. The teacher had moved to another class and therefore he had stopped coming to the school. According to the principal, Stanley is very close to the teacher.

As reported by the mother, some of Stanley's behaviours were a clear expression of his fear in certain situations. Let me explain one incident. Stanley was terribly frightened of Samad's (NPS) hyperactive and impulsive behaviour. He shrank

to himself or cried on several occasions when Samad came to him with his fist. This was another incident for Stanley to make some complaints. Stanley had a special way of jumping in certain situations. For example, when asked to go for lunch, when asked to go for computer classes and so on. Stanley hardly sat quietly in the class, but initiated conversations generally. She came to the teacher for simple things, unlike his classmates. Although Stanley interacted with everyone, he was a socially timid boy. The teachers report and my observations clearly showed that Stanley never participated in any of the social activities. For example, dance in the hall after lunch, school games, cultural activities and so on. During the group activities, Stanley used to walk around or engage himself in looking at the picture of some books or keep talking to his class teacher. Among the participants, he was the only one who never participated in the dance after lunch. Sometimes, he moved around the students who were dancing.

#### Relationship with the researcher

Stanley's complaints were the major connecting ingredient in our relationships too. On our first meeting, he was found to be eager to start a conversation with me. His behaviours in the first meeting were extraordinary. For example, smiling, shaking his hands, looking up and down, standing and sitting, looking at me and looking at the teacher occasionally. The first impression I got from his fidgeting behaviour was his curiosity to get to know about the stranger. However, in few days Stanley came to me with his questions and complaints. I soon observed that his complaints were the nature of nagging, which could test the patience of anyone. However, we both found time to interact together, played together, during the lunchtime and lunch break, playing together, and sometimes travelling together in the school bus. A remarkable event in the first phase of the study was Stanley expressing concern towards me when I got

fever and couldn't come to the school. On my arrival, he enquired about my absence. When I told him about my fever, he placed his arm on my forehead and checked if I still had fever. Thus he showed that he had real concern towards me. By the end of the first phase, listening to Stanley's stories has become a routine activity of me.

The relationship between Stanley and me grew stronger in the second phase, so also Stanley's complaints. Stanley's complaints were at its peak during the interschool sports competition. Stanley did not participate in any of the sports activities. He had agreed that he would participate for the sports competition, but when the time came he withdrew from it. Even after compulsion from everyone, he did not participate. He moved around, sometimes with his typical jumping and shaking hands, everywhere in the stadium. However, when he saw students receiving prizes, he was too upset that he asked the teacher for a prize. But he was shouted for that by saying "the prizes are given only for those who participated". Finally, he started crying by repeating the same words, "Nanage prize beku (I want prize)". He cried as if he was compensating for not participating in any of the events. Finally he came down and sat next to me and cried by putting his head down on my lap. Thus Stanley found me as a resort to relieve his tensions aroused from threatening social situations. Even though he found me as a resort in his tensions, he hardly asked me to spend time with him. Stanley never showed any desire to spend time with me in my room, but he expressed his desire to stay in the social situations. When I met Stanley's mother in the school, he exhibited the same behaviour of shaking his hands and jumping as if he is going to be caught for doing something wrong. A significant factor observed towards the end of the study was Stanley's participation with his own classmates. Stanley joined Nithin to play me one day (explained in section 4.4.3.4).

The most important part of Stanley's complaint as observed in our relationship was that his complaints were focused on group situations.

### Discussion

Stanley's withdrawal from any social activity is a clear indication of his social insecurity (Jenkins, et al, 1977). However, it was likely that Stanley could never accept the fact that he was socially insecure. This is clearly expressed through his 'some other engagements ' during any group activity. For example, he could never (not even once while I did my field work) participate in the dance at lunch break, or games in the school. Instead, he pretended to be engaged in some reading or walking around or talking. His intensity to seek the proximity of some elders (e.g., teachers, carers) was a clear indication of his distress. Through seeking proximity, he was in fact regulating his distress (Bowlby, 1973) to work in the social situation. Stanley's sudden stopping of coming to school was an evidence of this. His behaviours reflected that he found his class teacher as a source to relieve his distress. But in her absence, presumably he was threatened and from that he stopped coming to the school. Finally, he demanded that he needed his class teacher in his class. A clear link between Stanley's social insecurity and complaints could be observed here. The complaints seemed to have originated from Stanley's social insecurity. In that respect, the complaints had two functions. On one side it acted as a protective mechanism, while on the other side it acted as a tool to maintain his relationship with the social world.

Stanley's complaints generally occurred in-group situations. This clearly indicates that Stanley was using his complaints as a mechanism to protect his self by denying the fact that he was socially insecure (Freud, A. 1968). Presumably, he was being threatened in some of the social situations and protected himself with an increased amount of complaints. The interschool sport was one of those sorts.

Although he agreed that, he would participate in the sports, he did not when the time came. His self seemed to have threatened by seeing the crowd at the ground. Though he wanted to participate, he was helpless in the situation. However, he was not ready to accept the fact that he could not perform due to his fear and therefore he was denied of a prize. This was clearly evident from his demand for the prize. Stanley was not ready for any compromise, but prize. His crying along with his demand for a prize was an obvious indication of the conflicts he underwent during the sports competition. It looked the regular use of 'complaints' was not enough to protect himself from the threat he encountered on the sports day and he used another act of crying.

The second function of Stanley's complaints as observed from his behaviour was the way he used it as a mechanism to develop and maintain his relationships with the social world. Although, he was incapable of participating in any social activity, he did not want to be aloof and withdrawn from the society. This is clearly evident from Stanley's presence in all the social situations. Although he interacted in a wide circle (more than any other participant), in the neighbourhood and school, he could never involve in any of the group activities. On one side, it looked like Stanley did not want the social world to know that he was insecure, and on the other side he wanted to keep the relationship with them. Therefore, it could be assumed that Stanley used complaints as the best strategy. Through his complaints, he could divert the attention of the people around and develop relationship with them simultaneously. His behaviour also gives the reflection that Stanley never wanted to be a secluded child withdrawn from the society. Therefore, to sustain the relationship he had to communicate through his complaints.

Stanley's complaints were the major component of our relationship too. In majority of our interactions, he came up with some complaints and clearly expressed

that he was not happy with a number of things. In few days of our acquaintance, listening to his unending stories of complaints was a part of our interaction. However, through the exchanges of complaints and other activities the friendship between us grew faster. It looked as if when he found someone who could tolerate his complaints, he turned his focus more on that person (researcher). Engaging in a relationship with a new person seemed to have provided a temporary shelter for Stanley's unhappiness. Presumably, through our interaction Stanley had learned that clinging on to me could bring relief from the conflicting situations. A clear example of this could be observed from his approaching me on sports day. He came to me, sat next to me, demanded for a prize, cried and finally put his head down to my lap. Through these series of behaviours, Stanley projected his real self. His crying by putting his head on my lap was also a way of protecting himself from the threat. He seemed to have used two protective mechanisms in this event itself. While his putting the head on my lap was a denial mechanism, his crying was a reflection of his tendency to regress to an earlier comfortable stage (Freud, A. 1968). May be if his mother was present he might have done something similar. Through this event Stanley expressed how secure he was in the dyadic relationship with me. May be the difference he found in the teacher and me would be the nature of interaction here<sup>10</sup>.

Although on several occasions Stanley came to me for a temporary relief, he was not happy to confine himself into one-to-one relationships. He did not have any difficulty in dyadic relationships and he did not have any significant problems in his home relationship. Stanley's difficulty was only in his social performance, and therefore he wanted to be secure in social situations. Therefore, Stanley was looking

---

<sup>10</sup> Teacher can never allow the relationship to grow a level beyond. The professional role is a defined role and it has limitations while developing a relationship with their students. However, in my case since I had a specific research aim on me, I hardly used criticisms or negative comments on the participants. This was one of the major difference I could see in this case.

for his fit in the social situation. His behaviour gives the indication that he was not ready to involve in a one-to-one relationship where he is away from the crowd. This was very obvious in our relationship too. He asked me to come to his class, lunch hall and school bus. But he never asked me to come and sit with him in my room or anywhere we both could interact alone. From the point of view of Stanley, it could be reasonable to assume that I was a temporary reliever of his conflicts. His tendency to involve in larger network of people shows his desire to function in the society. Although Stanley could establish a strong relationship with me, it didn't bring any substantial change in his behaviour. A remarkable thing he achieved due to the relationship was developing some friendships (explained in section 4.4.3.4). His relationship development with Nithin could be considered as a significant aspect in the study. Stanley's story is also an example of the desire and capacity of children with MR who suffer from emotional problems, to involve in a good friendship.

This case study gives implications for the importance to look at the atypical behaviours in children with mental retardation before attributing them to the condition of mental retardation.

### **Summarizing the cases**

Each case is unique as obvious from the description above. Statistical summary or classifying the children according to their disability will not do justice to the topic of this research. The focal point of inquiry through the case analysis was how the children varied or converged on their relationship-building pattern with the researcher and others. The researcher made an attempt to know the world of the children with MR in the first instance, develop a close relationship with each of the participants in the second stage. Here, the researcher's tactic to interact with them,

helped her to know more about the behaviours, aspirations, emotions, especially the complexities of emotions, and issues faced by these participants. Getting to know them better helped the researcher to exhibit similar behaviours, which were capable of producing happiness in the participants. The overall strategies lead to the point that each of which provided emotional support to the participants, which in turn helped them to develop a close relationship with the researcher. The researcher had a definite focus in this stage of her research that was to develop a strong relationship with children with MR. Hence, through the study; the researcher reinforced them with each of her actions.

The relationship development pattern of each child was different from the other, depending on the nature of previous interactions and the extent of services each one had in their life. Therefore, each child responded differently to the researcher. The pattern of relationship building is subjected to analysis from this point of view. The variance and convergence of each child's relationship building skill is analysed in the light of existing theories. This is explained in the following sections.

## **Section II**

### **4.2 Towards a general relationship pattern of the children in their family and school**

The individual analysis in the previous section dealt with the way each case has built relationships with various people in different life stage processes. This section attempts to draw a general pattern of relationship development in children with mental retardation by looking at the variance and convergence of each child's relationship building. As mentioned in the methods chapter, this aspect of relationship

was revealed through interaction with the participants, observation and interviews with the significant people of their life.

No relationship can be considered independently either from the social, cultural, and temporal situation in which it is embedded (Hinde, 1995) or from the ongoing connection between the persons involved (Reis, 2001). Since relationships involve processes of incredible complexity at a number of different levels (Hinde, 1995), it is important to look at the complex nature of these levels to draw a pattern of relationship. By virtue of these characteristics, the relationship of children with mental retardation can only be studied by looking at the gradual process of relationship development in the family and the school. Understanding the nature of interaction between the children with mental retardation and each of the social actors in these spheres form the facet of the pattern of relationship of children with mental retardation.

This section is organized into two subsections. The first part talks about the child's general nature of interaction in the family, whereas the interaction in the school is discussed in the second part.

#### **4.2.1 Relationships in the family**

Family relationships form a central core of the quality of life of people with mental retardation (Borthwick-Duffy, 1992). All the other relationships in the life of the child are depended on the type of relationships s/he develops in the family. In this sub-section we will look at parent-child relationships, sibling relationships and relationships with others in the family.

#### **4.2.1.1 Parent-child interaction**

A parent's position is an acknowledged source of power<sup>11</sup> in relation to her/his children, while the child's greater dependency is complementary to the parent's positional authority (Perlman, et al., 2000). This 'power-dependence' is the general nature of relationships observed among the cases in the present study. Let us consider the case of Seema to explain this relationship. In the previous section we have seen that Seema brought birthday chocolates to the school after two days of her birthday. When she was told about birthday chocolates her first response was to tell her mother about it. This indicates her dependence on her mother, whereas the mother's decision to send chocolates after two days was a reflection of her positional authority in the relationship. Although this power-dependence interaction is one of the many dimensions in normal parent-child relationship (Radke-Yarrow, et al., 1988), children with mental retardation due to their low functional abilities rely on their parents more than usual (mostly life long) for their existence and the parents attempt to bring changes in the behavioural outcome of these children with their influence (Thibaut & Kelley, 1959).

As happens in any normal developing children, the dependence is functional in the beginning (Bowlby, 1969) even in children with mental retardation. However, in normal developing children, the functional reference to dependence gives way to emotional dependence (Bowlby, 1969), and later independence (both emotional and functional). This transference from dependence to independence does not occur in children with mental retardation owing to their low functional skills. Instead, they remain dependent, both functionally and emotionally, on their primary care taker (mostly mother) throughout life. From the relationship perspective, it could be said

---

<sup>11</sup> The use of the term 'power' in the present study is to denote the positional authority and the expected care from a significant adult.

that a surreptitious agreement about the kind of relationship (Duck, 1995) comes in force between children with mental retardation and their parents. The parents agree to support and care their child with mental retardation by internalising the difficulty of their child to come out of the status of a child, whereas the children learn that the parents are capable enough to support her/him by internalising the authority of the parents<sup>12</sup>. All the participants in the present study expressed childlike behaviours<sup>13</sup> irrespective of their chronological age. Thus, possibly the agreement talked about the expectations concerning each other's behaviour in the future (Sroufe & Fleeson, 1988), where the children with mental retardation remain under the care of their parents (or a significant adult) throughout their life.

In Seema's case, her internalisation of the mother's positional authority made her to look at her mother while taking the decision of bringing birthday chocolates to the school. Seema's mother's internalisation of Seema's dependence did not allow her to look for other options to send chocolates on birthday itself. May be if Seema was a normal developing child, the mother might have looked for some options to send chocolates or Seema herself could take a decision to bring chocolates on the same day. This pattern of power-dependence interaction could be observed with all the children in the study. None of the children were allowed to take an independent decision, but the parents did the decision making on behalf of their children on the grounds that the child is mentally retarded. The significance of this relationship is the very fact that the children with mental retardation seem to perceive this authority of

---

<sup>12</sup> A cultural explanation of this power relationship could be observed in Ramanujan's (1983/1999) description of the Indian Oedipus. Unlike the Freudian Oedipus, the Indian Oedipus is submissive, where the parent exercises power over children. For example, the story of 'Perunthachan', or the story of 'Yayathi'. While 'Perunthachan attacks his son, Puru (Yayathi's son) sacrifices his youth for the father. In both the stories the sons are at the disposal of the father submitting his power. Ramanujan (1999: 126) has portrayed this power paradigm with a reverse direction of the original Greek Oedipus complex.

<sup>13</sup> This is the major reason for the use of 'children' for the participants throughout study.

the parents as satisfying (Hinde, 1995), and therefore the relationship moves forward. More specifically, they remain secure in such dependence to a significant adult throughout life. Therefore, this dependence could be considered as a reflection of the close relationship between the children with mental retardation and their parents. We shall return to this later in the section.

### Prolonged infancy

The power-dependence relationships evolve through a long period of interaction between the mother and the child with mental retardation. This prolonged phase occurs due to the developmental delays of this marginal section of the society. Lets consider the example of Radhika to explain this. The developmental records reported that Radhika's motor and sensory developments were delayed. She could sit at the age of 18 months (one and half years), stand at 24 months (two years) and walk at 30 months (two and a half years). She spoke her first words at three years old. While normal developing children attain their milestones at the expected age, for e.g., walk at 12 months, Radhika attained the same on 30 months. The delay for a period of 18 months provided Radhika the opportunity to receive the same kind of infant level interactions from the mother. Therefore, I would call this delay in development as 'prolonged infancy'<sup>14</sup> in the present study.

---

<sup>14</sup> This terminology has similarities with Kakar's (1978) use of the term 'prolonged childhood' for the prolonged interaction between a child and its mother in Hindu joint families. Kakar holds the view that the prolonged interaction with the mother leaves the child unprepared for independent activity. Pierce Clark (1933), a psychoanalyst, emphasised that the low effectiveness of psychoanalysis in people with mental retardation is due to their fixation at the foetal level of development. Although the present study does not agree with this view, the implication of the life long interaction between the person with mental retardation and the mother at the foetal level of development is agreeable in the context of this study.

Inhelder did another classification about the delay in development of people with mental retardation. In her classificatory system the severely and profoundly mentally retarded adult (she uses the term "idiot") is viewed as fixated at the level of sensorimotor intelligence; the moderately retarded adult ("imbecile") is seen as incapable of surpassing the preoperational intuitive subperiod; the mildly retarded adult ("moron") is characterized as unable to progress beyond the level of concrete operations; and, finally, the borderline adult is seen as able to use only the simpler forms of formal operations.

Since all the children in the study had developmental delays, the prolonged infancy could be considered as a general pattern, which provides long-lasting mother-child interaction. This relatively long stage of interaction is the foundation for the power-dependence relationships. The pattern of interaction during the prolonged infancy stage between the child and the mother is the result of the contributions of each and the influences of each (Bowlby, 1969). The agreement about the kind of relationship as mentioned above, occurs during this stage. Therefore, even though the child acquires the basic developmental milestones (for example, sitting, standing, walking) the parents find it difficult to agree that the child would do something of her/his own. On the other side, the children's introjection of their dependence on the mother becomes a characteristic of them beyond this prolonged infancy (Ainsworth, 1989). The major reason for this could be although the age range of the participants in the present study varied from 8-16 years, none of them exhibited any age appropriate behaviours, but childlike behaviours. Therefore, the childlike behaviour to be dependent on the mother for security was a major characteristic of the children in the present study.

#### Infant-mother attachment

The attachment between the child with mental retardation and the mother could be well explained from the evolutionary and interactional perspective of attachment theory (Bowlby, 1969). We have seen in chapter two that according to attachment theory human beings are innately equipped with attachment and care giving behavioural systems (Bowlby, 1969). Therefore, we have all the reason to think that due to the condition of mental retardation (helplessness aroused from the condition) the child maintains proximity to the mother, whereas the mother responds to the child's needs. This support and proximity received by a child with mental

retardation from the mother is more than any normal developing child. Let us see how this interaction takes place.

Researchers have argued that the parents, especially the mothers, undergo a series of emotional stages from denial leading to acceptance at the diagnosis of their child with mental retardation (Peshawaria, 1998). We have seen in the previous section that Vinaya's mother was shocked at the diagnosis of Vinaya's condition of mental retardation. However, she did not refrain from child caring. It was likely that the child rearing process was mixed with intense ambivalent emotions for Vinaya's mother. Presumably, one side was comprised of negative emotions (for example, anger, fear, guilt and disappointment (Peshawaria, 1998)), whereas the other side was filled with positive emotions (for example, love, care and affection) of care giving towards the child (Bowlby, 1969). If she had withdrawn from looking after Vinaya, the outcome would possibly have been different. By travelling through mixed emotional stages she could finally accept her child's condition. Therefore, I would consider the acceptance stage as a reflection of the attachment of the mother towards the child with mental retardation.

Now we will turn to Naveen to look at his interactions with the mother during his prolonged infancy stage. Owing to his condition of mental retardation and the attachment behavioural system (Bowlby, 1969), he seemed to have sought more help from the mother. Although his development was delayed, there was no evidence that he failed to sensitise the stimulations from his mother. However, I do not completely rule out the possibilities of lack of responsiveness in Naveen as a result of his condition. Yet, I argue that the prolonged infancy period was of assistance to him to compensate his rather slow sensitivity to the mother. The outcome of the slow responsiveness was a prolonged interaction between the mother and Naveen, possibly

two or more times than any of his normal developing siblings. Presumably, the bodies talked more than words (Duck, 1986) to develop this attachment relationship between Naveen and his mother. It seemed each action of Naveen was a signal for the mother and the mother's sensitivity was a cue for the child. Thus, through this long rotation of interaction, I argue that there was a high probability that Naveen developed a secure attachment with the mother. This is the best explanation I can abstract for the close relationship of all the other children (Rahul, Bhavya, Vinaya, Rajeev, Stanley, Seema and Nithin) with their mother. By stating this, I disagree with the general notion that children with mental retardation do not develop attachment security in their early years due to lack of sensitive interaction (see Wall, 1998). Although this was the general pattern observed, we could see that Navaz, Faizal and Radhika do not fit into this blueprint. However, in the light of the above explanation, the reasons for this could be attributed to absence or lack of sensitive mother-child interaction. We shall return to this in the next section.

Let us come back to the emotional security of the child with mental retardation in the relationship with the mother. Even though the interaction is of mutual exchange, the mother dominates the situation by virtue of her role. Being a mother she is the provider most of the time and child is the receiver. As I mentioned earlier, when the mother introjects the child's dependency through the prolonged infancy stage she takes the responsibility to protect the child by providing more care. In the case of normal developing children, the care gradually decreases, as the child grows older to independency, whereas for children with mental retardation the care increases as the child grows. For children with mental retardation, the prolonged infancy is a communication to the mother for his long lasting dependency. This authority of the mother over the child and the dependency of the child on to the mother is a matter for

pleasure for both. More specifically, both mother and child see this power and dependence as proper or desirable (Hinde, 1995). Therefore, this is a clear reflection of the attachment relationship between the mother and the child with mental retardation.

#### Schema of attachment relationship

As happens in any normal developing individual, the child with mental retardation also forms working models of her/his relationship history. All the other relationships in the life of a child with mental retardation depend on this dyadic attachment relationship formed with the mother. This is possible because the child develops internal working models (schema) of self and others that reflect the attachment relationship with the mother (Bowlby, 1973). The understanding, trustworthy and responsive approaches from the mother lead the child to positive views of others in a new relationship. Lets see how the child's schema of past experiences in close relationships reflects in the new relationships.

#### Father-child relationship

The mother does not limit the child's relationship in a dyadic level. She invites the father to be a part in the process. Through her invitation, the mother makes sure that the child with mental retardation may also depend on her/his father for emotional security. In reality through her invitation, the mother deliberately involves the father in the care giving process. The child's positive schema of past attachment relationship helps her/him to perceive the new relationship with the father positively. As observed in the cases in the present study, it was likely that the children may view the father as another source of support where they can depend upon. The relationship of Bhavya and Vinaya with their fathers is a clear example of this in the present study. However, since the father is still the primary breadwinner in the family, his everyday

involvement in childcare seemed difficult and therefore the mother remained the primary care giver (Kashyap, 1989) for the majority of the children in the study.

The differences in the relationship with the father and mother could be well observed in a comparison between Radhika and Seema. We have seen in the case analysis that Radhika lost her mother at five, whereas Seema lost her father at six. For Radhika, the loss of the mother resulted in loneliness and unhappiness. However, Seema did not seem to have experienced the loss of the father. This behavioural outcome at the loss explains the differences in the way children with mental retardation relate with their father and mother. While Radhika's loss was more of emotional, Seema's loss was more of material related. Therefore, Radhika became aloof at the loss, but there was no change in Seema. In spite of both being children with Down syndrome, the contradiction in their behaviour gives evidence for the influential role of mother among children with mental retardation. Although this is the general pattern, there can be variations based on other personal or cultural factors. For example, as we saw in Navaz in the previous section, his closeness to the father resulted from his expectation to unite the father in Gulf.

The above discussion pointed out the way the agreement of the kind of relationship (Duck, 1995) between the parents and the children. They agree to have a power-dependent relationship, which could ensure dependence and emotional security of the children with mental retardation. This specific nature of the relationship between the parents and the children is a reflection of mutual attachment relationship. Most of the children in the present study, expressed childlike behaviours than age appropriate behaviours. Therefore, owing to the condition of mental retardation, it could be said that the dependency on the parents is a reflection of the attachment security in children with mental retardation. As long as the relationship remains in a

dyadic level (mother-child) or even triadic (mother-child-father) level, children remain secure under the shadow of their parents. However, the situation changes, when the network of relationship becomes wider. We shall discuss this in the next section.

The general nature of studies observed on the parents of children with mental retardation is on the care giving burden, stress (Olsson & Hwang, 2001; Skotko & Bedia, 2005) and coping (Peshawaria & Menon, 1991) of the parents having a child with mental retardation (Hastings, 2002). Generally, studies of this sort undermine the positive outcome of parenting and the resultant close relationships they develop with their disabled child. Although the stress of the parents is acknowledged, I suggest that there should be opportunities for the parents to talk about the positive aspects of rearing a child with mental retardation. This should enable them to look at the strengths of their child and the fun involved in parenting a disabled child. Such an approach would help both the parents and the children to experience the excitements of life.

#### **4.2.1.2 Sibling relationships**

Children with mental retardation, just like any other normal developing children, spend a great deal of their time inside the family with siblings. As observed from the cases, the child is happy with the interactions with the elder siblings, whereas s/he retaliates the relationships with the younger ones. Lets consider the case of Stanley to explain his relationships with his elder brother. Stanley's relationship with his elder brother provided him emotional security from two directions. On one side, Stanley's relationship with his elder brother seemed to have provided him a context in which he could experience the point of view of his brother who has greater maturity. This aspect is more or less the same in the parental relationship. However,

the second aspect was slightly different from this. His relationship with the elder sibling provided him an opportunity to engage in a relationship with someone who is more mature but still an equal (Attili, 1985). This element of equality seems to facilitate the children with mental retardation to look at their elder siblings for self-development. This self-development in children with mental retardation could be seen as the child's desire towards normality. Through their inclination towards the elder ones they express their utmost desire to be independent without any handicapping condition. Or more specifically, this could be considered as a jump towards normality. This was the major motive reflected in Rahul's relationship with his elder brother. Rajeev, Seema, Bhavya, Navaz, Radhika, Naveen and Fazial had elder siblings in the present study apart from Stanley and Rahul. All these children benefited from their relationships with the elder siblings in one way or the other way. Presumably, they accepted the care received from the positional authority of the elder siblings. The rivalry towards the younger siblings reflects their insecurity in the relationship with the mother. We shall return to this in the next section 3.

The findings in this study support the findings of the earlier studies on sibling relationships of people with MR (Seltzer, et al, 1991; Krauss, et al, 1996; Peshawaria, 1995). Seltzer, et al, found that adults with MR received instrumental and affective supports from their siblings. Whereas Krauss, et al, observed that there was a high level of contact between the disabled and non-disabled siblings. However, a common pattern observed in the studies of Seltzer, et al, and Krauss, et al, was that these were done on ageing adults with MR who lives independently of their siblings. Although it cannot be taken as such in Indian conditions, the support factor shown in these studies are noteworthy and the same could observe in the present study too.

#### **4.2.1.3 Others in the family**

Now let's look at the child's relationships with other family members. Since family is an integrated whole, the parents perceive the necessity to incorporate their children into the network of relationships (Hinde & Stevenson-Hinde, 1987) irrespective of the child's condition. In this process, the parents transmit their influence over the children to other family members too. Because the child is mentally retarded the parents demand more care from the family members. As a result the other family members also provide more care from their positional relationship with the child with mental retardation. Thus the child's dependency spreads to others involved in the family.

All the above-mentioned relationships are common with the normal developing children as well. The implication is that therefore the authority of the parents, siblings and other family members are normally an accepted factor. However, in the case of normal developing children, this authority diminishes gradually, whereas for children with mental retardation this remains throughout their life. The child with mental retardation seems to have accepted the care of the family members in the familial network. As long as the child perceives this power oriented relationship a satisfying one, the relationship moves forward (Hinde, 1995). Because, the family is the primary care taker for a person with mental retardation in India, the submission to the authority of the family members is very significant. This could also be considered as the consent from the people with mental retardation to be cared by the family members. Thus people with mental retardation proclaim their life long dependency in relations to family members.

Although the children are happy and content with the exchanges in the familial network, the concern of the parents do not allow them to confine in the four walls of the house. Parents take them outside in different settings. This is discussed next.

#### **4.2.2 Relationships at school**

School was the first and foremost external systems of social network where the relationships of all the children in the present study grew into different levels. The larger network of relationships in the school comprised of different dyads, triads, and other smaller groups. In this sub-section we will look at the relationships of the children with service providers, peers and others in the school.

##### **4.2.2.1 Service provider-service user relationship**

School is a strange situation for all children. Therefore, it is quite natural to seek security on admission to schools. In this situation, the interactions between the children and the significant adults (teachers, carers or other professionals) become noteworthy. Unlike mainstream schools, the schools for children with mental retardation are service based especially to develop functional skills in them. Therefore the adults in the schools are referred as ‘service providers’ and the child who receives services is ‘service-user’ in the present study. Most of the time, the interaction between the service user (child) and the service providers in the school (teachers, carers, professionals) reflect a combination of ‘demanding-accommodating’ and ‘demanding-resisting’ style. On one side the child accommodates with the demands placed on her/him, but on the other side s/he refuses the same.

After parents, teachers were the most significant adults for all children in the present study. Because the school environment is a strange situation from the home environment, the child’s emotional security may be in a threat on admission to school. However, the positive schema formed from the relationships with the mother

(Bowlby, 1973) helps the child with mental retardation to cling to the teacher for security and survival. It was observed in the present research school that on admission normally young children were placed in early intervention classes (explained in chapter 3, page 71). Lets look at Bhavya to see her relationships with the teacher in the early intervention class. We have seen that Bhavya had good relationship with her teacher. Although Bhavya was eight years old, her behaviour could be compared to that of a child in her phallic stage. As a response to her age inappropriate behaviour the teacher had to provide more care and Bhavya seemed to have satisfied her needs for security and protection in the school through her relationship with the teacher. Since the youngest children were in the early intervention classes, the teacher-student interactions had a strong maternal element. Therefore, the emotional security of the children in the early intervention class was protected as it was in the prolonged infancy stage.

Not only in the early intervention classes, but in other classes also children with mental retardation looked at their teachers for emotional security. Stanley's attachment with the class teacher explains this. We have seen in the previous section on case analysis that Stanley was socially insecure and one of the major reasons for his bonding with the teacher was that of seeking protection in the social situations. Stanley's expectations and the teacher's care were in consonance at this point. Teacher's care was capable enough to influence Stanley's behaviour (Thibaut & Kelley, 1959) and he was comfortable in the presence of the teacher. Thus by submitting the authority of the teacher the child exhibits her/his desire to be cared by an elder member. The children with mental retardation are found to be comfortable in their relationships with the teachers as long as their need for security is met in the relationships. More specifically, through these they express their desire to remain

dependent on a significant adult. An important point noted in the above-mentioned interaction is the nature of dyadic relationship within the group structure. Therefore, the child may perceive the teacher as a reflection of the mother and accommodate with a new dyadic relationship easily. In reality the child accepts the dyadic (mother-teacher) or triadic (mother-father-teacher) relationship on her/him at this stage.

However, this relationship changes as the interactions between the teacher and the child changes. Since the major aim of the schools is to provide special services to children and make them functionally independent, most of the time the teachers are found to be demanding some specific behavioural skills from the children. Since the root cause of dependency is attributed to the characteristics of mental retardation, parents give their consent to teachers in supporting the child to overcome the atypical behaviours. Therefore, teachers do their best to provide services so that the children would become self-sufficient. Then on the interactions are service based, where only the deficits of the children are focussed. We shall return to this issue in the next section of this chapter.

Since the major purpose of the education is to make the child independent, the parents link with other service providers (carers, other professionals) in the school. In this process the child has to function in a large network, where all others are looking at his deficits. In this situation, the usual response of the child is to exhibit resisting behaviour to the demands placed on her/him. In this process, the communication becomes one-sided, where the child lacks the opportunity to express her/himself. The outcome of the situation is that the child tries to keep her/him away from interacting with the service providers. As the services increase the child's dependency gets more threatened. Therefore, children normally do not try to accommodate with this part of

the social network in which s/he belongs. However, children receive opportunities for mutual exchanges with peer group. This is discussed next.

The general nature of studies on teachers or professionals in relation to children with mental retardation focus either the effectiveness of deficit based services or the stress of the service providers while interacting with these children. This approach never allows the teachers and the professionals to think beyond their professional role. An urgent call for a humanitarian perspective is required for future research.

#### **4.2.2.2. Mutual exchanges of the disabled peer group**

Researchers have suggested that sibling interactions may help to smooth the passage to relationships with peers (Attili, 1985). Peers' function consists in providing opportunities for the development of social skills, problem solving, friendship networks and mutual security in children with mental retardation, not available in relationships with others. Let me describe how security is ensured in the interactions of the disabled peers from the study. We have seen in the case analysis of Bhavya that she approached the older students in the school to sit on their lap and to be cuddled. Bhavya with her childlike behaviour was seeking more emotional security through these behaviours. Such interactions helped Bhavya to foster her emotional dependence on the elders; whereas this helped the older students express more care to a disabled youngster.

Let me narrate a typical example of this from the present study to bring out the problem solving skills of children with mental retardation in their interactions with the peers. One day, I was standing at the door of the academic class to see the snack time activities of the children. Suddenly, I noticed that Vinaya was sitting in her own classroom with an apple she brought from home. When asked the teacher said that

Vinaya brings snacks from home and therefore she was allowed to sit in her own class. I have observed that she was very fuzzy to eat her apple and at some point she kept it on her table. No sooner, Ashwin (NPS) who had already finished his biscuit came and picked it. Although Vinaya was reluctant to eat the apple, she did not want to give the same to someone else. Somehow she managed to take hold of her apple from him and hid herself under the table. When he saw her hiding under a table he moved towards her slowly. Seeing him approaching, Vinaya too started moving keeping a specific distance from him. However, finally she reached the corner of the class and there was no space for her to move further. At this stage, her behaviour was amazing. She bit the apple, took a small portion of it and gave to Ashwin. He was happy and ate it and stretched his hands for more. Vinaya took another bite, this time a bigger portion and gave to him. Ashwin looked satisfied and happily left the scene. We have seen in the above example that how Vinaya strategically solved the issue by providing apple to Ashwin. Rather than looking at someone for help, she found the mechanism to escape from the problems she encountered. This reflected a very innovative problem solving strategy from Vinaya. Such competence in children with mental retardation can only result through the interactions with the peers. If a teacher were present, the outcome would have been different. The implication here is that children with mental retardation do have a number of skills in relation to their peers, but are unrecognised.

The interactions of the disabled peer group in the study indicated their interdependence in various groups. We have seen that Radhika, Seema, and Vinaya were lunchtime friends for a long time and later Bhavya joined this group. The exchanges in this group show how the group was capable enough to meet the needs of each of its member. Vinaya was a submissive child, who was under a number of

services in the school and therefore, Vinaya never developed any friendship with any of the service providers in the school. Rahika was a girl with more elderly behaviours and Seema by virtue of her leadership was powerful. Both Radhika and Seema were of caring nature and Vinaya was of cared nature. This caring nature of Radhika and Seema possibly attracted Bhavya and she joined the group. The complementary behaviours among these four children helped them to act according to the needs of each one. Sometimes, they might not be able to meet their needs in the interactions with the adults.

#### Play in peer relationships

Play was the major mechanism to the development of social relationships in children with mental retardation with their peers. All the classes except the academic class in the research school provided maximum opportunity for the children to engage in different games and activities. Most of the time, all the children participated in the different fun activities. Apart from the class room play, there were leisure time activities, especially the dance in the hall and travel in the school bus, games in the corridor and so on were various contexts for the children to engage in different play.

#### **4.2.2.3 Relationships with others in the school**

As observed from the cases, all the children in the present study had other opportunity to socialize in the school. Others in the school included van drivers, office staffs, and visitors in the school (parents, siblings, trainees, casual visitors etc). Majority of the children in the present study had good relationships with few of the others, especially the van drivers. Rajeev, Stanley, Navaz, and Nithin (towards the last part) were very close to van drivers. Seema and Bhavya were friendly with office staffs, few of the other parents and the trainees in the school. Owing to the condition

of mental retardation, the people in the social network most of the time makes use of a positional authority to care the children with mental retardation.

## **Conclusion**

From the above discussions we have seen that children with mental retardation are involved in a wide network of social relationships where the attachment security is maintained. The general pattern observed about the kind of relationship is power-dependence. Through a long period of interaction in the prolonged infancy stage, the mother and the child undergo an agreement of power-dependence. This dyadic relationship of power-dependence is a reflection of the attachment relationship between the child and the mother. The child may develop attachment with father, siblings, service providers, peers and others as long as the emotional security could be maintained in the relationships. More specifically, children were found to be happy in relationships, which could provide them security as it was in the prolonged infancy stage. However, there will be situations in which the child was not involved in the agreement and those who cannot carry on the agreement. This is the very situation the child exhibits conflicts and disagreement in the interactions. This is the subject matter of next section.

## **Section III**

### **4.3 Conflict and disagreement in interaction**

In the previous section we have seen that the pattern of relationship of the children with mental retardation is power-dependence, where the children enjoy the care and security from an attachment figure. This section talks about the different contexts where conflict occurs in the relationships. As explained in chapter three, this was revealed through interviews with the significant people and the observation of the interaction between the participants and the significant people.

Lack of agreement between the partners in a relationship can result in conflicts (Hinde, 1995). Since the agreement between the mother and the child in the prolonged infancy stage is to ensure the attachment security of the children, anything that interferes with this pattern leads to disagreement. Lack or absence of sensitive interaction may be a threat to the child's security. Therefore, it is necessary to look at those situations where the disagreement occurs in the life of children with mental retardation.

This section is organized into two parts. The first part talks about the contexts of emotional insecurity in the family and the second part deals with the same in the schools. The section ends by pointing out the need to ensure security in the relationships of children with mental retardation.

#### **4.3.1 Reasons for emotional insecurity in the family**

We have seen in the previous section that in the prolonged infancy stage there establishes an agreement between the mother and the child with mental retardation. The mother agrees with the child's life long dependence and the child agrees with the mother's (any significant adult) authority. This dependence is the child's tendency to be cared by a significant adult, especially mother. Therefore, if there is an absence of sensitive interactions between the mother and the child, the possibility for the child to rely on the mother is very less and so also the development of an attachment relationship. In such a situation, the child may perceive all such contexts as threatening as they come in between her/him and the mother.

##### **4.3.1.1 Lack of sensitive interaction between the mother and the child**

We have seen in section 1 that the possible reasons for Faizal's challenging behaviours were an insecure attachment (Clegg & Sheard, 2002). This insecure attachment seemed to have resulted because of a lack of sensitive interaction between

Faizal and his mother. Being born in a poor large family of 12 children, Faizal was deprived of a sensitive interaction (Bowlby, 1969), which was necessary for infant-mother attachment, from his own mother. The mother's strive to meet the basic needs seemed to have thwarted the need for love and care between Faizal and his mother. Presumably, his condition of mental retardation did not produce an alarming state in his parents. This may be due to the fact that he was born as the third child with disability in the family. As mentioned in Faizal's case report, by the time of his birth, presumably the parents had accepted the status of having a child with disability. Therefore, rather than worrying about the condition of mental retardation, they worried about the extent of food and services they could provide to their children. This lack of sensitive interaction between Faizal and his mother might have resulted in an insecure attachment in Faizal (Atkinson, et al, 1999).

We have seen in the previous section that the power-dependence pattern of relationship with the mother ensures the child's emotional security. However, the above explanation brings the point that the possibility of a power-dependence relationship was very minimal in the case of Faizal and so also the attachment security. Since his mother and the elder sisters shared the responsibility to look after him according to their convenience, Faizal did not have someone to be called as a primary care taker in his prolonged infancy stage. The above discussion points out that the lack of sensitive caring in the prolonged infancy stage, did not allow Faizal to direct his functional dependence (Bowlby, 1969) to a single figure. Presumably, this resulted in developing a negative schema about relationships in Faizal. This may be the reason that he could not develop an emotional dependence with anyone in his relationships. However, the attention seeking nature of his challenging behaviours as we saw in section 1 indicated his desire to involve in an attachment relationship with

a significant adult. Therefore, it could be argued that lack of sensitive interaction with the mother in the prolonged infancy stage stands as a fundamental issue in the later relationships of children with mental retardation.

#### **4.3.1.2 The arrival of younger siblings reduces the attention of the attachment figure**

The arrival of the younger siblings is a conflicting situation for the child, because in this situation the child's dependency on the mother is threatened for the first time. More specifically, this is one of the early triadic relationships in the family against the wish of the child. Naveen, Rajeev, Rahul and Nithin in the present study had rivalry towards their younger siblings. Lets take the example of Naveen. In section 1 we have seen that Naveen didn't like his younger brother and fought with him quite often. Complex, but interrelated emotions of fear, anxiety and jealousy could be observed in Naveen's behaviour. Naveen seemed to have perceived the arrival of his younger brother as a threat to the dyadic interactions between his mother and himself. This fear of loss of the attachment figure may have produced anxiety in Naveen (Bowlby, 1969). Presumably, this anxiety resulted from his perception of affection from the mother as a tangible and finite substance and the amount varies if it divides between his younger brother and himself (Robey, et al, 1988)<sup>15</sup>. Therefore it was possible that Naveen developed jealousy towards his younger brother who takes away a considerable amount of affection from his mother. This was reflected in his frequent fighting with his younger brother.

---

<sup>15</sup> This explanation is basically grounded on Robey, et al (1988) version of the naïve (Heider coined the term) theory of affection. It consists of the belief that affection is a tangible and finite substance, and that the amount of affection given to one person therefore lessens the amount that can be given to another one. Children holding this implicit understanding of affection would believe that the more affection and attention their parents give to others, the less they will have to give to them. The consequences of seeing affection given to another is jealousy, just as it would be with a truly finite resource such as money or space.

Although this was the general pattern observed with the children who had younger siblings, Navaz deviated from this pattern. In section 1 we have seen that Navaz liked his younger brother as much as he liked his elder brother. Since he was brought up with the aspirations of joining his father in Dubai after his studies, he seemed to have developed an attachment (through imagination) with the father. As a result of this, he might have considered a tie with the father is more important than with the mother. Therefore, it could be well thought-out that because of his target to join the father he never found the concern of the mother towards his younger brother as a threatening one. The case of Rahul is also slightly different from the general pattern. Being born in a joint family, Rahul expected love and warmth from both mother and grandmother. However, as we saw in section 1, he was denied of the love from the grandmother. At this stage, the arrival of the younger sibling was a threat to his dependence with the mother and his possible union with the grandmother. His emotional security with two significant people was threatened with the arrival of his younger sister.

The above-discussed process of rivalry towards younger siblings is a general pattern even for normal developing children owing to the attachment relationship with the mother. However, as they grow older normal developing children become independent by easily accommodating the new demands of the social world. On the other hand, as I mentioned in the previous section, because of their difficulty to come out of the status of a child, people with mental retardation perceive the arrival of the younger sibling as a threat to their smooth relationship with the mother. Since all the participants in the present study exhibited childlike characteristics, even in their adolescent stage (for example, Naveen and Rajeev) they expressed their dislike towards the younger siblings. This finding has utmost relevance in Indian culture.

Unlike Western countries, independent living for people with MR is never a matter of discussion in India. Looking after the disabled person is considered as an inherited duty of the non-disabled siblings after the death of the parents. Therefore it is necessary to foster emotional involvement and tolerance between the disabled and non-disabled siblings in our culture. This finding gives implication for the importance of developing good sibling relationships for the quality of life of people with MR and their siblings.

#### **4.3.1.3 Loss of attachment figure is a threat to attachment security**

The general pattern observed in the present study was that of an attachment relationship between the child with mental retardation and the mother through a prolonged infancy. We have seen in the previous section that due to the childlike behaviour of these children, the parents, especially the mother and the children come to an agreement of caring and cared life long. In this situation, the sudden loss of this primary caregiver results in emotional reactions (Bowlby, 1973) in children with mental retardation (Schwabenland, 1997/1998). The child's emotional security is shattered in this context. Radhika in the present study is a typical example of the loss of the attachment figure. We saw in section 1 that Radhika lost her mother at five years old. Because of the agreement of lifelong dependency with the mother, the death of the mother resulted in grief (Bowlby, 1973) and eventually loneliness in Radhika. Although Radhika could develop other relationships in the family with her father and sisters, her contradictory behaviours of passivity and activity in social contexts (explained in section 4.1.3) were reflections of her mixed emotions of sadness and unhappiness. Therefore, even though Radhika had relationships with other significant people, she could not substitute any of these relationships for the lost one (Ainsworth, 1989).

Although a person can develop multiple attachments (Ainsworth, 1989), the chances for the same are limited in people with mental retardation. There may be various reasons for this. Owing to the condition of mental retardation, the child needs extra care to meet her security needs. Most of the time, the mother is found to be the only one person who provides such incessant care. As we saw in Radhika, after the death of her mother, her father and elder sisters provided good care, but it seemed that Radhika could not meet her security needs in these relationships. Presumably, the care given by them was more on her functional independence and physical care. The result of such an attitude would be a lack of warmth in the interactions and the eventual neglect of the emotional dependence. In this situation, it was likely that Radhika could not ensure her needs to be cared. Therefore, the loss of an attachment figure poses serious threat to the attachment security of the children with mental retardation.

#### **4.3.1.4 The traditional beliefs of the family can be a threat to emotional security**

As we have seen in the case report of Rahul in section1, the traditional beliefs of the family can be a powerful threat to the attachment security of children with mental retardation. Being born in a joint family, Rahul wanted to integrate into the joint family system. However, he was rejected on the grounds that he was born with mental retardation. The grandparents viewed his mental retardation from a traditional viewpoint and believed that his condition resulted from a curse of the previous life. Since grandmothers play a role as equally as the mother in child rearing in joint families, the love and warmth from the grandmother is essential for the child's incorporation into the whole family system (Kurtz, 1992) and the resultant attachment security in joint families. Therefore, unlike other children in the study, the attachment security in Rahul was ensured not only with the attachment with the mother but also with the attachment with the grandmother and other family members. The failure in

developing a close relationship with the grandmother threatened Rahul's emotional security.

#### **4.3.1.5 Over protectiveness of the parents**

Although there is an agreement of power-dependence between the parents and the children, the over execution of power on the child's dependency can be a threat to their dependency itself. An interesting observation of the relationship between the parents and the children was the protective nature of the parents to their children with mental retardation. On one side there was caring by providing things of the children's interest, while on the other side it was found to be taking away things from them. Majority of the parents of the children in the study reported that they do not allow their children with MR to do the household activities. Although the child was able to do, they did not allow on the grounds that s/he needed to be cared well. An example would be not allowing Radhika to do any of the household works (refer section 4.1.3). Another common factor observed among the parents were that of not allowing the child with MR to go out alone. Except Stanley's parents (see section 4.1.11) all were reluctant to send their children outside home alone. Vinaya and Bhavya were not allowed to travel even in the school bus without either of the parents. None of the children in the present study were encouraged to interact with someone whom the parents do not know. If at all any new relationship occurred, it was found to be uncomfortable for the parents until they get to know about the person. An example would be Navaz' mother's response while I rang up Navaz' house for the first time (explained in section 4.1.9). Most of the parents were agreed that they provide the best possible services, food, or clothes to their children. Thus, the life of the children was filled with protective mechanisms.

The protective mechanisms have both positive and negative effects on children with mental retardation. The positive factors would be the opportunity to develop close and trusting relationship with the family members and the children with mental retardation. However, this protective nature of the parents generally prevented the possibilities of the children to develop new social contacts. Although, it was absolutely right from the part of the parents, unknowingly it affected the other relationships of the children in the study. Because of the protective and controlled parenting, the children were found to be extremely dependent on their parents. This seemed to have affected their general level of social interaction and the number of social contacts. More specifically, the over protective parenting took away the opportunities of the participants to develop more friendships on several occasions.

Now lets look into those situations of emotional insecurity in schools.

#### **4.3.2 Reasons for emotional insecurity in schools**

Although the agreement in the prolonged infancy stage was to ensure the child's need for care and dependence, the mother relates with the social world to make the child independent. However, it looks like the child is so honest with the agreement that s/he does not welcome the idea of becoming an independent being. Since the mother breaks the agreement, the child exhibits distress with her and the authority of the social world that do not foster her/his need to be cared in a dependent relationship. The new relationship networks (for example in the school) are formed for a specific purpose to do services to make the child independent. But the child who is already in secure relationship with the mother does not accommodate with these demands of the social world. This may be due to the fact that the child may perceive the authority of the social world as threatening because the new relationships with the outside world do not foster her/his desire for dependency, but work for his

independency. Therefore, the child may see the interactions between himself and the social world as dissatisfying. Lets look at some of the social contexts where the child with mental retardation fails to accommodate with the demands of the school.

#### **4.3.2.1 Deficit based services focus only on functional independence**

We have seen in the previous section that the parents break the power-dependence agreement and work for the independence of the child. The professionals of various disciplines are a group of service providers in the school whom the parents transfer their authority. By then, the people who focus on the deficits of the child are already in a triadic or larger network of relationship (parents-teachers-professionals). This union of the parents, teachers and the professionals is a threatening condition for the child. Since the purpose of this group is to find out the deficits of the child and to provide necessary skill focused training, there is no meaningful communication occurs between the child and the professionals. All the communications become one sided and the child's opportunity to express is limited.

Lets look at Vinaya to figure out the authority of the service providers in her life. Since Vinaya was the one with more health related and other developmental issues among the participants, she was considered as a child with a number of deficits. Therefore, to make her independent, the parents joined hands with teachers and the professionals. Though the services enhanced the physical functioning, it failed to provide any emotional support to her. Her responses were a clear evidence of her aversion towards the services and the resultant frustration. Vinaya on various occasions responded openly to the situation. For example, Vinaya never liked physiotherapy. She expressed verbally and behaviourally her dislike in being in physiotherapy. Once she said that she did not like the physiotherapist. The reason was that the physiotherapist created pain in her. The behavioural expression of her

dislike was frequent, sometimes hiding under a table so as not to encounter the therapist. Since the interactions between the service providers and Vinaya are focussed only on functional independence, she seemed to have perceived this as a threat to her emotional security. In this situation there are possibilities to have a clash between the emotional dependence of Vinaya and the services focussing on physical independence (Amado, 1993; Sheehy, 2005). Majority of the children in the present study had some or the other services in the school.

While recognising the positive benefits of these therapies, the researcher emphasises that these therapies do not meet the emotional needs of the children with mental retardation. The parents and the professionals strive towards transforming their child with mental retardation to an independent being with all the necessary skills. This is definitely the best thing parents could offer for their disabled child and professionals for their client. However, it restricts the freedom of the child as the child has to function according to the therapist's interests. This in turn blocks the flow of spontaneous emotions, which is capable of putting children under frustration. This leads to the production of other unwanted behaviours, which makes the parents and staffs to exert strategies to stop it. Though there will be reduction in the target behaviour, it results in new behaviours. Thus the process becomes a cycle. The ultimate result is that the mental health of the children with mental retardation is affected and the relationship needs of these children become even stronger. Therefore, I argue that along with skill training there should be interventions to meet the emotional needs of these children, which may even help other skill focused services.

#### **4.3.2.2 Unrealistic expectation about the skills reduces attachment security**

We have seen in the previous section that the parents joined the service providers to make the child independent by breaking the agreement in the prolonged

infancy stage. This occurred even when the children do not exhibit atypical behaviours. Here the major concern of the parents is the child's competency with her/his own non-disabled peer group. For this purpose, the parents join hands with the teachers of the academic class in the special schools. In the academic classes the interactions between the teacher and the student occurs mainly one-to-one, where the teacher rigorously train the student to acquire the basic reading, writing, and maths. By virtue of the authority from the parents, the teachers often beat up the students for not doing the academic work. Seema, Stanley, Vinaya, and Nithin were always victims of the punishments of the teacher for either not doing the work or slow in doing the work. As we have seen in the cases of Vinaya and Nithin, the outcome of this could be a dislike towards the teacher and severe emotional problems in the children.

Let us turn to the case of Nithin. We have seen in the case report of Nithin in section 1 that he was often overburdened with his academic work. As mentioned in Nithin's case since he was transferred recently from mainstream to special school he could perform a level just above the level of his disabled peers. However, the parents misinterpreted this and expected him to perform a level equal to his non-disabled peers. Therefore, the mother joined the class teacher to make him competent with his non-disabled counter parts. Nithin's behaviour in the class (refer section 4.1.2) was an indication of the conflicts he experienced with the triadic relationship (mother-teacher-Nithin). His mother's over expectation to make Nithin as competent as the normal developing children made her to relate with other members to work against the wish of Nithin. This was the reason Nithin started tuition at home. Nithin who seemed to be happy with the dyadic and triadic relationship with the parents did not like the idea of widening the relationship network with a focus on improving his

performance. His development of stuttering in front of the mother and the teacher were likely to be the expression of his frustration in the new relationship network who focus only about his academic competence (Hinde, 1995).

Having an agreement of dependency in the relationship with the mother, Nithin seemed to have perceived the new social network as a threat to his dependency. His stuttering (which was purely selective) was a reflection of his disagreement of the power of the partners in the new interactions (Hinde, 1995). Presumably, Nithin's expectations were to submit the authority of the parents in a life long dependence relationship. However, his parents' expectations were of unrealistic to his condition of mental retardation. This made them to relate him with the outside network with a purpose of developing his performance. Nithin seemed to have observed the authority of his teacher and the tuition teacher as a threatening situation for his life long dependency. In special schools students in the academic session are prone to over expectation of the parents and the teachers. A major reason underlying this process is the inadequate transfer of information between the teachers and the parents.

#### **4.3.2.3 Punishments are threats to emotional security**

We have seen in the case of Faizal in section 1 that lack of sensitive interaction in the prolonged infancy stage resulted in insecure attachments and eventually challenging behaviours in him. Punishments were the immediate outcome for Faizal from the service providers and the family members (see section 4.1.1). We have seen in 4.2.2.1 that Faizal was already in a threatening situation as he lacked the chances of developing an attachment security in his prolonged infancy stage. Therefore, the punishments seemed to have produced severe conflicts in Faizal's relationships with the service providers and the family members. On one side Faizal

could not develop a security relationship with a responsible figure, and on the other side all the responsible elders punished him to make him a child without any challenging behaviours. As mentioned in Faizal's case report, the punishments did not bring any expected change in his challenging behaviour. Why is that?

The above-mentioned issue is a common phenomenon in special schools in our country. However, the same continues for children who exhibit challenging behaviours. In such situations what happens is that the child would neither come out of his problems nor develop a good relationship with those who exert punishment on them. As we saw in the case of Faizal, the challenging behaviours may have a specific purpose. The tendency of the significant people of children with mental retardation is to link any unusual behaviour as an additional component of mental retardation. Therefore, as usual, some strategies are used to reduce this. However, I argue that this situation needs to be changed for the emotional well being of the children with mental retardation. The professionals, teachers and the parents should look at any unusual behaviour as signs for some intense desires of these children. Since they are poor in communication, any behaviour can be a sign from them to the social world. May be their wish to involve in an attachment relationship with a caring adult.

#### **4.3.2.4 Neglect could be a factor for emotional insecurity**

We have seen in section 1 that Naveen had poor communication skills and he was extremely shy. Therefore, he was reluctant to take any initiation in any social situation. Although his verbal communication was poor, he had all the skills for personal care. Therefore, the service providers in the school did not have to provide any special care to look after him. The result was that he was neglected in most of the social situations in the school. Since Naveen did not exhibit any problem behaviours, the tendency of the elders was that of leaving him unattended. Along with this, since

he did not have proper speech or communication skills, the chances of him being neglected was higher compared to his peer group. In this context, the emotional security of Naveen would possibly have threatened. This may be the reason for his withdrawal in the presence of others. Therefore, he was not fortunate enough to receive enough social stimulation to form a close friendship with anyone. However, this doesn't mean that he doesn't long for friendships and relationships. From the fieldwork experience the researcher argues that even though people with mental retardation have poor communication skills, the need for friendships and close relationships are strong in them.

### **Conclusion**

The above discussion pointed out that any threat to attachment security result in disagreement and conflict in children with mental retardation. We have seen in the previous section that a child with mental retardation is happy with the dyadic relationship with the mother because of the agreement of attachment relationship taken in the prolonged infancy stage. In this section we have seen that children who did not sign this agreement in the prolonged infancy stage had problems in their other relationships. We have also seen that since schools do not move according to this agreement of emotional dependence, conflicts occurs in children's relationships in the school. Therefore, a natural question comes to our mind is how this conflicts can be reduced in the school setting? The next section answers to this research question.

## **Section IV**

### **4.4 Interpersonal chemistry in a new dyadic interaction**

In section two we have seen that children with mental retardation are happy in the dyadic attachment relationship with the mother, and in section three we have seen that the relationships which do not foster emotional security results in conflicts. In this

section we will see how this conflicts in the relationships of the children can be reduced in a new dyadic attachment relationship in the school setting. As mentioned in chapter three, this aspect was studied by developing a close relationship with each of the participants.

In the previous sections we have seen that conflicts in relationships stem from two dimensions: (i) due to the lack of sensitive interactions in the prolonged infancy stage with the mother; (ii) due to the heavy focus on skill training programmes in the school. Since schools are the foremost external social agents, it is very important to look at how these conflicts can be reduced in a school setting. Since the attachment security was observed as the reason for conflicts, it was very important for the establishment of this aspect in school level interaction. Therefore it is necessary to look at how these conflicts are reduced in a new sensitive interaction in the school.

This section has been divided into three parts. The first part talks about the significance of the dyadic relationship. The pattern observed in the dyadic relationship is discussed next. The third part deals with the effectiveness of developing an attachment relationship with children with mental retardation in the present study. The chapter ends by discussing a theoretical model emerged from the study.

#### **4.4.1 Significance of the dyadic relationship**

There were two major purposes for the attachment relationship between the researcher and each of the 11 children with mental retardation. The first objective was to study the possibilities of developing an intimate relationship with the children, whereas the second purpose was to increase their happiness through this. The researcher's approach and the children's responsiveness as described in section 1 clearly indicate the extent of close relationship between each other (Reis & Shaver, 1988). However, few important questions come here on this relationship. How was

this relationship different from other relationships in the school? What was significant in this relationship?

#### **4.4.1.1 Attachment security in a maternal level sensitive interaction**

The interactions between the children and the researcher were in fact reflections of the sensitive kind of interactions between a mother and a child. This was one of the distinguishing elements of the present interaction. We have seen in the previous sections that all the children in the present study exhibited childlike behaviours irrespective of their chronological age. Therefore, the foremost element required to keep them happy and secure was to provide a sensitive interaction of the maternal kind. We have seen in section 2.2 that the service providers, peers, and other school staffs (drivers, sweepers, and so on) were the people whom the child could relate with. Since these roles are defined roles and the roles make them to relate with the children, it is not reasonable to assume that these roles would ever be considered central to attachment relationships (Ainsworth, 1989) in schools. This was not the case with the researcher. Since the researcher was not bounded by any defined roles of the sort mentioned above, there was no specified boundary in the interactions. Therefore, the importance of the present interaction was that this maternal element could be applied in an institutional set up, which was against all the existing relationships in the school. Therefore, the children could engage in a strong dyadic attachment relationship with the researcher.

Although the service providers are in defined roles, I don't completely disagree their ability to develop attachment relationships. This could be possible through a sensitive interaction. However, it is not practical for them to interact from the position of a peer.

#### **4.4.1.2 Reciprocal exchanges reflected the peer group interaction**

The furthestmost advantage of the interaction was to participate with the children as a peer. We have seen in section 2 that most of the children in the present study had good relationship with disabled peers and were happy in mutual exchanges. Although the maternal level interaction was able to provide security, it was incapable to provide the freedom and equality of interaction. A clear distinction in the interactions from the service providers and the researcher could be observed by looking at some of the specific situations. For example, travelling in the schools bus. All the teachers sat at the front seats of the bus and the students behind them. But when I travelled in the school bus, I sat with the students. Another typical situation was the leisure activities in the hall after lunch. The teachers and the service providers sat at the door of the hall keeping a certain distance from the students, whereas I sat with them and joined them in their play and other leisure activities. Play permitted us to engage in an equal level mutual exchanges. Another typical situation where I could act one among them was the classroom. While the teachers remained at the front of the class, I could sit with them as one among them. Through these I could interact from their level, which was not possible for the service providers due to their defined roles.

#### **4.4.1.3 Unusual behaviours were treated as communications**

The unusual behaviours in the children were effective means of communications for the researcher in the interactions. We have seen in the previous section that generally any unusual behaviour is treated as deficits arising from the condition of mental retardation. But in the present study, these behaviours were in fact assets through which the researcher could know more about the needs of the children. The atypical behaviours explained the difficulties of the children. The conflicts and

the disagreement in the interactions with children with mental retardation are mainly due to the inability of the parents and the service providers to respond to the communications of these children. Instead, the parents and the service providers consider these unusual behaviours as something to be treated in a systematic way. Any unusual behaviour of the children was communications for the researcher to develop relationships with them. When these communications were responded adequately emotional dependence could be established in the new dyadic relationship (Auhagen & Hinde, 1997).

#### **4.4.2 Pattern observed in the dyadic relationship**

The initial behaviour of the children to a stranger in the present study reflected their individual relationship history. Faizal, Rahul, Navaz, Radhika, Nithin, and Vinaya were resisting in the new relationship, whereas Seema, Bhavya, Rajeev, Naveen (smile filled with shyness) and Stanley were welcoming a new relationship. We have seen in the case analysis that the relationship histories of Faizal, Rahul, and Radhika were problematic at home, while Nithin, Vinaya and Navaz experienced difficulties with the services in the school. Presumably they developed a negative schema from such relationships and generalised to new ones. Seema, Bhavya, Rajeev, Naveen and Stanley were inviting the new relationship. We have seen that all these four children had good relationships at home. By virtue of their skills they were not given some specific services in the school. Therefore, they had good relationships with even the teachers. May be this resulted in a positive schema (discussed in section 4.2.1.1) reflected in the new relationship.

The general understanding of children with Down syndrome is that they are friendly and sociable. However, this was not the pattern observed in the present study. Faizal, Radhika, Vinaya, Seema, and Bhavya were children with Down syndrome.

Among them only Seema and Bhavya were friendly and sociable from the initial interaction. All the others took time to initiate. While Faizal and Vinaya became friendly in few days, Radhika took really long. We have seen in the previous section that Faizal, Radhika and Vinaya had issues related with their past relationships. Therefore, from this it could be well thought out that even the general behaviour characteristics cannot be taken as a mark for studying relationships. From the individual analysis, it was very clear that the issues in the past relationships made them to generalise their perception to the persons in the new relationships. This negative attitude had to be removed to develop an attachment relationship with each of these children. This change in attitude was possible through a sensitive kind of interaction, which ensured the emotional needs of the children. All the children (Faizal, Rahul, Navaz, Radhika, Nithin, and Vinaya) responded to the interactions with high intensity and developed close relationship. However, this process of change in attitude is not smooth especially given the institutional set up in which existing intervention takes place. Therefore, a realistic alternative intervention plan should identify the factors that may come on the way of evolving a working relationship as described above.

#### **4.4.3 The effectiveness of the dyadic relationship**

The changes as we have seen in the individual analysis in all the children were the reflections of the assurance of attachment security in them. These changes were the reflections of the re-establishment of attachment security as it was in the prolonged infancy stage.

##### **4.4.3.1 Emotional dependence is guaranteed in the dyadic relationship**

We have seen in the previous section that the life long dependence agreement of majority of the children was under severe threat. For Faizal, Radhika and Rahul the

dependence at home itself was under threat. Although Rahul found the school providing a base for his desire to develop social relationships, Faizal and Radhika did not find their desire to engage in a close attachment relationship are met in the school. Even though, they had other relationships, as mentioned in the previous section their behaviours reflected that they were missing an attachment relationship, which could ensure their emotional security and subsequent happiness. Therefore, when they could form an attachment relationship with the researcher, they tried to remain in that dyadic level. Presumably they were experiencing the same kind of happiness if they had a sensitive maternal level interaction at this stage. We have seen that both Faizal and Radhika were not on an attachment relationship with the mother. For Faizal this was due to lack of sensitive interaction from the mother in the prolonged infancy stage, whereas in Radhika this was due to the sudden death of her mother at five.

As we saw in section 1 Radhika's desire to spend long periods of time with the researcher was in fact the best responsiveness from Radhika. Through this she seemed to have going back to the stage of her sensitive dyadic level of interactions with her mother. After the death of the mother, it was likely that her emotional dependence was threatened and no other relationships were able to counteract the threat. However, when she was involved in almost similar kind of dyadic relationship with the researcher, her behaviours reflected the change the relationship brought in her. The only possible reason of this could be the fact that the dyadic relationship with the researcher was capable enough to ensure the emotional dependence she was missing in all the other relationships. Presumably, after the death of her mother she was never involved in such a close relationship with anyone.

Unlike Radhika, Faizal never had an attachment relationship with anyone. Therefore, it could be considered that he was looking for one of that sort throughout

his life, may be through his challenging behaviours. We have seen in section 1 that Faizal too spent long periods with the researcher exactly like Radhika. When a strong dyadic attachment relationship was developed, Faizal's communications changed to other levels in the interaction. He could even empathise with the researcher in many occasions (see section 4.1.1). His challenging behaviours gave way to empathy as discussed in section 1. This was a clear expression of the attachment security he received in the interactions with the researcher. May be this was for the first time he was engaged in a relationships where his needs are met.

The family members and the service providers treated the unusual behaviours (challenging behaviours in Faizal and sitting alone or engaging in busy activities in Radhika) in Faizal and Radhika as deficits resulted from the condition of mental retardation. However, in the interactions with the researcher, these behaviours were considered as effective communications of their inner most desire to have an attachment relationship. Both children responded to this approach of the researcher with high intensity. Rather than the school situation, the issue for them was rooted at home. However, it was likely that none in their life identified this aspect, but treated their issues as resulted from the condition of mental retardation. This is a serious issue, because any unusual behaviour is put in the category of mental retardation and receives systematic treatments. Although Rahul had problems rooted at home, his case was different. He couldn't develop an attachment relationship with the grandmother on the reason that he was a boy with mental retardation. The dyadic relationship with the researcher helped him to have more social relationships, which was a step towards his integration into the family.

Among the other children, the dyadic relationship helped Navaz and Nithin to overcome the stigmatisation to a great extent by making friendships with the

researcher. Both of them had difficulties to accept the fact that they had moved from mainstream to special school. The treatments in the school, especially the one-sided communication, presumably put them under more stigmatisation. It was likely that due to the heavy emphasis on the academic activity in the school, both of them could not develop an attachment relationship with the service providers. More over, in the case of Nithin, the unrealistic expectation of the mother about his abilities had put him under real stress. Therefore, when he could engage in a relationship to foster his emotional needs, he responded to it with much enthusiasm. For Navaz, apart from reducing stigmatisation, his aspiration to go to abroad was strengthened as a result of the dyadic relationship. Here the major difference between the approach of the researcher and the service providers in the school was that of providing freedom for the children to express their desires rather than imposing something on them.

The change in Stanley was slightly different from other children. Since Stanley was a child who was troubled with social insecurity, he did not have any close relationship with anyone. Although he was fond of his teacher, his behaviour reflected that the teacher was a temporary relief in threatening situations. The relationship with the researcher was also a tool for him to seek protection in the threatening social situation. Since Stanley had problems in interacting with the social world, he was never content to limit himself in the dyadic relationship. Infact he used the dyadic relationship with the researcher as a basic step to develop more social relationships. The major difference between the school's approach and the researcher's approach here was the perceptual difference in the atypical behaviours of Stanley. The researcher considered the atypical behaviours as communications from Stanley, whereas the school considered these as a nagging behaviour from Stanley.

We have seen in Vinaya that she was troubled with all the deficits services. Although this was common for most of the participants, this was more problematic for Vinaya. Her response with the service providers and the researcher was a clear expression (explained in section 4.1.10) of how she has benefited from the dyadic interaction with the researcher. The case of Bhavya was different from all the other participants. We have already seen that Bhavya was in a number of dyadic relationships, which fostered her emotional needs. The new dyadic relationship helped her to boost up the ones she had already. This was almost similar in the case of Seema as well. However, since Seema was in the academic class with the pressure on putting more efforts on the academic skills, her happiness in the relationship with the teacher was comparatively less. Her clinging behaviour in the dyadic relationship was a reflection of the attachment she could establish with me. The changes of Naveen and Rajeev will be discussed later in the section. The table below gives the change in behaviour of the participants due to the close relationship with the researcher.

**Table 4.1: The major behavioural change resulted in the children from the dyadic relationship with the researcher**

<b>Names</b>	<b>Initial Behaviour</b>	<b>Change in behaviour</b>	<b>Comment</b>
Faizal	He exhibited challenging behaviours quite often	His challenging behaviours were reduced and he could empathise in the dyadic relationship with the researcher	The behavioural change was an indication of the attachment security he obtained in the relationship
Nithin	He was nervous, frightened, socially secluded	He became socially active, happy and interacting	The pressure on him was so high that he developed stuttering during the process, however sensitive interactions from mother, teacher and the researcher together reduced his stuttering
Radhika	She was lonely and unhappy	Her emotional involvement in interaction and general happiness increased; she was keen on to stick to the dyadic relationship	Her tendency to stick to the dyadic relationship indicated the re-establishment of power-dependence in the relationship
Rahul	He was a secluded boy due to the rejection of the significant members of his joint family	He could integrate his active individual side and passive social side to develop more social relationships in the dyadic relationship	His tendency to develop more social relationship was an indication of his desire to develop an identity (we-self) in the joint family
Seema	She hugged and kissed the people whom she was attached to	She hugged and kissed the researcher quite often in the dyadic relationship	This clinging behaviour is a reflection of the attachment relationship
Naveen	He was extremely shy and lacked eye contact	His shyness reduced and developed eye contact with the researcher in the relationship	Shyness was a mechanism for developing social relationships
Bhavya	She was sociable and inviting in the relationship	She integrated her recognition and the dyadic relationship to develop more social relationships	Her desire to develop more social relationships was an indication of her desire to have more recognition in the society
Rajeev	He was happy and sociable	Empathy in the relationships	The relationship could bring out an important emotion (empathy) in him
Navaz	His behaviours reflected stigmatisation	His power boosted up and relief from stigmatisation	Indulging in close relationship with non-disabled people is a mechanism to overcome the stigma
Vinaya	Dependency was threatened due to deficit services	Provided a comfortable situation through the dyadic relationship	The attachment relationship benefited other deficit services
Stanley	He was socially insecure reflected through his complaining and questions	The interactions helped him to find out another source of support in threatening social situations	The relationship provided him a temporary relief.

Due to the heavy emphasis of services to independence, the emotional dependence of all the children in the relationships with the service providers was likely to be threatened. However, the new dyadic relationship with the researcher proved that they could establish the dependence even in school amidst of all the services. Although, nothing was specifically done to sustain these behavioural changes in the children, some of the children sustained the behavioural changes even later. For example, in the case of Radhika, the reports of the teachers and my observation after a gap of one year showed that Radhika could sustain the happiness she experienced in the dyadic relationship even later. May be the security of emotional dependence she received in our dyadic relationship led her to a new sphere of emotional independence. At the moment, I'm unable to look into it, but set this as a future concern of this case.

The implication of this finding in the study is that special schools on their strive to do services for the children with mental retardation do not consider the emotional well being of these children. As we saw in the previous section, the result of this is disagreement in the interaction. This focus of the special schools to make the child independent through a number of structured services seemed to be against the wish of the life long dependency of the child. When importance is given only to the functional independence, the emotional dependence of the child is under threat. There should also be measures to protect the child's emotional security while carrying out services for functional independence. Therefore, alternative relationships should be encouraged in the special education settings.

#### **4.4.3.2 Bringing out empathy in children**

An incredible realization of the study was to learn about the empathic ability of children with mental retardation. We have seen in section 1 that how Faizal and

Rajeev responded while the researcher was in distress. While Rajeev fed me with his lunch on the realization that I was missing lunch, Faizal massaged me few times when I got hurt and reacted to the one who caused my pain. The same attitude of empathy could be observed in Stanley as well on knowing that I had fever. The dyadic relationship with the researcher was capable enough even to arise the feelings of concern and empathy in them, in the similar sense it happens with normal developing children. When they received an empathic concern from the researcher, they could also respond to it in the same intensity. Normally the relationships in the school (and at home) do not provide an opportunity for the child with mental retardation to express such intense desires of the children. By lack of opportunity, I mean the relationships are not strong enough to produce empathy in either of the partners. This aspect of the relationship paradigm has been hardly touched by the researchers too.

The above discussion brings an important aspect of the relationship ability of children that they could empathise in a sensitive interaction. Therefore, based on this result, I argue that people with mental retardation are not due to low relationship skills, as shown in some of the previous studies (see Ritchardson & Ritchie, 1989; Wall, 1998). These studies have focussed only on the relationship skills of people with mental retardation to explain the lack of friendships. We have seen in chapter two that relationship is never a one-sided process (Hinde, 1995); both partners have equal responsibilities in building up a relationship. This aspect was very clear in my research as I had taken pain and cares to develop a strong attachment with the children. Therefore, I would suggest future researchers to look at the skills of both partners before reaching a conclusion on the low relationship skills of people with mental retardation.

#### **4.4.3.3 Emergence of functional independence in the dyadic relationship with the researcher**

An astonishing element occurred in the relationship is the emergence of functional independence in Naveen. We have seen in section 1 that Naveen was neglected in the social activities due to his shyness in interacting in the presence of service providers. His poor communication skills and absence of eye-to-eye contact were considered as obstacles to social interaction. However, when these deficits were considered as assets, he responded well in the relationship with the researcher. Towards the last phase of the study, he responded by developing eye contact with me. Although eye-to-eye contact is one of the foremost elements in social relationships, this was never a barrier in our bonding. May be when the emotional dependence was re-established by giving him special attention, it was able enough to provide him a feeling of worthiness. Although nothing was done to develop any skill in the relationship, the development of a functional skill through an attachment relationship has special implications.

This result gives an alternative framework to develop functional skills. We have seen in the previous section that when the skills are taught in structured framework, conflict results in the interaction. However, as happened in the case of Naveen, social skills can be emerged in a natural way through an attachment relationship. Therefore, the implication of this study is that skills should not be taught in a structured environment, but it would be done in an unstructured environment. In such an approach both the therapist and the child would enjoy the interaction and this would foster the emotional well being of the child with mental retardation. Although in our interactions I never intended to develop eye contact in Naveen, the interactions were so powerful that this behaviour has emerged in him in a very natural way

through a natural process. So my argument is that, the child need not be put in the structured environment to develop some social skills. This result gives implications for further research of the same kind in developing functional skills in children with mental retardation. This result also gives implications for a new approach for skill training programmes in the school.

#### **4.4.3.4 Interpersonal chemistry among the children during the 10 months interactions with the researcher**

One of the major achievements of the study was the formation of dyadic, triadic and group networks between the children (participants and non participants in the study) themselves. We have already seen that the snack time, lunch time, lunch break, travel in the school were some of the situations where the researcher could interact with the children in their group. During the lunch break in the hall, everyone could meet each other. There were hardly one or two sat with me in the beginning of the study. But later on, the circle increased in circumference day by day. Not only the participants in the study, but also some other children joined the group. Thus, towards the end of the study, the circle around the researcher increased in size.

The interpersonal dynamics of this group was an interesting factor in the study. Let me narrate an example. One day after lunch, when I went to the hall, Seema, Bhavya, Stanley, and Nithin asked me to sit next to them, but they were sitting in different places. Because they were spread out I went and sat beside Vinaya and Radhika. The responses of these four children were amazing. They rushed to me, pulled and pushed each other to get a place beside me. When everyone secured a comfortable place, Nithin was still searching for the same. Finally, Nithin settled on my lap all of a sudden. Apart from the happiness it brought with, it expressed his freedom with me. This is something the children lack in special schools. This incident

expresses the ability of the children with mental retardation to involve in interpersonal dynamics exactly like normal developing children.

We have seen in section 1 that Radhika led a group in her own class to work against Faizal. One of the major motives of the group members was to work against Faizal. As mentioned in section 4.1.3 Radhika had a negative attitude towards Faizal and those who shared the same attitude joined her for attacking Faizal (Bosson et al, 2006). However, during the interactions with the researcher, an enormous change occurred with this group towards Faizal. They started accommodating Faizal, rather than working against him. The only possible reason of this could be their engagement in a sensitive interaction was strong enough to remove the conflicts and disagreement they had in their own personal capacity. When Faizal was engaged in a strong relationship, his challenging behaviours reduced and the attention given by the teachers also reduced. For Radhika, the satisfaction in the new relationship helped her to interact sensitively to Faizal.

An interesting example for a dyadic relationship could be seen in a joint activity of Nithin and Stanley in the last phase of the study. One day after lunch I told them that I would be going back after the lunch break. Both of them didn't like the idea of me going back and asked me to come to their class. However, I was bound up with my work that I was not in a position to stay back that day afternoon. At two o'clock a surprising thing happened that these two boys took my bag and ran ahead of the teacher aiming their class. I had to follow them and when asked they said to me that they knew I would come to their class to collect my bag. In this incident, the coordination of a number of activities could be seen with these two boys. First of all it expressed their intimacy with me. Secondly, it expressed their ability to bond together and do a cooperative activity. In this incident, I had observed that when I told them I

won't be coming to the class in the afternoon, they both were sitting together and whispering something, and looking at me in between. It never strike to me that they were planning something against me. I never thought they would do some activity together with such a good cooperation. Here, even my conviction about children with mental retardation was different and they proved me that I was also wrong. The differences between the school's approach and my approach could be very evident in this incident. The response of the teacher towards this incident was shouting at the boys, whereas I saw this incident as something, which expresses the child's ability to coordinate, and cooperate activities. All the participants except Faizal and Radhika were looking beyond the dyadic relationship formed between the researcher and the participants. All of them were eager to integrate someone (may be parents or siblings or some other friends) in the relationship. This is a clear expression of their desire to develop social relationships or become a part of the wider society.

From the above discussion and the discussions in section 1 clearly indicates that people with mental retardation are involved in a wide range of relationships. This also shows that people with mental retardation do have relationship skills and ample opportunity to develop relationships. This finding is against the general findings of people with mental retardation that they are lonely and lack friendships (Richardson & Ritchie, 1989). The primary variation is in the cultural difference. These studies have done in Western countries where individual living is encouraged. Moreover, these studies have done on people with mental retardation that live independently in either flats or some homes. The situation may not be true in India due to the cultural difference. According to our culture, independent living for people with mental retardation is never a matter of discussion as we give emphasis to group living. Apart from this, relationship researchers have pointed out on the applicability of

relationships that because norms may differ markedly between societies, and between cultures and subcultures within societies, they may hinder communication and generate misunderstanding between those attempting to cross the boundaries (Hinde, 1995). Therefore, I argue that unlike Western studies, the people with mental retardation in India do have social opportunities to develop social relationships and they are not lonely just because they are born as a child with mental retardation, but the issue was that of lack of sensitive interaction.

#### **4.4.3.5 Change in the approach of the teachers towards children**

A remarkable achievement of this research was that of the changes occurred in the approach of the teachers while interacting with the children. We have seen that Nithin developed stuttering (selective stuttering to the teacher and the mother) on the face of pressure to develop academic skills. It was also noted that his stuttering was reduced when the approach of the mother and the teachers changed (explained in section 4.1.2). In this case, while I saw Nithin's stuttering as a reflection of his frustration, the mother and the teachers saw it as a problem, which needed to be treated. This approach of the teachers and the mother were in fact a reason for increasing the intensity of stuttering. Although the present study did not have a focus on either increasing skills or decreasing undesirable behaviours, the specific condition of Nithin aroused during the study period, made the researcher to look for some measures to reduce his stuttering. The series of discussions between the mother, class teacher and the researcher pointed out the need for sensitive interactions with Nithin. The discussions also pointed out the need for viewing his stuttering as an intense message from him about his difficulties in the interactions.

A second change observed among the teachers is the reduction of punishment for the simple mistakes for children with mental retardation. We have already seen that Faizal was the one who received maximum number of punishments in the school. Towards the end of the study, not only with Faizal, but also with other students the frequency and the severity of punishments reduced in the school. Therefore, the present study brought some remarkable changes even in the punishment system of the school.

#### **4.4.4. Concluding remarks**

In section 4.1 we have seen the individual case analysis of each of the participants. The section analysed the relationship of each of the children in the family, school and the new attachment relationship. Section 4.2 talked about the relationship pattern of the children in their family and school drawing inferences from the previous section. The general pattern reflected the desire of the children to engage in a secure relationship with an attachment figure. Inability to form a secure attachment results in conflicts, which was discussed in section 4.3. The reduction of the conflicts through an attachment relationship was the subject matter of section 4.4. By developing an intimate relationship with each of the 11 children, the researcher studied the possibility of developing an attachment relationship with children with mental retardation.

One of the major arguments about loneliness in people with mental retardation is that they are due to low relationship skills (Wall, 1998) and social skills (Luftig, 1989; Richardson & Ritchie, 1989). The base of this argument lies with the reference to social skills in the definition of mental retardation. As we saw in chapter two, a major characteristic of mental retardation is the limitations in adaptive behaviour as

expressed in social skills (Luckasson et al, 2002). Therefore, any behaviour, which is not appropriate in a social situation, is viewed as the child's lack of adaptive skill originated from the low relationship skills. The above explanation has given emphasis only on the skills to define the relationship quality of people with mental retardation. However, relationship researchers have pointed out that each relationship involves a series of interactions (Hinde, 1997) between two individuals (Hinde, 1995). Therefore, relationships have properties that are not predictable from the characteristics of either participant alone. The implication of this theory is that the quality of the relationships in people with mental retardation is not dependent only on the behaviour of this marginal section of the society, but also dependent on the skills and interactions of the people who work with them.

Therefore, based on the present study, I argue that the relationships of people with mental retardation cannot be explained only by looking at the skills of either of the partners. Relationship is something, which cannot be explained just by looking at the skills of one partner. Not only the skills of the children, but also the skills of both partners involved in relationship need to be verified. A person's skills may be more active with one partner, but need not be with another partner. However, this present study explains that there are other aspects than skills to form relationships. The communication and interaction of both the partners are important to study relationship. By looking at the interactions between the child and the other person, the relationship quality can be well explained. To consider interactions, the initial behaviour, the nature of interactions, the time taken to respond, the duration of the interaction, and the interchanges in the interaction need to be considered. The interactions, which provide maternal element, sibling satisfaction and peer satisfaction are very important in developing relationships with children with mental retardation.

Along with this, the communication of the persons with mental retardation also needs to be taken into consideration. Rather than looking at the verbal communications, the non-verbal communications and the unusual behaviours are effective communications from children with mental retardation. Any unusual behaviour, which is not a characteristic of mental retardation, should be considered as communications.

*Chapter 5*  
***Summary and Conclusion***

## Summary and Conclusions

This chapter is organised into four sections. The first section (5.1) gives an overview of the research objectives and the methodology adopted. In the second section (5.2), I return to the three research questions raised in the first chapter, and summarise the main findings. The third section (5.3) discusses the educational suggestions for implementation. The last section (5.4) gives the methodological contributions of this study and suggestions for further research.

### 5.1 Objectives and Methodology

The overall aim of the study is to generate psychological insights regarding mental retardation through developing an intimate relationship with children with mental retardation. However, it was disaggregated to three sub-objectives.

i) To study the possibilities of developing an intimate relationship with persons who have mental retardation. (ii) To understand the life pattern and relationship pattern of persons with mental retardation. (iii) To identify the emotional and social issues of persons with mental retardation.

The study, with an exploratory design, adopted qualitative methodology. The study had two distinctive stages. In the first stage four different schools for children with mental retardation were visited to study the nature of interventions used in the schools. In the second stage, one school was narrowed down and 11 participants were selected. The researcher had attempted to build an intimate relationship with each of the participants. The interaction continued for one academic year. Further, the significant people related with them were interviewed. Based on all these, individual level analyses were prepared. Also, some generalizations regarding the emotional and social life of persons with mental retardation were derived from the case analysis.

## **5.2 Major findings**

This section summarises the main findings of the study. The first research question of the dissertation was to study the possibilities of developing an intimate relationship with persons who have mental retardation. This has been explained in section 5.2.3. However, before turning to this question, I have summarised the findings from other two objectives. The first objective could be fulfilled only by carrying out the latter objectives. Therefore, section 5.2.1 discusses how a general pattern of relationship (as the children with mental retardation develop in their life cycle) could be drawn from the individual cases studied in this research. Section 5.2.2 talks about the emotional and social issues in the relationships of children with mental retardation.

### **5.2.1 Pattern of relationship in children with mental retardation**

Owing to the condition of mental retardation, children who were studied as cases in this research are comfortable to remain in a 'power-dependent' relationship with a significant adult. This pattern originates through an extended period of interaction with the mother in the prolonged infancy stage (see section 4.2.1.1). The mutual exchanges in the prolonged infancy stage result in an agreement between the child and the mother about the kind of relationship. The parents agree to support and care their child with mental retardation by internalising the difficulty of their child to come out of the status of a child, whereas the children learn that the parents are capable enough to support her/him by internalising the authority of the parents. Through this the child develops a positive 'schema' about future relationships. Therefore, the 'power-dependence' could be considered as a reflection of the attachment security between the mother and the child. In the present study it was

observed that children with mental retardation are happy and content in the interactions, which ensured attachment security. The most satisfying relationship in the lives of children with mental retardation was observed to be the dyadic (child-mother) relationship with the mother. However, the intensity differed based on the nature of mother-child interaction. All the other relationships of the child with mental retardation depend on this dyadic relationship formed with the mother (see sections 4.2.1 and 4.2.2).

Just like any other normal developing children, the mother leads the child with mental retardation to other relationships whether it is in the family or in the school. The mother conveys the agreement to all the other members of the family in due course and makes each one a part of the agreement. Therefore, the child enjoys the relationships with the family members. However, in the case of children with mental retardation, the mother breaks the agreement and joins hands with the service providers to make the child independent at school. This is because the service providers formally train children with mental retardation to develop functional skills. At this stage, conflict occurs between the functional independence and the child's life long dependence. Therefore the child seems to form a new 'schema' different from the one mentioned above, about the kind of relationship at this stage (see section 4.3). The new relationships are viewed with a negative attitude. It needs a genuine effort from the partners in the new relationship to change this attitude. This change in attitude is the reflection of the child experiencing the attachment security as it was agreed in the prolonged infancy stage with the mother. This general pattern can explain all the cases. However, the pattern itself can be seen as a continuum on which the cases like Seema (close attachment with the mother) and Faizal (very little attachment with the mother) vary. This variation in pattern could be explained by the

nature of interactions (Radhika) and the intensity of support services (Vinaya) received by children with mental retardation.

### **5.2.2 Emotional and social issues in the relationships**

The key issue in the relationships of children with mental retardation is the specific nature of conflict in interaction. Since the agreement between the mother and the child in the prolonged infancy stage is to ensure the attachment security of the children, anything that interferes with this pattern leads to conflicts. This generally originates in the family and extends to school. Primarily, when the parents join hands with the service providers, the collective power of the parents and the service providers become a threat to the child's dependence (see section 4.3.2). The relationships in the family ensure dependence until the child undergoes some services, whereas this situation changes with the onset of some services. This is because the services focus only on the functional independence, but neglect the emotional security of the children. The consequences of such services are conflict and disagreement in the interaction. In this process, the parents break the power-dependence agreement formed in the prolonged infancy stage. Subsequently, the child expresses disagreement in the interactions with service providers and the parents, especially when they are involved in a network of relationships (child-mother-teacher, child-mother-teacher-professionals) to work against the wish of the child's dependence.

Secondly, due to either lack of interaction or absence of interaction, the child does not receive an opportunity to ensure dependence with a significant adult (see section 4.3.1). Since the prolonged infancy is an expression of the child's life long dependence, there should be sensitive interactions between the child and a primary care giver to establish attachment relationship. However, there are situations where this sensitive interaction between the child and the mother did not occur in the

prolonged infancy stage. In this situation, the child's instinctual desire for life long dependence is threatened and this result in all the later relationships. There are other situations like the sudden loss of the attachment figure; the birth of the younger sibling, over protectiveness of the parents, and sometimes the traditional beliefs of the family can also be threatening situations for the child's life long dependence with the attachment figure.

### **5.2.3 Possibility of developing an intimate relationship**

The possibility of developing a relationship with children with mental retardation was studied by the researcher through developing a relationship with each of the participants. In the course of a period of 10 months interaction, the researcher could develop an attachment relationship with each of the 11 children. This was possible because the relationship could re-establish the agreement formed with the mother in the prolonged infancy stage. The interactions focussed on those key factors, which were absent in the relationships of the children with mental retardation, especially in the school. The first one was that of its focus on a maternal style, which was against all the other interactions in the school (see section 4.4.1.1). In the interaction, all the unusual behaviours or the so-called 'problem behaviours' were considered as communications from the children instead of 'deficits' (see section 4.4.1.2). And the final element was that of providing an opportunity for the children to develop trust on me through mutual exchanges reflecting peer group interaction (see section 4.4.1.3). When all these elements were combined the interactions were very innovative in an institutional set up. However, the focal point of the interactions between the children and the researcher was that of responding to the individual needs of each of the children.

The dyadic interaction helped each of the children individually to either establish or re-establish the 'power-dependence' relationship. For some children, like Radhika and Faizal, it helped them to establish an attachment security of the kind with the mother. Rahul found this relationship as a strong base towards his desire to integrate with his joint family. In the case of Seema, and Bhavya, the dyadic relationship helped them to boost up their already comfortable stage of interactions. For Vinaya, the attachment with the researcher provided more security in deficit based services. Navaz and Nithin, observed this dyadic relationship as a means to overcome the stigmatisation they experienced. Emerging a social skill, for example, looking into eyes, was the direct behavioural change of this approach in Naveen. For Rajeev, the dyadic relationship was even capable of bringing out a remarkable relationship skill of empathy underlined in him. A temporary relief from the threatening social situation was the outcome of this in Stanley (see section 4.1). Virtually, the child's life long emotional dependence is ensured in this new relationship, but indirectly this relationship takes the child to a new sphere of emotional independence. Apart from these individual changes, the dyadic relationship provided the participants with a group security through the formation of a number of informal groups during the 10 months study. Thus, the researcher's role was that of a catalyst which could trigger the beginning of a new series of healthy relationships. Along with the changes in the children, few important changes occurred in the approach of the teachers and the carers towards children with mental retardation, for example, reduced punishment and increased sensitive interactions (see section 4.4.3.5).

### **5.3 Educational suggestions for implementation**

There is a need to distinguish between the needs of the children, needs of the parents and the needs of the service providers. During the relationship development process, I could observe the differences between the needs of all these three groups and the resultant conflicts in the process of meeting these needs. The parents' needs and the service providers' needs are almost similar to make the children independent in most of the situations. However, most of the time, the needs of the children are to ensure emotional security rather than the functional independence. This aspect is neglected due to the emphasis on support services. Therefore, schools should have a sensitive interaction to foster the emotional needs of the children with mental retardation. As we have seen in the study, ensuring this emotional security may lead to emotional independence and eventually the psychological freedom in the children. Since the roles of the teachers and other service providers are defined roles, it is not fair to expect them to provide sensitive interactions throughout. An alternative suggestion is the appointment of some professionals who can provide individual attention to the children.

Parental involvement is another suggested approach in the schools. Although the parents come quite often to the school, most of the time the opportunities to exchange information do not occur. Therefore, one of the important requirements in the schools is an opportunity for a proper exchange of information between the parents and the school. In the present day education of children with mental retardation, this exchange is only about the limitations and the required functional skills of the children. This approach needs to be changed for the emotional well being of the children, parents and the service providers in the school. Parents should have more opportunity to exchange information about the simple to complex behaviour of

their children with other parents and teachers. Since schools are the primary community sphere for children with mental retardation, this is the best opportunity for the parents to meet other parents of the same kind.

Siblings of children with mental retardation are another group who should have timely meetings in the school. Unlike Western countries, in India, friendship outside family and school is difficult for children with mental retardation. This lacuna can be compensated through adequate programmes for the siblings in the school. We have seen in the present study that some of the children were keen on developing friendships with non-disabled peer group. The meetings of the siblings in the school should be an appropriate strategy to meet these needs of the disabled children. Rather than the meetings focus only on non-disabled sibling interaction, it should have opportunity for the mutual interaction of both disabled and non-disabled siblings. While in the parent group children are more protected, this group can provide more space for mutual interaction. Therefore, both disabled and non-disabled siblings will be benefited from this quite a lot. This would create positive feelings in the children with mental retardation, whereas such programmes would help the siblings to cultivate tolerance with their disabled siblings.

Another implication of this study is the importance of opportunities for friendships among the students in the school. Although our schools have ample opportunity to develop friendships between the students, the academic classes in the special schools are obstacles to this. Since the academic classes in the special schools provide a heavy-emphasis on developing the academic skills of the children, it could be observed that there are hardly any opportunities for interaction among the students. This result in more conflicts among the children and therefore this situation needs to

be changed. There should be opportunities for more exchanges and interaction in the academic classes.

A further important observation in the study was that of attributing any unusual behaviour in the children to the condition of mental retardation. This leads to adopt either inappropriate interventions or no interventions. Both approaches put the children under more conflict. Therefore, before classifying any unusual behaviour as resulted from mental retardation, there should be a thorough investigation about the needs of the children. For this purpose, parents, siblings, and service providers may meet together. This would provide a multi faceted perspective on the unusual behaviour of the child with mental retardation.

Finally, the study gives implications for the importance of unstructured settings for carrying out interventions. In a special educational set up, there are many opportunities for developing a skill in an unstructured environment. For example, it could be during the leisure hours, during lunchtime, in the school bus, or during the different games when all the students gather. Normally the interventions take place in the therapists' room or in the classroom. Both settings are able to create frustration in the children, as the focus of the therapy is the primary factor here. On the other hand, if the same interventions done in a more relaxed environment, the children would also be more relaxed and the effectiveness of the interventions would be more visible without much delay. A natural question would arise in such an approach about the 'distraction' in the above-mentioned environment. The answer to such questions lies in the ability and the rapport built by the service provider to attract the children towards her/him.

#### **5.4 Methodological contributions and suggestions for future research**

This study makes some methodological advancement in the discipline of psychology, especially through its grounded theory approach. The study was started with a general research problem of developing an alternative intervention to increase the happiness of children with mental retardation. None of the conventional research methods (for example, survey, tests, behaviour modification techniques, skill training programmes) used in other research provided me an insight into how to go about with my research problem. Therefore, I had to search for a unique methodology to address this issue. Unlike the conventional methods in the discipline of psychology, I used ethnographic methods to learn about the life and issues of children with mental retardation. This search spread out for a year in the exploratory stage helped me to emerge with a clear concept of relationship as the central theme of the study. More over, the exploration also helped in the emergence of the research setting, and the sample (Glaser & Strauss, 1967). The familiarization in the exploratory stage provided me more access to the research setting in the case focussed stage. Maintaining a relationship with everyone in the research setting throughout the study period provided me easy access to data throughout. More over, this approach provided a theory of relationship for children with mental retardation.

Since relationship is a dynamic process, occurring gradually over time (Hinde, 1995), it can be argued that the evolution of relationship can only be studied through long-term qualitative methodologies. One of the key methods employed was that of naturalistic observation for a long period of time compared to a snapshot observation. Rather than knowing it as secondary information, my regular observations for a long period helped me to see how the relationships between the children and others in the school were evolved. To get to know about the complexities involved in the

relationship, one must spend long periods of time in the specific research setting and observe them closely in various contexts. One might say we could study relationship by interviewing the various actors in the relationship. Of course, it is true that those are important data but I should say that in a research on relationship, these interview material could be used only as supporting material to the primary data of developing relationship itself, or knowing the subjects itself.

However, just by observing or collecting information from the significant people, would not be sufficient to experience the process of relationship building. Active, day-to-day involvement in the setting is very important for this purpose. Since my aim in the present study was to build a relationship with each of the 11 cases, it was very important for me to actively participate with them in their group. To experience the actual interaction, an observation without participation was not sufficient. Although some of the children in the present study, at some point articulated about the relationship, most of the time it was difficult to get verbal information from the children. However, the long period of 10 months helped me to look at their behavioural attributions and defences (Hinde, 1995) closely to get information about their subjective feelings in the relationships.

Developing relationship with children as a method poses important concerns. The researcher is in a dual role of observing the children, and observing herself since her subjective experience about relationship could mould the way 'observations' about children are formulated. This epistemological advantage of participatory observation is one of the key methodological advancement in this research.

#### Future research

This study has proposed a theory of relationship for children with mental retardation. The process of breaking the mother-child agreement at the time of

interacting with the service providers need to be tested by looking at a variety of situations. This could be quantitatively tested by examining the relationship skills of the children, parents and service providers. Whether the possession of skills correlates with the communication and interaction pattern is an important aspect to be examined. Further, how the skills contribute to the ability to build relationship and happiness needs to be tested. This testing could be done on children with mental retardation drawn from wide variety of special schools. Important control variables are the attachment of children with mother and other family members, the nature of family, level and type of mental retardation and the initial behaviour in a new relationship.

More participatory and inclusive researches should be encouraged as this helps the researchers, as well as the participants. While quantification has its own advantage, it is qualitative research, which produces robust theories that could be tested using quantitative methods. In psychology, as the qualitative methods are neglected, the information generated by conventional research need not be contextually relevant on various occasions. This lacunae in research tradition need to be addressed, and there is a need to encourage qualitative researches especially on sensitive issues such as relationship needs. Participatory approach on such issues will be able to enter into the world of beliefs of these subjects making substantial contribution to the knowledge body.

Educational strategies need to be researched in its own right. Often research takes place on theoretical issues, and strategies are suggested from these researches. These strategies are adopted in the educational setting and other institutions, which are emanated in the form of national or state policy. Very rarely, the strategies themselves are studied. This is due to the fact that method of research is always separated from the issue of research. Thus, the research on strategy ends up as an

evaluation of the success or failure of a strategy through pre and post-tests. On the other hand, researching the strategy can be done using process approach or constructivist approach. Here strategy itself becomes method.

The perspective emerged from this study indicate that the field of mental retardation is overwhelmed with an orientation generated by applied psychology. More fundamental research studies are needed with an orientation derived from developmental psychology, social psychology, and general psychology. Stress should be given to research methods that are comfortable to the participants, and if possible, helping them in significant ways. The study provides specific implications regarding the perspective, nature of research questions and the methods that can be adopted in further studies.

*References*

## References

- Achen, C., & Snidal, D. (1989). Rational deterrence theory and comparative case studies. *World Politics*, 41(2), 164.
- Ainsworth, M. D. S. (1989). Attachments beyond infancy. *American Psychologist*, 44, 709-716.
- Ainsworth, M. D. S., Blehar, M. C., Waters, E., & Wall, S. (1978). *Patterns of Attachment*. Hillsdale, NJ: Lawrence Erlbaum Associates, Publishers.
- Aloia, G. F., & Macmillan, D. L. (1983). Influence of the EMR label on initial expectations of regular-classroom teachers. *American Journal of Mental Deficiency*, 88(3), 255-262.
- Amado, A. (1993). *Friendships and Community Connections Between People with and without Developmental Disability*. Baltimore, MD: Paul H. Brookes.
- Andrulonis, P. A. (1982). The psychopharmacology of emotionally disturbed and mentally retarded children and adolescents. In I. Jakab (Ed.), *Mental Retardation*. Basel: Karger.
- Argyle, M. (1999). Causes and correlates of happiness. In D. Kahneman, E. Diener & N. Schwarz (Eds.), *Well-Being: The foundations of Hedonic Psychology* (pp. 353-373). New York: Russell Sage Foundation.
- Argyle, M. (2001). *The Psychology of Happiness*. East Sussex: Routledge.
- Argyle, M., & Martin, M. (1990). The psychological causes of happiness. In F. Strack, M. Argyle & N. Schwarz (Eds.), *Subjective Well-being: An Interdisciplinary Perspective* (pp. 77-100). Oxford: Pergamon Press.
- Atkinson, D. (1986). Engaging competent others: a study of the support networks of people with mental handicap. *British Journal of Social Work*, 16(1), 83-101.
- Atkinson, L., Chisholm, V. C., Scott, B., Goldberg, S., Vaughn, B. E., & Blackwell, J. (1999). Maternal sensitivity, child functional level, and attachment in Down's syndrome. In J. I. Vondra & D. Barnett (Eds.), *Atypical Attachment in Infancy and Early Childhood Among Children at Developmental Risks*. Philadelphia: Society for research in child development.
- Attili, G. (1985). The extent to which children's early relationships are adapted to promote their social and cognitive development. In R.A.Hinde, A. Nelly, Perret-Clermont & J. S. -Hinde (Eds.), *Social Relationships and Cognitive Development*.
- Auhagen, A. E., & Hinde, R. A. (1997). Individual characteristics and personal relationships. *Personal Relationships*, 4(1), 63-84.

- Banister, P., Burman, E., Parker, I., Taylor, M., & Tindall, C. (1998). *Qualitative Methods in Psychology: A Research Guide*. Buckingham: Open University Press.
- Barkow, J. H., Cosmides, L., & Tooby, J. (1992). *The Adapted Mind*. New York: Oxford University Press.
- Bartholomew, K. (1993). From childhood to adult relationship: attachment theory and research. In S. Duck (Ed.), *Learning About Relationships* (pp. 30-62). Newbury Park: Sage Publications.
- Batshaw, M. (1997). *Children With Disabilities*. Baltimore: Paul H. Brookes Publishing Co.
- Baumeister, R. F., & Leary, M. R. (1995). The need to belong: desire for interpersonal attachment as a fundamental human motivation. *Psychological Bulletin*, *117*, 497-529.
- Beeghly, M., & Cicchetti, D. (1994). Child maltreatment, attachment and the self-system: emergence of an internal state lexicon in toddlers at high social risk. *Development and Psychopathology*, *6*, 5-30.
- Belsky, J. (1999). Modern evolutionary theory and patterns of attachment. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of Attachment: Theory, Research, and Clinical Applications* (pp. 141-161). New York: Basic Books.
- Bennett, A., & George, A. L. (2004). *Case Studies and Theory Development in the Social Sciences*. Massachusetts: MIT Press.
- Benson, B. A. (1985). Behaviour disorders and mental retardation: Associations with age, sex and levels of functioning in an outpatient clinic sample. *Applied Research in Mental Retardation*, *21* (1), 79-85.
- Benson, B. A., & Havercamp, S. M. (1999). Behavioural approaches to treatment: principles and practices. In N. Bouras (Ed.), *Psychiatric and Behavioural Disorders in Developmental Disabilities and Mental Retardation*. Cambridge: Cambridge University Press.
- Berlin, J., Cassidy, J., & Belsky, J. (1995). Loneliness in young children and infant-mother attachment: a longitudinal study. *Merrill-Palmer Quarterly*, *41*(2), 91-103.
- Bhargava, M. (1994). *Introduction to Exceptional Children*. New Delhi: Sterling Publishers.
- Bird, F. L., Sperry, J. M., & Carreiro, H. L. (1998). Community habilitation and integration of adults with psychiatric disorders and mental retardation: Development of a clinically responsive environment. *Journal of Developmental and Physical Disabilities*, *10*(4), 331-348.

- Bleichrodt, N., & Born, M. P. H. (1994). A meta-analysis of research on iodine and its relationship to cognitive development. In J. S. Stanbury (Ed.), *The Damaged Brain of Iodine Deficiency-Cognitive, Behavioural, Servomotor and Educative Aspects* (pp. 195-200). New York: Cognizant Communication Corporation.
- Borthwick-Duffy, S. A. (1992). Quality of life and quality of care in mental retardation. In L. Rowitz (Ed.), *Mental Retardation in the year 2000*. (pp. 52-68). New York: Springer-Verlag.
- Borthwick-Duffy, S. A. (1994). Epidemiology and prevalence of psychopathology in people with mental retardation. *Journal of Consulting and Clinical Psychology*, *62*(1), 17-27.
- Bosson, J. K., Johnson, A. B., Niederhoffer, K., & Swann, W. B. (2006). Interpersonal chemistry through negativity: Bonding by sharing negative attitudes about others. *Personal Relationships*, *13*(1), 135-150.
- Bowlby, J. (1969). *Attachment and loss: Vol.1. Attachment*. London: The Hogarth Press.
- Bowlby, J. (1973). *Attachment and Loss: Vol. 2. Separation, Anxiety and Anger*. London: The Hogarth Press.
- Bowlby, J. (1979). *The Making and Breaking of Affectional Bonds*. London: Tavistock Publications.
- Bowlby, J. (1980). *Attachment and Loss: Vol.3. Loss, Sadness and Depression*. London: The Hogarth Press.
- Bowlby, J. (1988). *A secure base: parent-child attachment and healthy human development*. New York: Basic.
- Bowley, C., & Kerr, M. (2000). Epilepsy and intellectual disability. *Journal of Intellectual Disability Research*, *44*(5), 529-543.
- Bretherton, I., & Beeghly, M. (1982). Talking about internal states: the acquisition of an explicitly theory of mind. *Developmental Psychology*, *18*, 906-921.
- Bretherton, I., Ridgeway, D., & Cassidy, J. (1990). Assessing internal working models of attachment relationship. In M. T. Greenberg, D. Cicchetti & E. M. Cummings (Eds.), *Attachment in the Preschool Years* (pp. 3-50). Chicago: Chicago University Press.
- Bryman, A. (2004). *Social Research Methods* (2 ed.). Oxford: Oxford University Press.
- Buckley, S. (2002). *Issues for Families of Children with Down syndrome*. Hampshire: DownsEd Ltd.

- Burgoon, M., & Koper, R. J. (1984). Non verbal and relational communication associated with reticence. *Human Communication Research, 10*, 601-627.
- Butz, M. R., Bowling, J. B., & Bliss, C. A. (2000). Psychotherapy with the mentally retarded: A review of the literature and the implications. *Professional Psychology: Research and Practice, 31*(1), 42-47.
- Campbell, D. (1975). Degrees of freedom and the case study. *Comparative Political Studies, 8*(2), 178-193.
- Carr, E. G., & Durand, V. M. (1985). The social communicative basis of severe behaviour problems in children. In S. Reiss. & R. Boozin (Eds.), *Theoretical Issues in Behaviour Therapy* (pp. 219-254). New York: Academic Press.
- Carson, R. C., & Butcher, J. N. (1992). *Abnormal Psychology and Modern Life*. (9th edn.). New York: Harper Collins Publishers.
- Cassidy, J. (1988). Child-mother attachment and the self in six year olds. *Child Development, 59*, 121-134.
- Cassidy, J., & Berlin, L. J. (1994). The insecure/ambivalent pattern of attachment: theory and research. *Child Development, 65*, 971-991.
- Chapman, D. A., Scott, K. G., & Mason, C. A. (2002). Early Risk Factors for Mental Retardation: Role of Maternal Age and Maternal Education. *American Journal on Mental Retardation, 107*(1), 46-59.
- Clarke, D. (1984). *Mentally Handicapped People: Living and Learning*. London: Bailliere Tindall.
- Clarke, D. (1999). Functional psychoses in people with mental retardation. In N. Bouras (Ed.), *Psychiatric and Behavioural Disorders in Developmental Disabilities And Mental Retardation*. Cambridge: Cambridge University Press.
- Clegg, J., & Lansdall-Welfare, R. (1995). Attachment and learning disability: a theoretical review informing three clinical interventions. *Journal of Intellectual Disability Research, 39*(4), 295-305.
- Clegg, J., & Sheard, C. (2002). Challenging behaviour and insecure attachment. *Journal of Intellectual Disability Research, 46*(6), 503-506.
- Crane, L. (2002). *Mental Retardation: A Community Integration Approach*. USA: Wadsworth.
- Cuckle, P., & Wilson, J. (2002). Social relationships and friendships among young people with Down syndrome in secondary schools. *British Journal of Special Education, 29*(2), 66-71.

- Dagnan, D., Chadwick, P., & Proudlove, J. (2000). Toward an assessment of suitability of people with mental retardation for cognitive therapy. *Cognitive Therapy and Research*, 24(6), 627-636.
- Deb, S., Thomas, M., & Bright, C. (2001). Mental disorder in adults with intellectual disability. 2: The rate of behaviour disorders among a community-based population aged between 16 and 64 years. *Journal of Intellectual Disability Research*, 45(6), 506-514.
- Denzin, N. K., & Lincoln, Y. S. (1994). Introduction: Entering the field of qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of Qualitative Research*. Thousand oaks, Calif.: Sage Publications.
- Denzin, N. K., & Lincoln, Y. S. (2003). Introduction: The discipline and practice of qualitative research. In N.K.Denzin & Y.S.Lincoln (Eds.), *Strategies of Qualitative Inquiry*. Thousand oaks: Sage Publications.
- Dindia, K. (1994). The intrapersonal-interpersonal dialectical process of self-disclosure. In S. Duck (Ed.), *Dynamics of relationship* (pp. 27-57). Thousand Oaks: Sage Publications.
- Duck, S. (1986). *Human Relationships: An Introduction to Social Psychology*. London: Sage Publications.
- Duck, S. (1994). *Meaningful relationships: talking sense, and relating*. Thousand Oaks: Sage Publications.
- Duck, S. (1995). Talking relationships into being. *Journal of Social and Personal Relationships*, 12, 535-540.
- Duck, S. (1998). *Human relationships* (3 ed.). London: Sage Publications.
- Duck, S., & Acitelli, L. K. (1996). Sewing the field: the tapestry of relationships in life and research. In S. Duck (Ed.), *Handbook of Personal Relationships: Theory, Research and Interventions* (2 ed., pp. 1-24). Chichester: John Wiley & Sons.
- Dykens, E. M. (2000). Annotation: Psychopathology in children with intellectual disability. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, 41(4), 407-417.
- Elicker, J., Egeland, M., & Sroufe, L. A. (1992). Predicting peer competence and peer relationships in childhood from early parent-child relationships. In R. Parke & G. Ladd (Eds.), *Family-Peer relations: Modes of Linkage* (pp. 77-106). Hillsdale, NJ: Erlbaum.
- Erickson, M. R., Sroufe, A. L., & Egeland, B. (1985). Attachment theory: retrospect and prospects. In I. Bretherton & E. Waters (Eds.), *Growing Points of Attachment Theory and Research. Monographs of the Society for Research in Child Development* (Vol. 50, pp. 147-166).

- Feldman, M. A., Condillac, R. A., Tough, S., Hunt, S., & Griffiths, D. (2002). Effectiveness of community positive behavioural intervention for persons with developmental disabilities and severe behaviour disorders. *Behaviour Therapy*, 33(3), 377-398.
- Field, T. (1996). Expressivity in physically and emotionally handicapped children. In L. M. & M. W. Sullivan (Eds.), *Emotional Development in Atypical Children*. New Jersey: Lawrence Erlbaum Associates, Publishers.
- Firth, H., & Rapley, M. (1990). *From Acquaintance to Friendship: Issues for People with Learning Disabilities*. Kidderminster: BIMH Publications.
- Fletcher, R. J., & Poindexter, A. R. (1994). Current trends in mental health care for persons with mental retardation. *The Journal of Rehabilitation*, 62(1), 23-24.
- Freud, A. (1968). *The Ego and the Mechanisms of Defence* (Revised Edition ed.). London: The Hogarth Press & The Institute of Psycho-Analysis.
- Fridlund, A. J. (1991). Sociality of solitary smiling: potentiation by an implicit audience. *Journal of Personality and Social Psychology*, 60, 229-240.
- Gaedt, C. (1995). Psychotherapeutic approaches in the treatment of mental illness and behavioral disorders in mentally retarded people: The significance of a psychoanalytic perspective. *Journal of Intellectual Disability Research*, 39, 233-239.
- Garvey, K., & Kroese, B. (1991). Social participation and friendships of people with learning difficulties: a review. *British Journal of Mental Sub normality*, 37(1), 17-24.
- Gates, B., Newell, R., & Wray, J. (2001). Behaviour modification and gentle teaching workshops: management of children with learning disabilities\* exhibiting challenging behaviour and implications for learning disability nursing. *Journal of Advanced Nursing*, 34(1), 86-95.
- Gelder, M. G., D., & Mayou, R. (1989). *Oxford Textbook of Psychiatry*. ( Second edition ed.). Walton Street: Oxford University Press.
- Gillath, O., Shaver, P. R., Mikulincer, M., E.Nitzberg, R., Erez, A., & Ijzendoorn, M. H. V. (2005). Attachment, caregiving, and volunteering: placing volunteerism in an attachment-theoretical framework. *Personal Relationships*, 12(4), 425-446.
- Girimaji, S., Zaman, S. S., Wijetunga, P. M., & Pejarasangharn, U. (2001). *Mental Retardation: From Knowledge to Action*. South - East Asia: World Health Organization.
- Glaser, B. G., & Strauss, A. L. (1967). *The Discovery of Grounded Theory*. Chicago: Aldine Publishing Company.

- Grossman, K. E., & Grossman, K. (1991). Attachment quality as an organizer of emotional and behavioural responses in a longitudinal perspective. In C. M. Parkes, J. Steveneson-Hind & P. Marris (Eds.), *Attachment Across the Life Cycle* (pp. 93-114). London: Tavistock/Routledge.
- Guralnick, M. J. (1997). The peer social networks of young boys with developmental delays. *American Journal of Mental Retardation*, 101, 595-612.
- Guralnick, M. J. (1999). Early childhood intervention. In M. L. Wehmeyer & J. R. Patton (Eds.), *Mental Retardation in the 21st Century*. Austin: Pro-ed.
- Guralnick, M. J., Goffman, J. M., & Hammond, M. A. (1996). Effects of social setting on the friendship formation of young children differing in developmental status. *Journal of Applied Developmental Psychology*, 17, 625-651.
- Gutstein, S. E., & Sheely, R. K. (2002). *Relationship development intervention with young children : social and emotional development activities for Asperger syndrome, Autism, PDD and NDL*. London: Jessica Kingsley.
- Hastings, R. P. (1994). On "good" terms: labelling people with mental retardation. *Mental Retardation*, 32(5), 363-365.
- Hastings, R. P. (2002). Parental stress and behaviour problems of children with developmental disability. *Journal of Intellectual and Developmental Disability*, 27(3), 149-160.
- Heiman, T. (2000). Friendship quality among children in three educational settings. *Journal of Intellectual Development and Disability*, 25(1), 1-12.
- Heslop, P. (2005). Good practice in befriending services for people with learning difficulties. *British Journal of Learning Disabilities*, 33(1), 27-33.
- Hinde, R. A. (1979). *Towards understanding relationships*. London: Academic Press.
- Hinde, R. A. (1988). Introduction. In R. A. Hinde & J. Stevenson-Hinde (Eds.), *Relationships within Families: Mutual Influences*. Oxford: Oxford University Press.
- Hinde, R. A. (1995). A suggested structure for a science of relationships. *Personal Relationships*, 2(1), 1-15.
- Hinde, R. A. (1997). *Relationships: a dialectical perspective*. East Sussex: Psychology Press.
- Hinde, R. A., & Steveneson-Hinde, J. (1987). Interpersonal relationships and child development. *Developmental Review*, 7(1), 1-21.

- Holden, B., & Gitlesen, J. P. (2004). The association between severity of intellectual disability and psychiatric symptomatology. *Journal of Intellectual Disability Research, 48*(6), 556.
- Gabel, S. (2004). South Asian Indian cultural orientations toward mental retardation. *Mental Retardation, 42*(1), 12-25.
- Government of India. (2001). *Census of India*.
- Jacobson, J. W. (1990). Do some mental disorders occur less frequently among persons with mental retardation. *American Journal on Mental Retardation, 94*, 596-602.
- Jahoda, A., Markova, I., & Cattermole, M. (1988). Stigma and self-concept of people with mental handicap. *Journal of Mental Deficiency Research, 32*.
- Jakab, I. (1982). Psychiatric disorders in mental retardation - recognition, diagnosis and treatment. In I. Jakab (Ed.), *Mental Retardation*. Basel: Karger.
- Jenkins, C. D., Zyzanski, S. J., Ryan, T. J., Flessas, A., & Tannenbaum, S. I. (1977). Social insecurity and coronary-prone Type A responses as identifiers of severe atherosclerosis. *Journal of Consulting and Clinical Psychology, 45*(6), 1060-1067.
- Jones, W. H., Cavert, C. W., Snider, R. L., & Bruce, T. (1985). Relational stress: an analysis of situations and events associated with loneliness. In S.W.Duck & D.Perlman (Eds.), *Understanding Personal Relationships*. London: Sage.
- Kahneman, D. (1999). Objective happiness. In D. Kahneman, E. Diener & N. Schwarz (Eds.), *Well-Being: The foundations of Hedonic Psychology* (pp. 3-25). New York: Russell Sage Foundation.
- Kakar, S. (1978). *The Inner World: A Psycho-analytic Study of Childhood and Society in India*. Delhi: Oxford University Press.
- Kaplan, H. J., & Sadock, B. J. (1988). *Synopsis of Psychiatry: Behavioural Sciences, Clinical Psychiatry* (5 ed.). Baltimore: Williams & Wilkins.
- Karve, I. (1953). *Kinship Organization in India*. New York: Asia publishing house.
- Kasari, C. L., & Sigman, M. (1996). Expression and Emotion in atypical development: Autism and Down syndrome. In L. M. & S. M. (Eds.), *Emotional Development in Atypical Children* (pp. 109-130). Mahwah, New Jersey: Lawrence Erlbaum Associates Publishers.
- Kashyap, L. (1989). Family's role in providing support to disabled persons in India's changing times. *International Journal of Counselling, 12*, 261-271.
- Kavale, K. A., & Forness, S. R. (1999). *Efficacy of Special Education and Related Services*. Washington, DC: American Association on Mental Retardation.

- Kelley. (1982). 'A rose by any other name is still a rose: a comparative analysis of reticence, communication apprehension, unwillingness to communicate and shyness'. *Human Communication Research*, 8, 99-113.
- Kenrick, D. T., & Trost, M. R. (1997). Evolutionary approaches to relationships. In S. Duck (Ed.), *Handbook of personal relationships* (2 ed., pp. 151-177). Chichester: John Wiley and Sons.
- Khalifa, M. M., & Struthers, J. L. (2002). Klinefelter syndrome is a common cause for mental retardation of unknown etiology among prepubertal males. *Clinical Genetics*, 61(1), 49.
- King, G., Keohane, R., & Verba, S. (1994). *Designing Social Inquiry*. Princeton: Princeton university press.
- Kishore, M. T., Nizamie, A., Nizamie, S. H., & Jahan, M. (2004). Psychiatric diagnosis in persons with intellectual disability in India. *Journal of Intellectual Disability Research*, 48(1), 19-24.
- Knox, M., & Hicksen, F. (2001). The meaning of close friendships: the views of four people with intellectual disability. *Journal of Applied Research in Intellectual Disability*, 14(3), 276-291.
- Koskentausta, T., Iivanainen, M., & Almqvist, F. (2002). Psychiatric disorders in children with intellectual disability. *Nordic Journal of Psychiatry*, 56(2), 126-131.
- Koski, L. R., & Shaver, P. R. (1997). Attachment and relationship satisfaction across the life span. In R. J. Sternberg & M. Hojjat (Eds.), *Satisfaction in Close Relationships* (pp. 26-55). New York: The Guildford Press.
- Kozub, F. M., Porretta, D. L., & Hodge, S. R. (2000). Motor task persistence of children with and without mental retardation. *Mental Retardation*, 38(1), 42-49.
- Krauss, M. W., Seltzer, G. B., & Gordon, R. (1996). Binding ties: the roles of adult siblings of persons with mental retardation. *Mental Retardation*, 34, 83-93.
- Kurtz, S. N. (1992). *All the Mothers are one: Hindu India and the Cultural Reshaping of Psychoanalysis*. New York: Columbia University Press.
- Ladd, G., LeSieur, K. D., & Profilet, S. M. (1993). Direct parental influences on young children's peer relations. In S. Duck (Ed.), *Learning About Relationships* (pp. 152-183). Newbury Park: Sage Publications.
- LaFraniere, P. J., & Sroufe, A. L. (1985). Profiles of peer competence in the preschool: interrelations between measures influence of social ecology, and relation to attachment history. *Developmental Psychology*, 21(1), 56-69.

- Luckasson, R., Borthwick-Duffy, S. A., Buntinx, W. H. E., Coulter, D. L., Craig, E. M., & Reeve, A. (2002). *Mental Retardation: Definition, Classification, and Systems of Supports* (10 ed.). Washington DC: American Association on Mental Retardation.
- Luftig, R. (1989). Estimated ease of making friendships, perceived social competency and loneliness among mentally retarded and non-retarded students. *Education and Treatment of Children, 109*, 200-210.
- Lynch, C. (2004). Psychotherapy for persons with mental retardation. *Mental Retardation, 42*(5), 399-405.
- Main, M., Kaplan, N., & Cassidy, J. (1985). Security in infancy, childhood, and adulthood: a move to the level of representation. In I. Bretherton & E. Waters (Eds.), *Growing Points of Attachment Theory and Research. Monographs of the Society for Research in Child Development* (Vol. 50, pp. 66-104.).
- Main, M., & Solomon, J. (1990). Procedures for indentifying infants as disorganised/disoriented during the Ainsworth strange situation. In M. T. Greenberg, D. Cicchetti & E. M. Cummings (Eds.), *Attachment in the Preschool Years* (pp. 121-160). Chicago: Chicago University Press.
- McAdam, D. B., Zarcone, J. R., Hellings, J., Napolitano, D. A., & Schroeder, S. R. (2002). Effects of Risperidone on aberrant behaviour in persons with developmental disabilities: 11. Social Validity Measures. *American Journal on Mental Retardation, 107*(4), 261-269.
- McConkey, R., & McGinley, P. (1990). A time to be free. In R. McConkey & P. McGinley (Eds.), *Innovations in Leisure and Recreation for People with a Mental Handicap*. Chorley: Lisieux Hall.
- McLeod, J. (2001). *Qualitative Research in Counselling and Psychotherapy*. London: Sage Publications.
- Mills, R. S. L., & Piotrowski, C. C. (2000). Emotional communication and children's learning about conflict. In R. S. L. Mills & S. Duck (Eds.), *The Developmental Psychology of Personal Relationships*. Chichester: John Wiley & Sons, Ltd.
- Minuchin, P. (1988). Relationships within the family: a systems perspective on development. In R. A. Hinde & J. Stevenson-Hinde (Eds.), *Relationships Within Families: Mutual Influences*. Oxford: Oxford University Press.
- Moore, T., & Carey, L. (2005). Friendship formation in adults with learning disabilities: peer-mediated approaches to social skills development. *British Journal of Learning Disabilities, 33*(1), 23-26.
- Morisset, C. E., Barnard, K. E., Greenberg, M. T., Booth, C. L., & Spieker, S. J. (1990). Environmental influences on early language development; the context of social risk. *Development and Psychopathology, 2*, 127-149.

- Myers, D. G. (1999). Close relationships and quality of life. In D. Kahneman, E. Diener & N. Schwarz (Eds.), *Well-Being: The foundations of Hedonic Psychology* (pp. 374-391). New York: Russell Sage Foundation.
- Nezu, C. M., & Nezu, A. M. (1994). Outpatient psychotherapy for adults with mental Retardation and concomitant psychopathology: Research and clinical imperatives. *Journal of Consulting and Clinical Psychology, 62*(1), 34-42.
- NIMH. (1999). *Mental Retardation: A Manual for Psychologists*. Secunderabad: National Institute for The Mentally Handicapped.
- Nixon, C. D., & Singer, G. H. S. (1993). Group cognitive-behavioural treatment for excessive parental self-blame and guilt. *American Journal on Mental Retardation, 97*(6), 665-672.
- NSSO. (2002). *National Sample Survey Organisation: Government of India*.
- Olsson, M. B., & Hwang, C. P. (2001). Depression in mothers and fathers of children with intellectual disability. *Journal of Intellectual Disability Research, 45*(6), 535-543.
- Peck, C. L. (1977). Desensitization for the treatment of fear in the high level adult retardate. *Behaviour Research and Therapy, 15*, 137-148.
- Peled, M., Iarocci, G. & Connolly, D. A. (2004). Eyewitness testimony and perceived credibility of youth with mild intellectual disability. *Journal of Intellectual Disability Research, 48*(7), 699.
- Perlman, D., & Peplan, L. A. (1981). Loneliness. In S.W.Duck & R. Gilmour (Eds.), *Personal Relationships 3: Personal Relationships in Disorder*. London & New York: Academic Press.
- Perlman, M., Siddiqui, A., Ram, A., & Ross, H. S. (2000). An analysis of sources of power in children's conflict interactions. In R. Mills & S. Duck (Eds.), *The Developmental Psychology of Personal Relationships*. Chichester: John Wiley and Sons, Ltd.
- Peshawaria, R., & Menon, D. K. (1991). Working with the families of children with mental handicap in India: various models. *Counselling Psychology Quarterly, 4*, 345-350.
- Peshawaria, R., Menon, D. K., Ganguly, R., Roy, S., Pillay, R. P. R. S., & Gupta, A. (1995). *Understanding Indian Families Having Persons with Mental Retardation*. Secunderabad: National Institute for the Mentally Handicapped.
- Peshawaria, R., Menon, D. K., Ganguly, R., Roy, S., Pillay, R. P. R. S., & Gupta, S. (1998). A study of facilitators and inhibitors that affect coping in parents of children with mental retardation in India. *Asia Pacific Disability Rehabilitation Journal, 9*(1), 46.

- Pettit, G. S., & Mize, J. (1993). Substance and style: understanding the ways in which parents teach children about social relationships. In S. Duck (Ed.), *Learning About Relationships* (pp. 118-151). Newbury Park: Sage Publications.
- Pidgeon, N., & Henwood, K. L. (1996). Grounded theory: practical implication. In J. T. E. Richardson (Ed.), *Handbook of Qualitative Research Methods For Psychology and Social Sciences*. United Kingdom: The British Psychological Society.
- Pierce Clark, L. (1933). *The Nature and Treatment of Amentia*. London: Bailliere Tindall & Cox.
- Planalp, S., & Dexas, K. G. (1994). Using mutual knowledge in conversation: friends as experts on each other. In *Dynamics of relationship* (pp. 1-26). Thousand Oaks: Sage Publications.
- Prager, K. J., & Buhrmester, D. (1998). Intimacy and need fulfilment in couple relationships. *Journal of Social and Personal Relationships*, 15, 435-469.
- Prout, H. T., & Nowak-Drabik, K. M. (2003). Psychotherapy with persons who have mental retardation: An evaluation of effectiveness. *American Journal on Mental Retardation*, 108(2), 82-93.
- Pyles, D. A. M., Muniz, K., Cade, A., & Silva, R. (1997). A behavioral diagnostic paradigm for integrating behavior-analytic and psychopharmacological interventions for people with a dual diagnosis. *Research in Developmental Disabilities*, 18, 185-214.
- Quinn, F. (1986). Associated conditions. In E. Shanley (Ed.), *Mental Handicap - A Handbook of Care*. Edinburgh: Churchill Livingstone.
- Radke-Yarrow, M., Richters, J., & Wilson, W. E. (1988). Child development in a network of relationships. In R. A. Hinde & J. Stevenson-Hinde (Eds.), *Relationships within Families: Mutual Influences*.
- RCI. (2001). *Manual for Training of PHC Medical Officers*. New Delhi: Rehabilitation Council Of India.
- RCI. (2003). *Disability Status India*. New Delhi.
- Reis, H. T. (2001). Relationship experiences and emotional wellbeing. In C. D. Ryff & B. H. Singer (Eds.), *Emotion, Social Relationship and Health* (pp. 57-86). Oxford: Oxford University Press.
- Reis, H. T., & Shaver, P. (1988). Intimacy as an interpersonal process. In S.W.Duck (Ed.), *Handbook of Personal Relationships*. Chichester: UK: Wiley.
- Reiss, S. (1999). Psychopharmacology and mental retardation. In M. L. Wehmeyer & J. R. Patton (Eds.), *Mental Retardation in the 21st Century*. Austin: Pro-ed.

- Richardson, A., & Ritchie, J. (1989). *Developing Friendships: Enabling People With Learning Difficulties To Make and Maintain Friends*. Oxford: Policy Studies Institute.
- Rickard, H. C., Thrasher, K. A., & Elkins, P. D. (1984). Responses of persons who are mentally retarded to four components of relaxation instruction. *Mental Retardation*, 22, 248-252.
- Robey, K. L., Cohen, B. D., & Epstein, Y. M. (1988). The child's response to affection given to someone else: effects of parental divorce, sex of child, and sibling position. *Journal of Clinical Child Psychology*, 17(1), 2-7.
- Robinson, H. B., & Robinson, N. M. (1965). *The Mentally Retarded Child - A Psychological Approach*. New York: McGraw - Hill Book Company.
- Robison, R. J. (2000). Learning about happiness from persons with Down syndrome: Feeling the sense of joy and contentment. *American Journal on Mental Retardation*, 105(5), 372-376.
- Rojahn, J., Matson, J. L., Naglieri, J. A., & Mayville, E. (2004). Relationships between psychiatric conditions and behavior problems among adults with mental retardation. *American Journal on Mental Retardation*, 109(1), 21-33.
- Roland, A. (1988). *In Search of Self in India and Japan: Toward a Cross-cultural Psychology*. Princeton: Princeton University Press.
- Roland, A. (2002). Retrieved 15th June, 2006, from <http://www.sulekha.com/blogs/blogdisplay.aspx?cid=4526>
- Ross, E., & Oliver, C. (2003). The assessment of mood in adults who have severe or profound mental retardation. *Clinical Psychology Review*, 23(2), 225-245.
- Rothbard, J. C., & Shaver, P. (1994). Continuity of attachment across the life span. In M.B.Sperling & W.H.Berman (Eds.), *Attachment in adults: clinical and developmental perspectives*. New York: Guildford press.
- Sarason, S. B. (1953). *Psychological Problems in Mental Deficiency* (3 ed.). New York: Harper and Row Publishers.
- Scherer, K. R., Walbott, H. S., & Summerfield, A. B. (1986). *Experiencing Emotion*. Cambridge: Cambridge University Press.
- Schneider-Rosen, K., & Rothbaum, F. (1993). Quality of parental care giving and security of attachment. *Developmental Psychology*, 29, 358-367.
- Schwabenland, C. (1997/1998). Introduction. In C. Schwabenland (Ed.), *Relationships in the Lives of People with Learning Difficulties*. London: The Elfrida Press.

- Seltzer, G. B., Begun, A., & Seltzer, M. M. (1991). Adults with mental retardation and their ageing mothers: impacts of siblings. *Family Relations*, 40, 310-317.
- Sheehy, K., & Nind, M. (2005). Emotional well-being for all: mental health and people with profound and multiple learning disabilities. *British Journal of Learning Disabilities*, 33(1), 34-38.
- Shinkfield, A. J., Sparrow, W. A., & Day, R. H. (1997). Visual discrimination and motor reproduction of movement by individuals with mental retardation. *American Journal on Mental Retardation*, 102(2), 172-181.
- Silka, V. R., & Hauser, M. J. (1997). Psychiatric assessment of the person with mental retardation. *Psychiatric Annals*, 27(3).
- Silverman, D. (2001). *Interpreting Qualitative Data: Methods for Analysing Talk, Text, and Interaction* (2 ed.). London: Sage Publications.
- Skotko, B., & Bedia, R. C. (2005). Postnatal support for mothers of children with down syndrome. *Mental Retardation*, 43(3), 196-212.
- Slough, N. M., & Greenberg, M. T. (1990). Five-year-olds' representations of separation from parents; responses from the perspective of self and other. *New Directions for Child Development*, 48, 67-83.
- Spinath, F. M., Harlaar, N., Ronald, A., & Plomin, R. (2004). Substantial genetic influence on mild mental impairment in early childhood. *American Journal on Mental Retardation*, 109(1), 34-43.
- Sroufe, L. A., Carlson, E., & Shulman, S. (1993). Individuals in relationships: development from infancy through adolescence. In D. C. Funder, R. D. Parke, C. Tomlinson-Keasy & K. Widaman (Eds.), *Studying Lives Through Time* (pp. 315-342). Washington, D.C: American Psychological Association.
- Sroufe, L. A., & Fleeson, J. (1988). The coherence of family relationships. In R. A. Hinde & J. Stevenson-Hinde (Eds.), *Relationships within Families: Mutual Influences*. Oxford: Oxford University Press.
- Stavrakaki, C. (1999). Depression, anxiety and adjustment disorders in people with developmental disabilities. In N. Bouras (Ed.), *Psychiatric and Behavioural Disorders in Developmental Disabilities and Mental Retardation*. Cambridge: Cambridge University Press.
- Sternberg, R. J., & Hojjat, M. (1997). Introduction. In R.J.Sternberg & M.Hojjat (Eds.), *Satisfaction in Close Relationships*. New York: Guilford Press.
- Stone, A. A., Shiffman, S. S., & DeVries, M. W. (1999). Ecological momentary assessment. In D.Kahneman, E.Diener & N.Schwarz (Eds.), *Well-being: The Foundations of Hedonic Psychology* (pp. 26-39). New York: Russell Sage Foundation.

- Strack, F., Argyle, M., & Schwarz, N. (1990). *Subjective Well-being: An Interdisciplinary Perspective*. Oxford: Pergamon Press.
- Sullivan, H. S. (1953). *The Interpersonal Theory of Psychiatry*. New York: Norton.
- Taylor, B., & Taylor, S. (1998). Gary's story: parents doing intensive interaction. In D.Hewett & M.Nind (Eds.), *Interaction in Action: Reflections on the use of Intensive Interaction*. London: David Fulton Publishers.
- Taylor, R. L., Sternberg, L., & Richards, S. B. (1995). *Exceptional Children - Integrating Research and Teaching* (2 ed.). San Diego: Singular Publishing Group, Inc.
- Thibaut, J. W., & Kelley, H. H. (1959). *The Social Psychology of Groups*. New York: Wiley.
- Thomasulo, D. J., Keller, E., & Pfadt, A. (1995). The healing crowd: process, content and technique issues in group counselling for people with mental retardation. *The Habilitative Mental Healthcare Newsletter*, 14(3), 126.
- Travers, M. (2001). *Qualitative Research Through Case Studies*. London: Sage Publications.
- Trent, S. C., Driver, B. L., Wood, M. H., Parrott, P. S., Martin, T. F., & Smith, W. G. (2003). Creating and sustaining a special education/general education partnership: a story of change and uncertainty. *Teaching and Teacher Education*, 19(2), 203-219.
- Trepanier, N. S. (2005). Toward an ecological risk assessment framework for special education. *The International Journal of Special Education*, 20(1), 1-12.
- Troy, M., & Sroufe, A. L. (1987). Victimization among preschoolers: role of attachment relationship history. *Journal of the American Academy of Child and Adolescent Psychiatry*, 26, 166-172.
- Turner, T. H. (1989). Schizophrenia and mental handicap: an historical review, with implications for further research. *Psychological Medicine*, 19(2), 301-314.
- Van IJzendoorn, M. H., Goldberg, S., Kroonenberg, P. M., & Frenkel, O. (1992). The relative effects of maternal and child problems on quality of attachment: a meta-analysis of attachment in clinical samples. *Child Development*, 63, 840-858.
- Van IJzendoorn, M. H., Juffer, F., & Duyvesteyn, M. G. C. (1995). Breaking the intergenerational cycle of insecure attachment: A review of the effects of attachment-based interventions on maternal sensitivity and infant security. *Journal of Child and Adolescent Psychology and Psychiatry*, 36, 225-248.

- Vaughn, B. E., Goldberg, S., Atkinson, L., Marcovitch, S., MacGregor, D., & Seifer, R. (1994). Quality of toddler-mother attachment in children with Down syndrome: Limits to interpretation of strange situation behaviour. *Child Development, 65*(1), 95-108.
- Veenhoven, R. (1990). Questions on happiness: classical topics, modern answers, blind spots. In F. Strack, M. Argyle & N. Schwarz (Eds.), *Subjective well-being: an interdisciplinary perspective* (pp. 7-26). Oxford: Pergamon Press.
- Wall, K. (1998). *Friendship skills and opportunities among people with learning disabilities*. Norwich: Social Work Monographs.
- Whitman, T. L. (1990). Self-regulation and mental retardation. *American Journal on Mental Retardation, 94*(4), 347-362.
- WHO. (2002). *The ICD-10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines*. Delhi: A.I.T.B.S. Publishers & Distributors.
- Willmott, P. (1987). *Friendship Networks and Social Support*. London: Policy Studies Institute.
- Ysseldyke, J. E., Algozzine, B., & Thurlow, M. L. (1998). *Critical Issues in Special Education*. New Delhi: Kanishka Publishers, Distributors.
- Zetlin, A., & Murtaugh, M. (1988). Friendship patterns of mildly learning handicapped and non-handicapped high school students. *American Journal of Mental Deficiency, 92*, 447-454.
- Ziv, A. (1984). *Personality and Sense of Humour*. New York: Springer-Verlag.

## Case Performa

### 1. Demographic data

Name:

Age:

Sex:

Date of birth:

Place of birth:

Education:

Religion:

Date:

Address:

Informants:

### 2. Prenatal history

Mother's age during pregnancy:

Illness, accidents, falls, medications, trauma, and shock during pregnancy:

### 3. Birth and Early milestone development

Consanguinity:

Nature of delivery: Premature, Full term, Post mature

Birth cry:

Birth complications:

Birth rank:

Major illnesses:

Milestones:

Smiles at others:

Holds head erect:

Puts objects into mouth:

Rolls from back onto stomach:

Uses whole palm to grasp:

Makes sounds 'anna & 'dadda':

Sits without support:

Responds to name:

Crawls:

Stands by holding on to an object:

Holds object with thumb and index finger:

Stands without support:

Says 'amma', 'akka', 'atta', meaningfully:

Walks without support:

Tells own name:

Drinks by self from others:

Shows body parts when named:

Indicates toilet needs:

Speaks in small sentences:

Unbuttons clothes:

Gives meaningful verbal answers to simple questions:

Differentiates big and small:

Identifies boy/girl:

Can button clothes:

Combs hair:

#### **4. Family history**

Parents and other members:

Nature of family: JF, NF

Family background:

History of illness in the family:

Emotional attachment:

Attitude towards family members, friends, relatives, strangers:

**5. Personal history**

**5.1. Psychological**

Tests administered:

Cooperation:

Comprehending instructions:

Behavioural observation:

Tests results:

**5.2. Educational**

Age of school admission:

Separation anxiety:

Number of schools attended-Details:

Attitude towards classmates:

Friends:

Teachers:

Cooperation in teamwork:

**5.3. Medical**

**6. Behaviour pattern**

**6.1. General appearance:**

**6.2. Skill Behaviours**

**6.3. Play:**

Parallel:

Cooperative:

6.4. Leisure activities and interests:

6.5. Creative abilities:

6.6. Sexual history

Secondary sexual growth:

Behavioural problems associated with puberty:

Self care:

Sexual knowledge:

Masturbation:

6.7. Habits: Eating:                      Sleeping:                      Excretory functions:

6.8 Orientation

Time:

Place:

6.9 Unwanted behaviours

Bedwetting, Nail biting, Thumb sucking, Temper tantrums:

\*\*\*\*\*

# Codebook for qualitative data analysis

## Milestones/physiological achievements or deficiency

- Absence of a good care taker
- Absence of birth cry
- Birth date
- Birth order
- Cesarian birth
- Low birth weight
- Delay in development
- Development of eye contact
- Development of trust
- Premature birth
- Prenatal complications
- Presence of birth cry
- Speech impairment
- Full term normal delivery

## Descriptive -situations

- Academic session
- Class room activities
- Colour dress
- Colour preference
- Vocational class
- Playing after lunch break
- Meeting at home
- Meetings with the parents
- Group activities

## Descriptive-dyadic interaction of children

- Interacting during lunch
- Interacting with the parents
- Interaction in the classroom
- Interactions between the cases

## Behavioural observations

- Acceptance
- Approachable
- Attention seeking
- Auto-play
- Competitive nature
- Complaining about others
- Concern
- Continuos interaction
- Cooperative
- Co-ordination of different behaviour
- Curiosity
- Denial
- Defensive attitude
- Deficit behaviour

Desire for individual attention  
Desire to spend time  
Not paying attention  
Encoding  
Encouraged  
Enthusiasm  
Escapism  
Expectations  
Expressed concern  
Expressing oneself  
Expressing the emotions  
Expression of clear love  
Expression of emotions  
Scolding other students  
Beating other children  
Falling things from the hand  
Familiarity  
Freedom in communication  
Freedom in doing his desired activity  
Freedom in interacting  
Freedom to express his emotions  
Touching the genitals  
Stubborn  
Stuttering  
Playing  
Imitation  
Repetitive behaviour

#### Response to interventions

Punishment  
Prolonged punishments  
Dislikeness towards interventions  
Disobedience  
Disobedience to teacher  
Inadequate reinforcement  
Increasing self-esteem  
Motivation  
Making him to write on the blackboard  
Problem behaviours

#### Relationship tendencies

Seeking affection  
Seeking help  
Reciprocity  
Face-to-face contact  
Does not socialize  
Doesnot share  
Smiling  
Seeking proximity  
Poor interpersonal relationship

- Sibling relationship
- Mutual caring
- Intimacy
- Absence of curiosity
- Know the names of the family members
- Leadership skills
- Participating
- Relationship with significant people

Communication patterns

- Responding to physical harm
- Not responding
- Talking
- Listening
- Initiating play
- Invitation to play
- Inviting home
- Gratitude in return
- Mutual understanding
- Physical contact
- Poor communication skills

Personality variations

- General appearance
- Pleasant appearance
- Panic appearance
- Helping nature
- Lazy
- Dominance

Observation of emotions

- Calm
- Empathy
- Fear
- Fear of punishments
- Friendly from the beginning
- Friendship
- Friendship among students
- Gloomy
- Trust
- Hugging
- Stranger anxiety
- Insecurity
- Joy

Researcher's roles/responses to researcher

- Acting one among them
- Approach of the researcher
- Asking me to come to the class
- Asking me to sit next to her

- Asking to make phone calls
- Waiting for the researcher
- Greeting
- Going together in the school bus
- Talking about the researcher at home
- Searching for the researcher
- Obedience to the researcher
- Initial phase of intimate relationship

External issues

- Attitude of the society
- Best student
- Denial of school bus
- Emotional support
- Family constellation
- Family history
- Family size
- Family violence
- Religion
- Financial issues at home
- Medical history
- Paternal deprivation
- Lack of awareness of the parents
- Lack of love and affection
- Income of the family
- Absence of a good care taker
- Illness history in the family
- Parental stress
- Parent-child relationship
- Stress of the teacher
- Health related issues

Secondary data on children

- Class teacher reports
- Complaints of the teacher
- Diagnosis
- Educational history
- Siblings report
- Parental reports

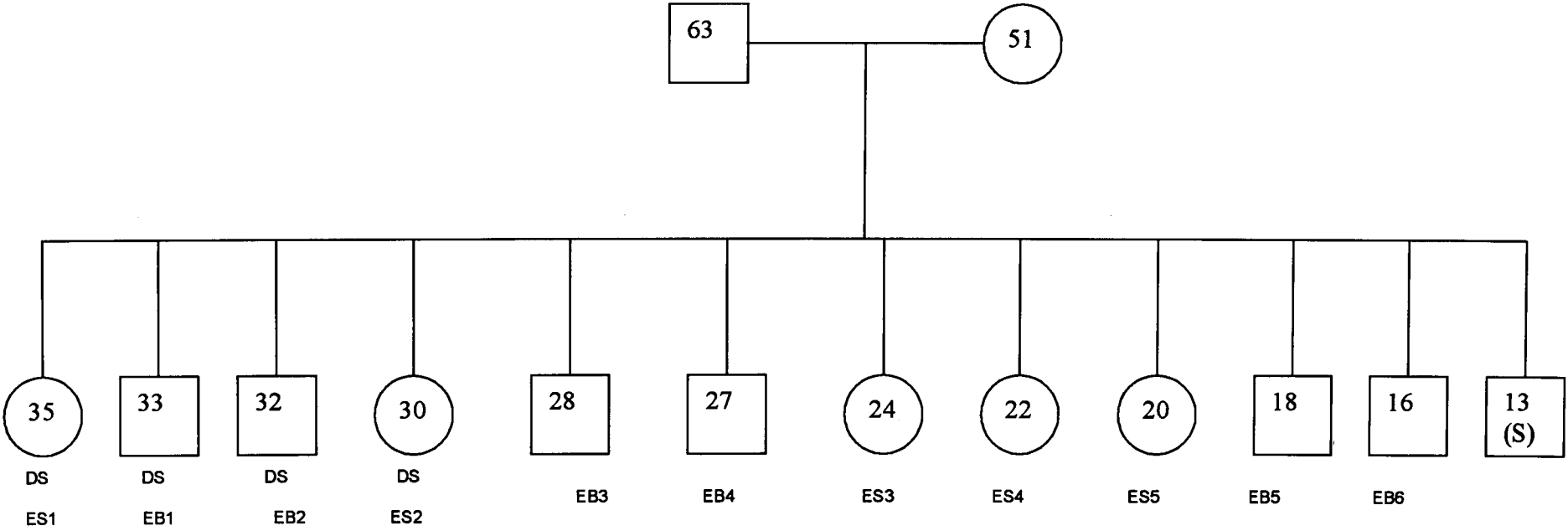
Miscellaneous

- Teacher power
- Figures drawn
- Finishing the activity soon
- Govt provisions
- Mainstream education
- Labelling
- Neglect

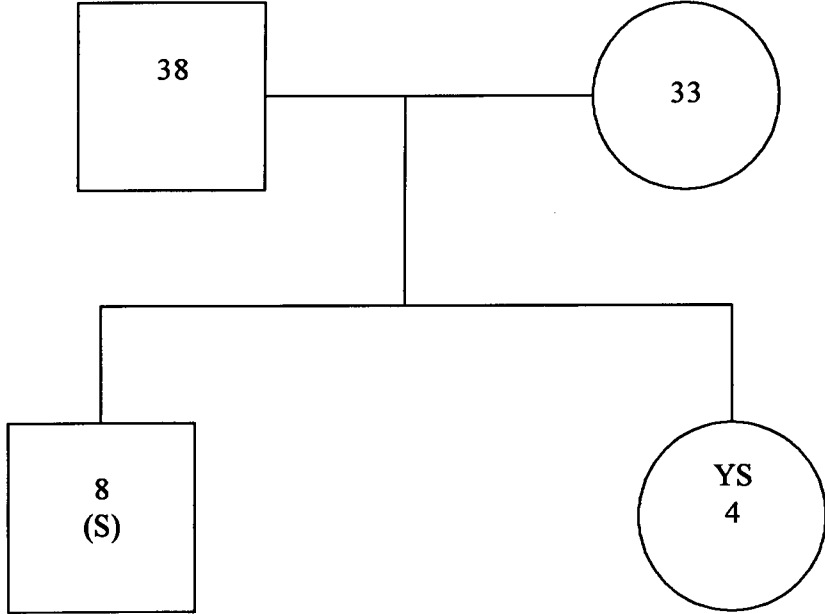
## Appendix 1

This appendix aims to provide background information about the families from which cases are studied. Family trees of 11 children are presented in the appendix. Each person in the family is indicated as either square or circles. Square indicates male members while circle indicate female members. The age of the member is written inside the shape. A direct horizontal line between two members indicates a marital relationship, while a vertical line indicates parental relationship. The particular child studied is indicated with 'S' (self). Where a member is no longer staying with the family, it has been indicated with 'DS' (do not stay). This is specifically the case for Faizal. Where a parent has passed away, it is written. It is specifically the case for Radhika and Seema. Elder brothers are indicated by 'EB', whereas 'ES' indicate elder sisters. Younger brothers are indicated as 'YB', while 'YS' indicate younger sisters.

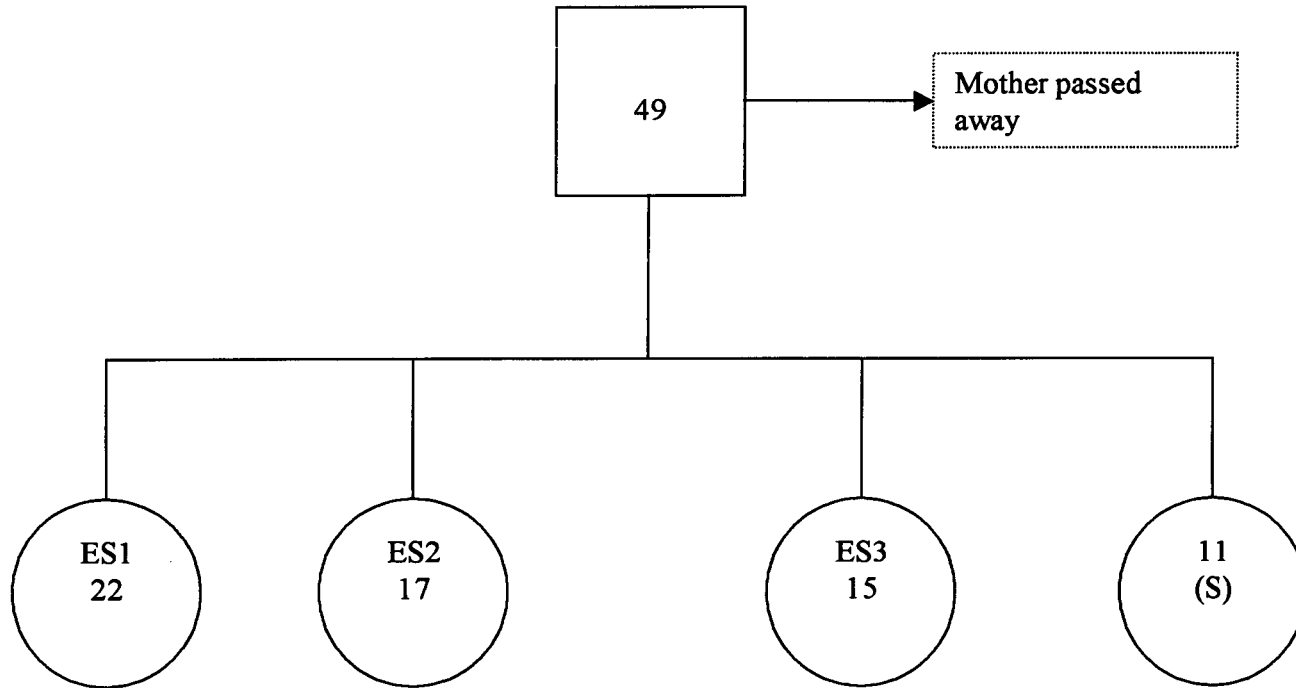
**Family tree of Faizal**



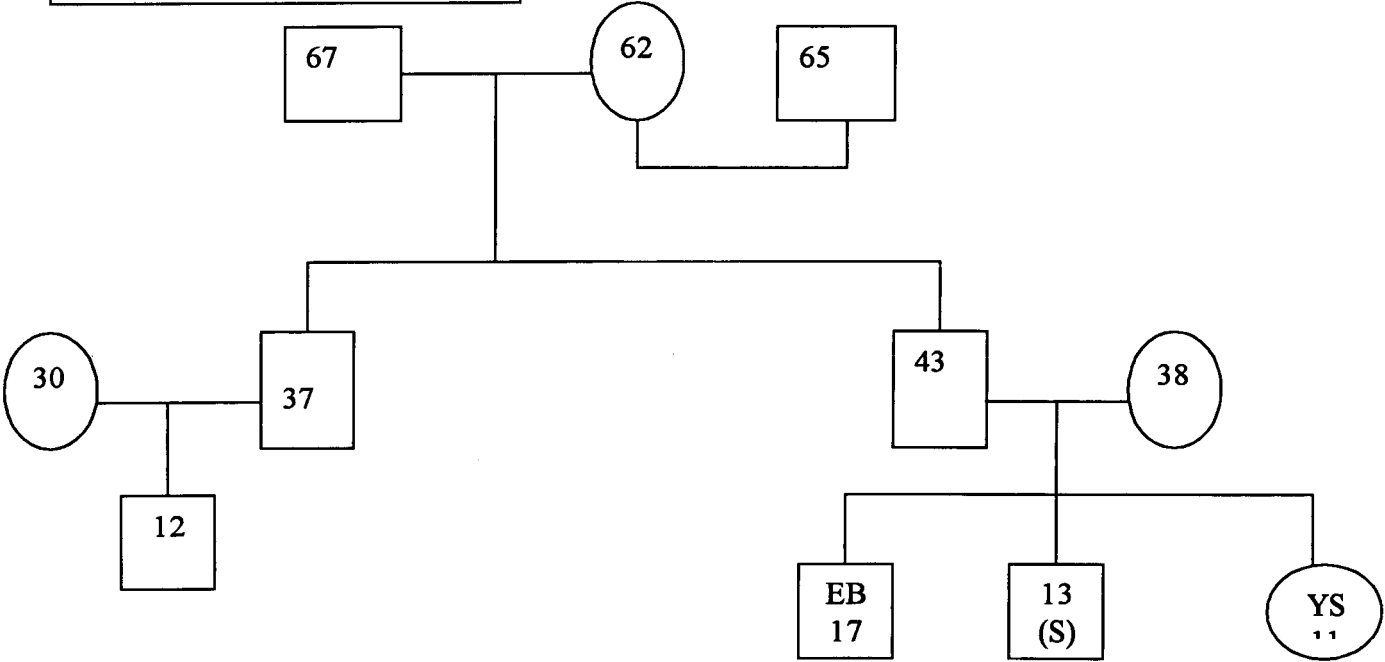
**Family tree of Nithin**



**Family tree of Radhika**

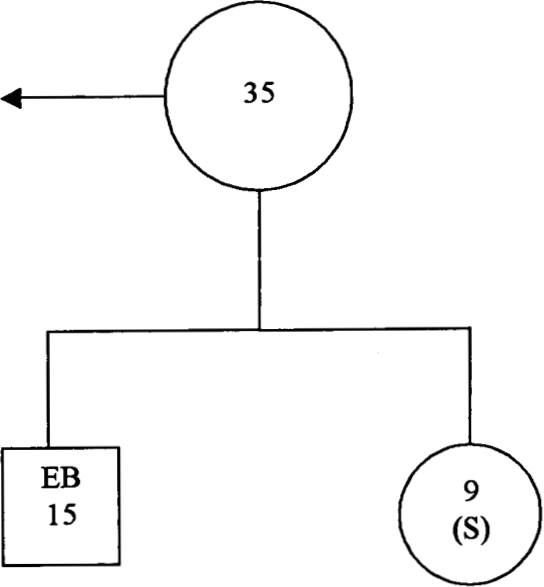


**Family tree of Rahul**

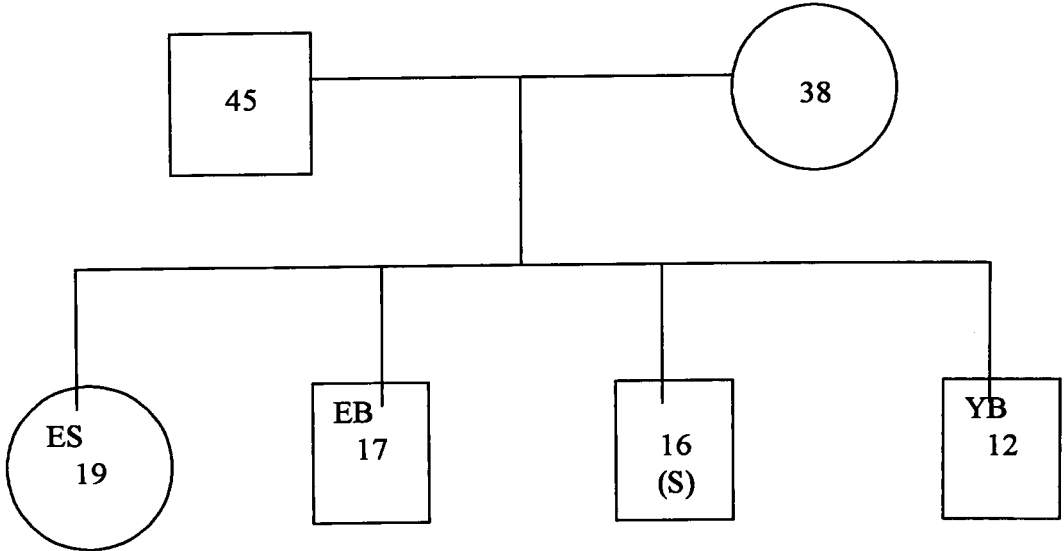


**Family tree of Seema**

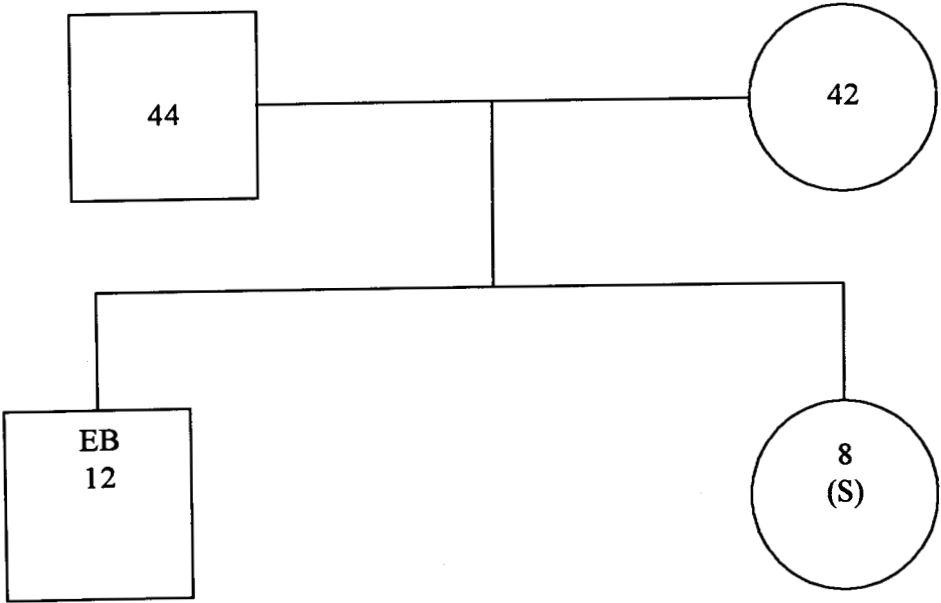
Father passed away



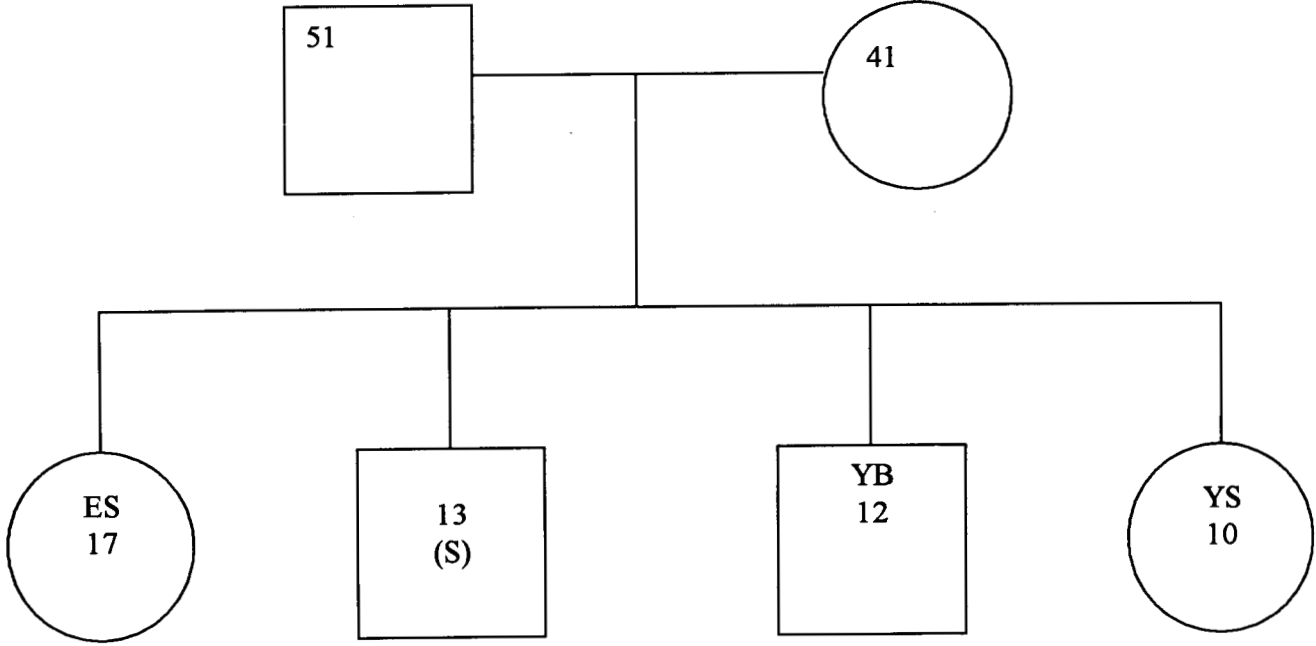
Family tree of Naveen



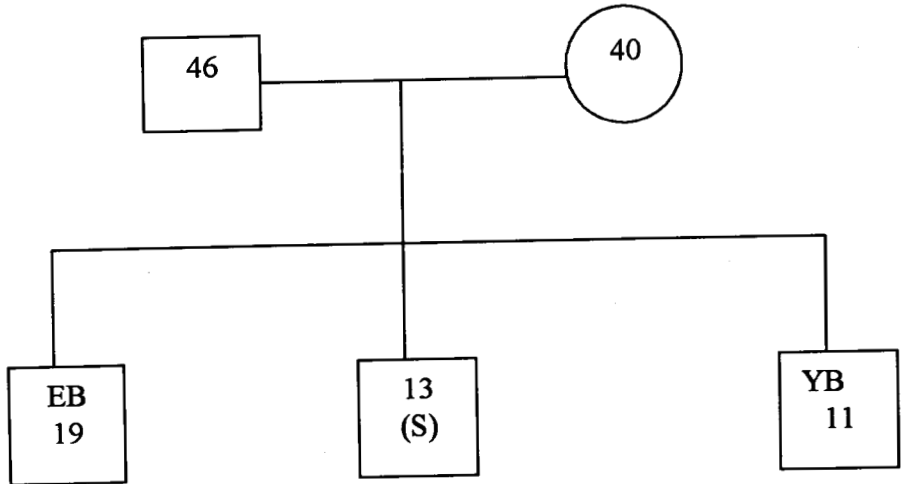
**Family tree of Bhavya**



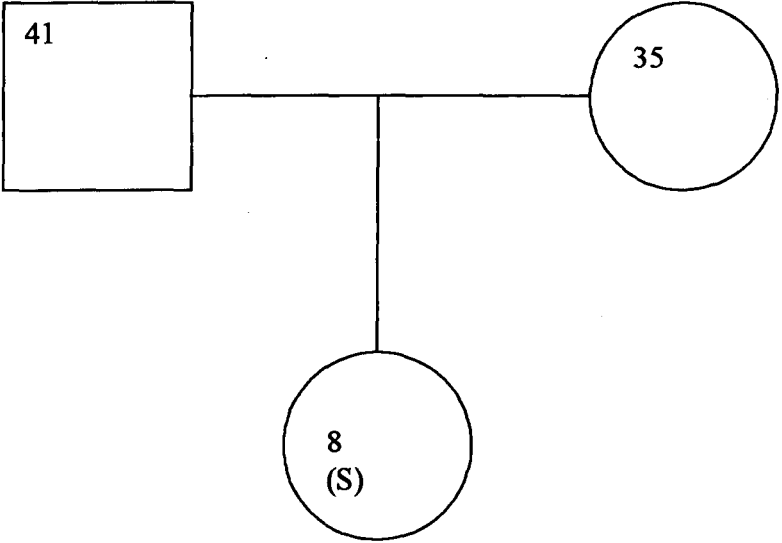
**Family tree of Rajeev**



**Family tree of Navaz**

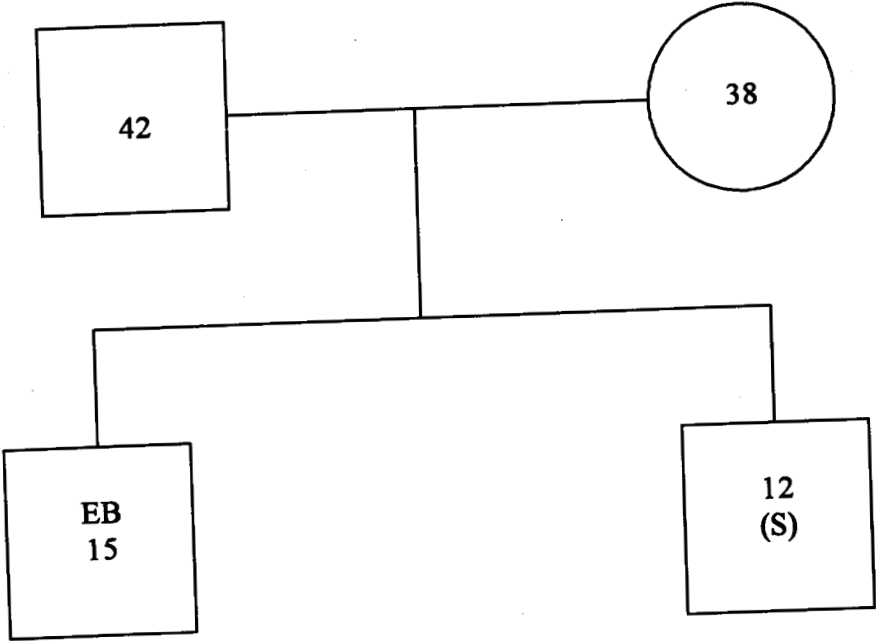


**Family tree of Vinaya**



38

**Family tree of Stanley**



NIB 4968

