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Psycho-Social Problems of the Parents of the Mentally Retarded and the Non-Retarded Children in Rajshahi City

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PSYCHO-SOCIAL PROBLEMS OF THE PARENTS OF THE MENTALLY RETARDED AND THE NON-RETARDED CHILDREN IN RAJSHAHI CITY

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Certificate

Certified that the thesis entitled **Psycho-social problems of the parents of the mentally retarded and the non-retarded children in Rajshahi city** has been completed by Syed Nadim Akhter, Department of Psychology, University of Rajshahi for the award of M. Phil. Degree and the work has been done under my supervision.

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Declaration

This thesis contains no material which has been accepted for the award of any other degree or diploma in any University and contains no material previously published or written by another person, except where due reference is made in the text of the thesis.

S.N. Akhter

Syed Nadim Akhter

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Abstract

Rearing a severe mentally retarded child by the family in the urban areas of Bangladesh appears to be very complex. The families are faced with many peculiar problems in such situations that include management, finance, lack of rest, lower leisure periods of the parents. Some families may cope very well and remain cohesive and creative units in which other children may grow up normally and happily. The presence of a mentally retarded child may overstrain some families. Though many of the parents possess potentials, are not being able to contribute significantly at home and in community as they mostly keep themselves confined at home with their mentally retarded children. If they can accept the reality, interact properly with others, they could lead a different life. In Bangladesh, the concerned professionals and counselors do not possess enough information and data in the related field. Sometimes they ignore many problem areas that should be given enough importance.

The main objective of this study entitled 'Psychosocial problems of the parents of the mentally retarded and non-retarded children in Rajshahi city' is to find out the number, nature and seriousness of the psychosocial problems of the parents of the mentally retarded children living in the city. And to compare their problems with the problems of the parents of the non- retarded children.

In this study, one Case Study form to assess the mentally retarded children, an Information Blank for the parents, Adult form of the Mooney Problem Check List, and an attitude measuring scale were used as instruments. Purposively selected 60 parents (30 mothers and 30 fathers) of the mentally retarded children and 60 parents of a counter group non-retarded children responded the questionnaire and other instruments.

On the basis of primary data, secondary data, free discussion with the parents and his personal observation the researcher concludes that the parents of the mentally retarded children face more psychosocial problems compared to the parents of the non-retarded children, mothers of the mentally retarded

children possess more psychosocial problems compared to the fathers of the mentally retarded children, parents of the mentally retarded children of lower middle class socioeconomic group possess more psychosocial problems compared to the middle class and poor socioeconomic groups, and large majority of the parents of the mentally retarded children do not possess scientific knowledge related to the factors of mental retardation in Rajshahi city. In addition the researcher found that large majority of the lower middle class severely retarded children are being given psychotropic drugs which are creating more problems to the children and their parents.

Considering his observation, the researcher strongly recommends the health wing of the City Corporation to undertake an appropriate measure to identify the mentally retarded children living in all the 30 wards of the city. Secondly, he recommends establishment of at least one Special Education School or Day Care Center in all the wards where these mentally retarded children should spend some time of the day. He thinks that during absence of these children from home in such schools or Day Centers, the mothers can at least take a break. The researcher also recommends both institutional and home based counseling programs for the parents to help them realize the exact condition of their handicapped children and plan what to do for them.

From discussion with the parents, the researcher understood that some social welfare benefit or monthly pension from the Government for the mentally retarded persons would increase the social status of the mentally retarded persons and their parents.

Finally the researcher strongly feels that a National Policy for the Mentally Retarded persons is urgently needed in Bangladesh that the NGOs can not do trials and errors with them and their parents

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CHAPTER - I
INTRODUCTION

The birth of a mentally retarded child is always some additional problem to the parents and the family. If the degree of retardation is severe and the child needs help of others in toilet, eating and clothing, the degree of problem to the family increases more. In Bangladesh, until very recently the severe and profound handicapped persons were dying mostly in their early ages due to faulty treatment and many other drawbacks. Nowadays such persons are experiencing relatively longer life because of EPI program, better medical facilities and awareness development in the country. But whether the life span of the mentally retarded person is short or long, the family members of the severe mentally retarded children face many problems that are not faced by the family members of the non-retarded children.

The number, nature and seriousness of the problems are different in different families and for individual subjects. Education, economic condition, social status, profession, quality of living places, surroundings, neighbors, relatives, values and perception of the families are important factors which determine the nature and seriousness of the problems. For a particular family the medical care facilities may be the most important problem. For another family the neighbors and relatives may become important problems.

It is observed that the rural mentally retarded persons and their family members enjoy relatively a better social environment compared to the urban mentally retarded persons in Bangladesh (Sufi, Yamashita, Nazneen, 1996). Therefore, it is assumed that the number, nature and seriousness of the psychosocial problems of the parents and family members of the rural mentally retarded persons are lesser compared to the urban parents and family members. In large cities, where the living patterns are more mechanized and formal, the mentally retarded children mostly remain confined inside their houses. They do not get the opportunity of enjoying nature and the warmth of the community. If the housing pattern is apartment type, the life of the mentally retarded children become more complicated.

The researcher observed many parents of the severe mentally retarded children in Rajshahi City who never plan to go outside their home together. Either the mother or the father remains at home to attend the mentally retarded child. In rural areas the picture is different. There are many relatives or neighbors who help the parents to look after the handicapped

children. Secondly, in the rural areas, large majorities of the families are yet joint families and the parents remain relatively more tension free.

This study is an attempt to investigate the psychosocial problems faced by the parents of the mentally retarded children in Rajshahi City and to compare the problems with the parents of the non-retarded children. This is not a complete study of all the parents of all the mentally retarded children living in Rajshahi City. This study was done with a small purposively selected sample of parents whose children are severe mentally retarded and need help in toilets, eating and clothing. But before entering into the study it is pertinent here to describe mental retardation and matters related to mental retardation.

Mental Retardation

We do not find any nation that can claim itself to be free from the problems of mental retardation. Of four billion inhabitants on our planet, about 1 to 3 percent are Mentally retarded (WHO, 1968). Mental retardation is a serious problem that is viewed from different angles by people of different disciplines. The medical people consider mental retardation from the viewpoint of disease and treatment. Educationists consider the mentally retarded persons as a slow learner. Psychologists view it as sub-normal intellectual capacity and psychosocial immaturity that lead to maladaptive behavior. However, all of them are interested to understand the nature and causes of mental retardation from a scientific point of view (Sufi, 1992).

Ancient and modern views

Ancient views: People were aware of the problem of mental retardation from ancient time and the ancient people also tried to understand and explain mental retardation with their limited knowledge. A brief review of the ancient views here may be interesting as well as enlightening with regard to some aspects of mental retardation.

Description of mentally retarded children is found to a significant extent in Sanskrit literature. Terms such as *Jada, Buddhimandyam, Manasmmandhyam, Mudha Budhi, Manasikadurblyam*, etc. are used to explain Mental Retardation (Kapila, 1964).

According to old Sanskrit texts, diseases and health are explained on the basis of *Tridosha* - the theory of three humors. Deficiency or excess in any one or all the three humors (supporting elements) of Personality (Prakriti) results in the discordance which is called *Roga* or disease. Similarly anything that afflicts the body or cell self (living personality) or both is called a disease. Mental Retardation, which is a deficiency (Mandata) in cognitive plane (Manasika), is therefore a disease according to the ancient Sanskrit Literature. According to these literatures a *Jada* or Mentally Retarded child is born due to the Morbid humours that are provoked by the deficits of Spermoplasm (Vijatmkadosh), the condition of the Uterus (Ashaya), Season (Kala) and the defects of the Mother's diet and behaviour (Maturahara viharcdoshaith) during gestation. It was postulated that a child is born out of some of the following factore:

1. Prenatal seeds (Matraja & Pitraja),
2. Spirit (Atmaja),
3. Nourishment (Rasaja), and
4. Mind (Sattvaupapadaka).

The Sperm cells (Vija) of the parents contain minute elements derived form each of its organs and tissues. Questions were raised as to why the *Jada, Kubja* (hunch backed), *Muka* (Mute), *Vyanga* (Deformed) and *Unmatta* (Insane) are unlike their parents. The answer is that a child is not developed according to the organs of the parents with their idiosyncrasies or acquired characters (Charka, 1949).

Rather it can be said that derangement in the Vata (wind) humour of pregnant mother is mainly responsible for the birth of Mentally Retarded children (Shastry, 1938).

Balodhi (1985) mentions that according to these ancient texts the factors that are considered important in Mental retardation are:
(1) Hereditary,
(2) Defective fetus,
(3) Inappropriate child rearing,
(4) Malnutrition, and
5) Divine influence.
Except divine influence all the four other factors bear similarities with the modern outlooks.

From above discussion of the Sanskrit literature it becomes evident that existence of Mentally retarded persons are not new in this part of the world.

In Greece and Rome, the retarded persons were viewed with horror and exposed so that he or she might perish. The word *idiot* comes form the Greek and it means a person who can not take part in public life and can not take part in conversation. The term *imbecile* had its origin in Bacillum meaning a short stick, for an imbecile was a person who could not stand unsupported. In sparta all children at a state of their life were viewed by civic fathers and the handicapped children including the mentally retarded children were condemned to death. In ancient times even in India, an officer was appointed to single out the handicapped children and they were put to death. Marcus Valerius, a first century poet describing children with mental handicap writes *acute capit et auribus longibus, quae is moventur ut assellorum*, (with narrow heads and long ears they move in the manner of assess). During the Roman Empire, deformed idiots were kept in many household for amusements. Unfortunately even today persons with mental handicap often become sources of amusements for people (Sufi, 1992).

The Jewish Talmud stresses that mental Retardation is a mental disease, not connected in any way with diabolical possession and that physician and not the priest should be consulted for its treatment. It classifies epileptics and retarded persons under the same headings. It also stated that persons

suffering form Mental illness were not held responsible for their actions and therefore should not be punished (Sufi & Yamashita, 1996).

The Holy Quran however has showed a much more reasonable attitude – "Give not unto those who are weak of understanding the substance which Allah has appointed you to preserve for them but maintain them therewith and clothe them and speak kindly to them". In the Holy Quran, there are descriptions of the mentally retarded persons in Sura Nesa, Sura Mariam and in many other places. These *Ayats* clearly described the conditions and the responsibility of the society towards the mentally retarded persons (Afsaruddin, 1988).

Today, the words like fool, imbecile, or idiot are no longer in use. Rather the term Mental Retardation is used to describe various forms of mental deficiency.

The civilization started in Bangladesh approximately 5000 years ago and the Mentally retarded people were present form the very beginning. In the old literatures we find many references to these dull people. The characters were shown sometimes as a laughing stock, sometimes as a helpless one. In many novels the characters were shown as burden and source of anxiety to the family. In Bengali language they were termed as *Boka, Gadha, Adha Pagla*, etc (Solaiman, 2003).

Modern scientific views:

The terms mental Retardation or Mental deficiency or Hypophrenia or Oligophrenia are often synonymously used and it is sometimes hard to define these separately. The scientists concentrated their attention to the concept of mental retardation mainly during the decade of sixties. They understood that Mental Retardation refers to sub-average general intellectual functioning which originate during the developmental period of a child and is associated with impairment in adaptive behaviour.

The subaverage general intellectual functioning group includes all individuals whose performance on suitable objective tests of general intellectual ability is more than one standard deviation below the population mean. The upper limit of the developmental period is considered to be at approximately sixteen years.

Adaptive behaviour is manifested in three principal manners: (1) maturation, (2) learning, and (3) social adjustment. Each of these three factors assumes primary importance during a certain stage of developmental period. Thus maturation, which refers to the rate of development of the

sensory motor skills such as sitting, walking, talking, is the important criterion of adaptive behaviour during the pre-school years. Learning defined as ability to acquire academic skills is important during the school-age years. Social adjustment assumes primary importance at the adult level. The principal indicators of social adjustment at the adult level are:

> the degree to which the individual is able to maintain himself independently in the community and in gainful employment as well as his ability to meet and to conform to other personal and social responsibilities and standards set by the community (Heber, 1959).

The quality of interpersonal relationship is an important manifestation of adaptive behaviour during the preschool and school periods. However, social adjustment is considered the primary criterion of adaptive behaviour only at the adult level.

In recent years the American association of Mental deficiency (AAMD) has defined mental retardation as:

> Significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behaviour, and manifested during the developmental period (AAMD, 1973).

Mental retardation is thus defined in terms of level of behaviourial performance; the definition says nothing about casual factors - which may be primarily biological, psychological or sociocultural, or a combination of these.

The American Psychiatric Association has adopted the same definitional approach for its latest classification (DSM-III) listing mental retardation as a disorder beginning before the age of 18. By definition any functional disorder equivalent to mental retardation that has its onset after age 18 must be considered dementia rather than Mental retardation. The distinction is an important one because, as has been pointed out, the psychological situation of the individual who acquires a pronounced impairment of intellectual functioning after attaining maturity is vastly different form that of the individual whose intellectual resources were subnormal throughout all or most of this early development.

Kolb (1962), writing the preface to Mental Retardation has the following pertinent comment to make.

> "We are concerned here with a consideration of those conditions given innately through genetic determinants or as they occur in the early developmental process of the growing foetus or infant which lead to arrest or limitation of cerebral development so as to preclude the successful evolution of an intellectual capacity adequate for an independent social existence".

Such a broadly based statement will not only include conditions that produce chemical and anatomical disturbances of the nervous systems which limit the capacity of the brain to respond to environmental stimuli and to integrate such stimuli, but also those conditions resulting from environmental deprivations that impair the full functioning of the otherwise well developed and intact central nervous system.

With the change of attitude towards the mentally retarded persons throughout the world, the definition of mental retardation also has changed a lot. We find the most recent definition, given in the 7th World Congress of the International Association for the Scientific Study on Mental Deficiency, as follows:

> Mental Retardation is not a disease or single entity, rather a term applied to a condition of retarded mental development present at birth or in early childhood and is characterized mainly by limited intelligence combined with difficulty in adaptation. Hence mental retardation is impaired mental ability. A retarded child learns more slowly and at maturity his capacity to understand will be less than normal. He finds difficulty in learning, social adjustment and economic productivity (Sen and Dutta, 1985).

Types of Mental Retardation

APA (1968) classifies mental retardation into the following five categories according to the degree of retardation:

Borderline: IQ 68 through 83 (i.e., between 1 and 2 standard deviations below the mean), Corresponding to a maximum adult mental age of about 11 to 13 years. This category numbers roughly 15 percent (almost 1 in every 6 persons) of the general population. All other degrees of mental retardation, with IQ less than 68, number roughly 3% of the total population.

Mild: IQ 52 through 67 (between 2 and 3 standard deviations below the mean), corresponding to a maximum adult mental age of about 8 to 11 years. Mild retardation is about eight times as frequent as all three more severe degrees of retardation combined. These children usually look normal, and show no signs of congenital malformations or physical handicaps. Such factors combine to make it unlikely that mild retardation will be recognised until after the child starts school and is identified as a slow learner. The absence of brain pathology has led mild retardation being described in such terms as physiological, clinical, residual, primary, endogenous and cultural- familial.

During age 0 to 5 years they can acquire, to a certain extent, social and communication skills, and they are rarely distinguished from the normal intelligent people until later age. They can learn academic skills to approximately 6th grade level by late teens. Mildly retarded children are also educable and at the age of 18 years and over, the are capable of social and vocational adequacy with proper education and training. But they frequently need supervision and guidance under serious social or economic stress.

Moderate: IQ 36 through 51 (between 3 and 4 standard deviation below the mean), corresponding to a maximum adult mental age of about 7 years. In adult life, individuals classified as moderately retarded attain intellectual levels similar to that of the average 7 year old child. With early intervention, special education and proper training they can learn the self-help activities and the social adaptive behaviour. Under sheltered workshops they can become semi-skilled workers.

Severe: IQ 20 through 35 (Between 4 and 5 standard deviations below the mean), corresponding to a maximum adult mental age of about 3 to 5 years. Usually their motor and speech developments are severely retarded, sensory defects and motor handicaps are common among them. They can develop

very limited skills for maintaining personal hygiene and self help. Throughout their whole lives they will be dependent on others for care.

Profound: IQ under 20 (more than 5 standard deviations below the mean), corresponding to an adult mental age no greater than that of the average 3year old child. The profoundly retarded are totally dependent. They number only in a thousand of the general population, and represent only 3% of all mentally retarded persons, but roughly 30% of the institutionalized retarded. During 0 to 5 years, they have gross retardation; minimal capacity for functioning in sensori motor areas; and they need extensive nursing care. During age 6 to 18 years, some motor developments occur; they can not profit from training in self help. Thus they remain totally incapable of self-maintenance and need complete care and supervision.

Clinical Types

Apart from these five categories of mental retardation in general, we find some specific clinical types of mental retardation. Each of these clinical types, discussed below, has its own distinctive symptomatic and etiological patterns.

Down's Syndrome: Langdon Down in 1866 first described this type of clinical condition associated with moderate and severe mental retardation. The term Mongolism is often used in referring to this syndrome. Afflicted persons frequently have almond shaped eyes (Golden & Davis, 1974).

In addition to almond shaped eyes, the skin of the eyelids tends to be abnormally thick; the face and the nose are often flat and broad, as is the back of the head; and tongue, which seems too large for the mouth, may show deep fissures. The iris of the eye is frequently speckled. The neck is often short and broad, as are the hands, which tend to have creases across the palms. The fingers are stubby and the little finger is often more noticeably curved than ate other fingers. Well over 50% of these persons have cataracts, which are not congenital but tend to make their appearance when the child is about 7 or 8 (Falls, 1970).

Majority of the Down's Syndrome cases have trisomy of chromosome 21 in group G, which results in a total of 47 chromosomes. A small proportion of cases have been attributed to mosaicism or to translocation. Down's Syndrome is the only common form of mental retardation due to autosomal abnormality (Gregory and Smeltzer, 1977).

Cranial Anomalies: Mental Retardation is associated with a number of conditions in which there are relatively gross alteration in head size and

shape, and for which the casual factors have not been definitely established (Wortis, 1973).

In 'macrocephaly' for example there is an increase in the size and weight of the brain, an enlargement of the skull, and visual impairment, convulsions and other neurological symptoms resulting from the abnormal growth of glia cell that form the supporting structure for brain tissues. Other cranial anomalies include 'Microcephaly' and 'Hydrocephalus'.

The term "Microcephaly" means small heatedness. It refers to a type of Mental Retardation resulting from impaired development of the brain and a consequent failure of the cranium to attain normal size. In an early study of the post mortem examinations of brains of microcephalic individuals, (Greenfield and Wolfson, 1935) reported that practically all cases examined showed development to have been arrested at the fourth or fifth month of fetal life. Fortunately, this condition is extremely rare. The circumference of the head of the microcephalic child rarely exceeds 17 inches, as compared with the normal size of approximately 22 inches, Penrose (1963) also described microcephalic youngsters as being invariably short in structure but having relatively normal musculature and sex organs.

Microcephaly may result from a wide range of factors that impair the brain development, including intrauterine infections and pelvic irradiation of the mother during the early months of pregnancy (Koch, 1967).

Miller (1970) noted a number of microcephaly in Hiroshima and Nagasaki that apparently resulted from atomic bomb explosions during World War II. The role of genetic factors is not as yet clear. Treatment is ineffective once faulty development has occurred, and, at present, preventive measures focus on the avoidance of infection and radiation during pregnancy.

"Hydrocephalus" is a relatively rare condition in which the accumulation of an abnormal amount of Cerebrospinal Fluid (CSF) within the cranium causes damage to the brain tissues and enlargement of the cranium. In congenital cases of hydrocephalus, the head is either already enlarged at birth or begins to enlarge soon thereafter, presumably as a result of disturbance in the formation, absorption, or circulation of the cerebrospinal fluid (Wortis, 1973).

The disorder can also develop in infancy or early childhood following the development of a brain tumor, subdural haematoma, meningitis, or other such conditions. Hence the condition appears to result from a blockage of the cerebrospinal pathways and an accumulation of fluid in certain brain areas.

The clinical picture in hydrocephalus depends on the extent of neural damage, which in turn, depends on the age of onset and the duration and severity of the disorder. While the expansion of the skull helps minimize destructive pressure on the brain, serious brain damage occurs nonetheless, leading to intellectual impairment and such other effects as convulsions and impairment or loss of sight and hearing. The degree of intellectual impairment varies, being severe or profound in advanced cases. A good deal of attention has been directed to the surgical treatment of hydrocephalus, and with early diagnosis and treatment, this condition can usually be arrested before severe brain damage has occurred (Geisz & Steinhausen, 1974).

Cretinism: Cretinism provides a dramatic illustration of mental retardation resulting from endocrine imbalance. In this condition, the thyroid either has failed to develop properly or has undergone degeneration or injury; in either case, the infant suffers from a deficiency in thyroid secretion. Brain damage resulting from this insufficiency is most marked when the deficiency occurs during the prenatal and early postnatal periods of rapid growth.

In severe cases of cretinism the individual has a dwarf like, thickest body and short, stubby extremities. Height is usually just a little over 3 feet, the shortness is accentuated by slightly bent legs and a curvature of the spine. The individual walks with a shuffling gait that is easily recognizable and has a large head; thick eyelids give the person a sleepy appearance. Other pronounced physical symptoms include a broad, flat nose, large and flappy ears, a protruding abdomen, and failure to mature sexually. Most individuals with cretinism fall within the moderate and severe categories of mental retardation. Early treatment of cretinism with thyroid gland extract is considered essential; infants not treated until after the first year of life may have permanently impaired intelligence.

As a result of public health measures on both national and international levels with respect to the use of iodized salt and the early detection and correction of thyroid deficiency, severe cases of cretinism has become practically nonexistent in the USA and in most of the developed countries. But such is not the case in other countries including Bangladesh.

Phenylketonuria (PKU): Phenylketonuria is a rare metabolic disorder, occurring in about 1 in 20,000 births retarded individuals in institutions who suffer from PKU number about 1 in 100 (Holmes, 1972; Schild, 1972). In PKU the baby appears normal at birth but lacks an enzyme needed to break down phenylalanine, an amino acid found in many foods. The genetic error manifests itself in pathology only when this condition, not being detected,

lead to the accumulation of phenylalanine in the blood that eventually produces brain damage. The disorder usually becomes apparent between 6 and 12 months after birth, although such symptoms as vomiting, a peculiar odour, infantile eczema, and seizures may occur during the early weeks of life. Often the first symptoms noticed are signs of mental retardation, which may be moderate to severe depending on the degree to which the disease has progressed. Motor incoordination and other neurological manifestations relating to the severity of brain damage are also common, and often the eyes, skin, and hair of untreated PKU patients become very pale.

Most older PKU patients show severe to profound Mental Retardation, with the median IQ of untreated adult phenylketonurics being about 20. Perry (1970) has reported the cases of two untreated PKU patients with superior intelligence. These findings have made PKU something of an enigma. It results from a liver enzyme deficiency involving one or more recessive genes (Burns, 1972). For a baby to inherit PKU, it appears that both parents must carry recessive genes.

Cultural - familial Mental Retardation: Children who fall under this category are usually mildly retarded. They make up the majority of persons labelled as mentally retarded. These children show no identifiable brain pathology and are usually not diagnosed as mentally retarded until they enter school and have serious difficulties in their studies. As a number of investigators have pointed out, however, most of these children come from poverty stricken, unstable, and often disrupted family backgrounds characterised by a lack of intellectual stimulation, an inferior quality of interaction with others, and general environmental deprivation (Birns & Bridger, 1977; Braginsky & Braginsky, 1974; Feurstein, 1977; Heber, 1970).

They are raised in homes with absent fathers and physically or emotionally unavailable mothers. During infancy they are not exposed to the same quality and quantity of tactile and kinaesthetic stimulation as are found in case of other children. Often they are left unattended in a crib or on the floor of the dwelling. Although there are noises, odours, and colours in the environment, the stimuli are not as organised as those found in the middle-class and upper-class environments. For example the number of words they hear is limited, with sentences brief and most commands caring a negative connotation (Tarjan & Eisenberg, 1972).

Causes of Mental Retardation

Scientists have found that mental Retardation may be caused by various factors. These factors may broadly be classified into the following categories.

Biological Causes

Genetic-Chromosomal Factors: Mental Retardation tend to run in families. This is particularly true of Mild retardation. However, poverty and socio-cultural deprivation also tend to run in families. So it is difficult to discern accurately the role exactly played by hereditary factors in causing such mild mental retardation.

Genetic and chromosomal factors play a much clearer role in the etiology of relatively rare types of mental retardation such as Down's Syndrome. Specific chromosomal defects are responsible for metabolic alternations that adversely affect development of the brain. Genetic defects leading to metabolic alternations may, of course, involve many other developmental anomalies besides mental retardation. In general, the mental retardation most often associated with known genetic-chromosomal defects are moderate to severe in degree.

Extraordinary technical developments in recent years have permitted an accurate and detailed study of the individual chromosomes of man. In 1956 it was demonstrated that a normal human being possesses 46 chromosomes. But individuals affected with Down's Syndrome have 47 chromosomes, the extra member being one of the small chromosomes of the G group. This trisomy condition is the consequence of meiotic nondisjunction, or failure of proper separation of a pair of homologus chromosomes during the maturation divisions of the egg. Down's Syndrome appears with increasingly higher frequencies among children of mothers of advancing age; the oocyte of older women are apparently prone to the abnormal process of nondisjunction. In rare instances, Down's Syndrome is not caused by non disjunction, but by another chromosomal aberration, translocation.

Researcher have long believed that the 'extra' chromosome in Down's Syndrome is in some way contributed by the mother. But in 1973 it was learned that in certain instances it is in fact contributed by the father (Sasaki & Hara, 1973; Uchida, 1973).

It has been known for many years that the incidence of Down's Syndrome increases in regular fashion with the age of the mother. A woman in her 20 s has about 1 chance in 2000 of having a Down's Syndrome baby, whereas the risk for a woman in her 40 s is 1 in 50 (Holvey & Talbot; 1972). Evidence of this type led normally to the speculation that the capacity of the older woman to produce a chromosomally normal fetus was somehow impaired by the aging process.

Quite recent research, however, Strongly suggests that age of the fathers at conception is also implicated, particularly at the higher ranges of parental age. In one study involving 1,279 cases of Downs Syndrome in Japan, Matsunaga and associates (1978) demonstrated an overall increases in incidence of the syndrome with advancing paternal age when maternal age was controlled. The risk for the fathers aged 55 years and over was more than twice that for fathers in their early 20s. thus it seems that advancing age in either parent increases the risk of the trisomy 21 anomaly. As yet we do not understand how aging produces this effect, a reasonable guess is that aging is related to cumulative exposure to varied environmental hazards, such as radiation, that might have adverse effects on the process involved in zygote formation or development.

But whatever the causes of the chromosomal anomaly, the end result is the distortion in the growth process characteristic of this clinical syndrome. There is no known effective treatment. When parents have had a child with Down's Syndrome, they are usually quite concerned about having further children. In such cases genetic counselling may provide some indication of the risk of abnormality. In recent years, the technique known as 'amniocentesis' has made it possible to diagnose most cases of Down's Syndrome 'in utero', thus permitting parents to make a rational choice concerning termination of pregnancy if the fetus is abnormal.

Delation: Sometimes a piece of chromosome breaks off resulting in a deletion of genetic materials. The effects of the loss of a portion of chromosome depend on the particular genes lost. A large delation, with the loss of many genes, is incompatible with life.

Dr. Jerme Lejeue and his colleagues, at the University of Paris, described in 1963 the peculiar effects in an infant of the loss of a portion of the number 5 chromosome of group B. Affected infants have a rounded, moonlike face and utter feeble, plaintive cries described as similar to the mewing of a cat. In fact, the disorder has been named *cri du chat* or 'cat cry' syndrome. Such unfortunate infants are mentally and physically retarded. Although originally thought to be exceedingly rare, at least 70 cases of this disorder have been reported since the initial discovery. The 'cri du chat' syndrome, are traceable to a loss, or delation, of a portion of a chromosome. A type of cancer (chronic myeloid leukaemia) has been associated with a specific aberrant chromosome (Philadelphia chromosome). A large proportion, as many as 25 percent, of early aborted human fetuses have been found to possess abnormal chromosome complements (Volpe, 1980).

Infection and toxic agents: Mental Retardation may be associated with a wide range of conditions due to infection. If a pregnant woman has syphilis

or is afflicted with German Measles, her child may suffer brain damage. Brain damage may also result from infection occurring after birth, such as viral encephalitis.

A number of toxic agents, such as carbon monoxide and lead, may cause brain damage during fetal development or after birth. Immunological agents, such as antitetanus serum or typhoid vaccine, taken by mother, may lead to brain damage of the fetus. Similarly, certain drugs taken by the mother during pregnancy may lead to congenital mal formations; an overdose of drugs administered to the infant may result in toxicity and brain damage. In rare cases brain damage results from in compatibility in blood types between mother and fetus-conditions known as Rh, or ABO, system incompatibility. Fortunately, early diagnosis and blood transfusions can now minimize the effects of such incompatibility.

Prematurity and trauma: Follow-up studies of children born prematurely and weighing less than about 5 pound at birth have revealed a high incidence of neurological disorders and often mental retardation. In fact, very small premature babies are many times more likely to be mentally retarded than normal infants (Mc Donald, 1964; Rothschild, 1967). Physical injury at birth can also result in retardation. Isaacson (1970) has estimated that 1 birth out of 1000 there is brain damage that will prevent the child from reaching the intelligence level of a 12-year-old. Although normally the fetus is well protected by its fluid-filled bag during gestation, and its skull appears designed to resist delivery stressors, accidents do happen during delivery as well as after birth. Difficulties in labour due to malposition of the fetus or other complications may irreparably damage the infant's brain. Bleeding within the brain is probably the most common results of such birth trauma. Use of forceps during delivery may cause brain damage that may lead to mental retardation. Anoxia - or lack of sufficient oxygen to the brain stemming from delayed breathing or other causes is another type of birth trauma that may damage the brain. Anoxia may also occur after birth as a result of cardiac arrest associated with operations, heart attacks, near drowning or severe electric shocks.

Ionizing radiation: In recent years a good deal of scientific attention has been focused on the damaging effects of ionizing radiation on sex cells and other bodily cells and tissues. Radiation may act directly on the fertilized ovum or may produce gene mutations in the sex cells of either or both parents, which in turn, may lead to defective offspring. Sources of harmful radiation were once limited primarily to high energy X-rays used for diagnoses and therapy, but the list has grown to include leakages at nuclear power plants and nuclear weapons testing, among others.

Malnutrition and other biological factors: Deficiencies in protein and other essential nutrients during early development can result in irreversible

physical and mental damage protein deficiencies in the mother's diet during pregnancy, as well as in the baby's diet after birth, have pinpointed as particularly potent causes of lowered intelligence.

A limited number of cases of mental retardation are also associated with other biological agents, such as brain tumors that either damage the brain tissue directly or lead to increased cranial pressure and concomitant brain damage. In some instances of mental retardation particularly of the severe and profound types the causes are uncertain or unknown, although extensive brain pathology is evident.

Unknown Prenatal Influence:

Cerebral Malformations: Anencephaly and hemianencephaly are among the most common congenital brain malformations, invariably resulting in death at birth or shortly thereafter due to absence of one or both cerebral hemispheres or even greater portions of the central nervous system. Malformation of gyri include argryia, macrogyria , and microgyria. The latter is a relatively common pathological condition found in the severely mentally retarded. Congenital porencephaly is characterized by large funnel shaped cavities occurring anywhere in the cerebral hemispheres.

Craniofacial anomalies: Primary microcephaly is transmitted by a single pair of autosonoal-recessive genes, and invariably associated with moderate to severe retardation. Microcephaly may also be secondary to exogenous lesions, resulting from infections, trauma, or asphyxia. This term is reserved for adults with a head circumference of 17 inches or less; or children with a head circumference of less than 13 inches at 6 months, 14 inches at 1 year, or 15 inches at 2 years.

According to the Psychiatrists, Severe, and Profound retardation are associated with brain disease, and often with congenital malformation and physical handicaps. The more severe the retardation, the more obvious it will be to nonprofessional observers, and greater the probability of associated physical disabilities. Hence medical advice is likely to be sought earlier than in the case of mild retardation. Such disorders as Down's Syndrome, microcephaly, and hydrocephaly may be easy to identify early, but it is extremely important to recognize disorders that may not be so grossly obvious but are treatable, such as cretinism, phenylketonuria, gatactosacmia, and hypoglycemosis, in order to obtain the best possible results. Prompt recognition and appropriate intervention are important conditions for better adjustment and rehabilitation of mentally retarded persons.

Mental Retardation in Bangladesh

It is mentioned earlier that no nation can claim to be free from the problems of mental retardation. In Sweden, 00.45% of the total population are mentally retarded (Walujo, 1987). In India it is estimated that the number of mentally retarded persons could be anywhere between 18 and 20 million, to which about 0.4 million are being added every year (Sen, 1985).

Bangladesh is a country with a population of about 130 million. It is not exactly known how many people in this country are mentally retarded. The Bangladesh Bureau of Statistics in their census of non-farm economic activities and disabled persons in 1986 reported that 10.8 million people of this country are handicapped. The figure mentioned by the Bureau of Statistics also included the Mentally ill persons of the country. Thus it is difficult to give an exact estimate of the mentally retarded persons in Bangladesh. But considering the similarities of the culture, economy and health conditions of Bangladesh with the Indians and WHO's report it may be assumed that approximately 1.00% of the total population are mentally retarded in Bangladesh.

If the urban population of Bangladesh is 20% of the total population, and 1.00% are mentally retarded, approximately 2,60,000 mentally retarded persons live in the urban areas of the country. From the psychological viewpoint, the mentally retarded persons of upper and middle class families of the urban areas live generally in unfavorable conditions than the rural mentally retarded persons. As there are restrictions in their movements and social contacts, they remain confined in their residences and can not move freely. Those who attend special education classes (negligible percentage) can come out of their residence during school hours and get little opportunity to make social contact with other persons. The lives of the adult female mentally retarded persons in the urban areas are far more miserable.

There is a general tendency to hide their mentally retarded children from others in the higher socioeconomic group. They usually try to appoint private nurses or servant to attend their mentally retarded child. These mentally retarded persons in the towns get the least opportunity of social and interpersonal interactions.

The middle class people also possess similar attitudes towards their mentally retarded children like the upper class socioeconomic groups. But they can not always afford private attendants for their children. Whether mild or moderately retarded these children are sent to the normal schools at the beginning. And in most cases they become dropouts. On being dropouts

these mentally retarded children either loiter around their neighborhoods or remain confined inside own houses.

The mental retardates of lower socioeconomic groups enjoy more freedom in loitering during day hours. Many mentally retarded children of the urban slums beg in the roads, loiter aimlessly or work casually as a day labor. Many of these children may become involved with delinquency.

Rural mentally retarded persons get enough opportunity of free movements. Since the risk of road accidents are lesser in rural areas, the mentally retarded persons get enough opportunity of free movements. The mentally retarded children of both sexes get enough opportunities of loitering in the agricultural fields and the village markets. They get opportunity of being day labourers in the agricultural works and in cattle mending. The female mentally retarded persons get many job opportunities for household activities. In the villages, if the degree of retardation is of mild nature and the person is male, he gets an opportunity to look after the parental properties, business, household matters, etc.

At present there is no special education school in the rural areas. If the mentally retarded child is capable of speaking and hearing, they usually attend the beginning classes of the normal schools. However, ultimately they drop out of the schools. If they become adult, they get married in many cases. Arrangement of such marriage is not a serious problem. In the long run they become absorbed in household works. But for the mentally retarded females, the marriage may not last long. On separation from their husbands these female retarded persons come back to their parental houses.

In the rural areas, most of the profoundly retarded children die in their infancy period, owing to diseases, faulty handling, wrong diagnosis, ignorance, etc. Those who survive infancy period also die in their childhood age after a lot of sufferings. In the rural areas, only the mild and some of the moderately retarded persons can expect a longer life span, provided they learn to communicate and acquire some basic skills. Fortunately in the rural areas the mental retardates get relatively better scope for socialization and enjoy more social acceptance in comparison with urban mental retardades.

The life and daily routine works of the villagers differ from that of the people of the town. Marked differences are also seen among the different classes of population. Life style of the urban rich people differs widely from that of the poor. In urban areas, the slum dwellers live differently from of other sections of people. These differences in the living conditions determine the outlook and attitude of the different section of population towards mental retardation. These things must be kept in view while

devising any programme to uplift and rehabilitate mental retardates in Bangladesh.

Marriage of the mentally retarded children is less common among educated group and apparently high among illiterate families. The frequency of marriage is higher among the rural people. Parents usually give a good portion of parental assets to their mentally retarded children. There are many evidences that the parents, usually of the mentally retarded females, offer dowry to the persons who marry their children. Such offers work as a good, incentive to the poor persons to marry the rich mentally retarded females.

In Bangladesh, the mentally retarded persons live with their families. There is no institution, like the institutions found in Europe and many other neighboring countries. They live with their parents when the parents are alive and with some other relation after the death of the parents.

Many mental retardates of the low economic group both in rural and urban areas mostly live in the streets or other people's houses, and for their livelihood they mostly depend on the mercy of others.

Although Bangladesh is mainly a Muslim country people of various cast and creed live in this country. The family laws are different for the Muslims and Hindus in the court of justice. The laws are quite old and these were introduced during British rule of India.

Muslim law preserves equal rights of the mentally retarded persons on the parental property. But there are many drawbacks in the laws that finally fail to protect underhand transfers of the properties of the mentally retarded persons.

The culture and customs under Muslim laws and conventions emphasize provision for food and shelter for the mentally retarded persons and the responsibility for care taking is laid on the shoulders of the elder brothers or sister or other near relatives in the absence of the parents.

Hindu law does not recognize any right of the mentally retarded persons on the parental properties. Under this law only those can inherit the parental properties who are allowed by religious rules to put fire on the dead body of the father. Usually a profound or severely retarded Hindu person is not allowed by rule to put fire on dead father and thus he is deprived of the parental properties. After the death of parents, they live on the mercy of their siblings. In India, the Hindu Disposition of property Act 1954 was amended which how reserves equal rights of the mentally retarded persons

like their other siblings. The same act in Bangladesh was not amended and therefore, the Hindu mental retardates are still deprived of their parental property in Bangladesh.The special education classes and day care centers available in Bangladesh do not differentiate the caste or class and mentally retarded persons of all caste receive equal rights in the schools here (Roy, 1987).

There is no special law for the mental retardates of the Christians, the Buddhists and the tribal people. The matters related to the rights and privileges of the Christians and Buddhists mentally retarded person in the court of law are sometimes reported to be dealt with lunatic act. The Lunatic Act introduced by the British Government in India is still in existence in this country. This law allowed interested parties to deprive many mentally retarded persons from their rights on properties (Sufi,1992).

However, in this country the mentally retarded persons are voters, tax payers and posses other rights equally as citizen of this country. But they are not provided with any special quotas for entering into job situations or other competitive situations (Sufi, Yamashita & Nazneen,1996).

The parents try to provide some treatment for their retarded children at the beginning but after some time give up all attempts. Religious healing, Ayurvedic and homeopathic treatments are very common practices bath in the rural and urban areas, In the urban areas the parents try some psychiatric treatments if they get opportunity in the hospitals, parents are not aware of either the importance or the existence of special education and training programmes for the mentally retarded children. Their faulty attitude and misconceptions about mental retardation further worsens the situation.

Services for the Mentally Retarded persons in Bangladesh

In recent years, increased attention has been given to the needs of the handicapped, children throughout the world. The United Nations designated 1981 as International year of Disabled person (IYDP). This event focused attention on the fact large number of disabled children reside in the developing countries. The United Nations Children's Fund (UNICEF) estimated that by the year 2000 there will be over 150 million disabled children under 15 years of age in developing countries. In Bangladesh their problem is more acute as little attention is being paid to the needs of these handicapped children.

Till 1977, practically nothing was done about the mentally retarded persons in Bangladesh. In 1977, Dr. Sultana Zaman. Professor of Psychology of Dhaka University first established an NGO (Society for the Care and Education of the Mentally Retarded Children) in Bangladesh for the mentally retarded persons. Mainly a parent's organisation, this NGO initially started with integrated special education classes for the retarded children in side wills little flower school Dhaka city. In 1982, this NGO in Collaboration with the Norwegian Association for the Mentally Retarded (NFPU) introduced a vocational education centre and Sheltered Workshop for the adults. This centre has come to be known as the Bangladesh Institute for the Mentally Retarded (BIMR). This centre has now become an Institute run by the professionals for staff training, research, publication, and model centre for the Mentally Retarded persons of all ages. BIMR continues the sheltered workshop and other model special classes. Bangladesh Government has recently recognised this institute and provided grants for its development. The NGO that established this Institute established more than 22 branches at different places of the country, which provide day care to about 2000 Mentally Retarded persons at present.

In May 1984, Dr. Sultana Zaman promoted another NGO known as the Bangladesh Protibandhi Foundation (BPF). The new NGO started functioning for the developmentally disabled children. This NGO also run one model institute with multidisciplinary professionals in Dhaka city known as Kalyani. The protibandhi Foundation has model centres both in the urban and rural areas of the country. This organisation has published several important books, journals, health education guides, etc.

The Government, through the Department of Social Services, runs the National Center for Special Education (NCSE) at Mirpur in Dhaka. Here few children with mental retardation, hearing and visual impairments have facilities of special education and residential care. The center now introduced special teacher training and staffs training programs, too. the

graduation program of special education teachers of this centre is affiliated by the National University.

The Sreepur Shisu Palli, near Gazipur, is one of the largest village for the homeless children in this country. This village has a residential programme for the mentally retarded children, too. The inhabitants are mainly severe and profoundly retarded children.

In 1992, The SIVUS Institute, a Voluntary Social Welfare Agency started functioning under the leadership of Dr. Anwarul Hasan Sufi of Rajshahi University mainly in the northwestern part of Bangladesh. This organisation provides home based counselling to approximately 700 mentally handicapped persons in approximately sixty villages through the Volunteers, mainly the students of Rajshahi University and Rajshahi Medical College. The main objective of the organisation is to promote awareness among the rural people to integrate the handicapped persons in the community and in easy works.

In Bangladesh, yet the major services to the mental retardates center around special education and some vocational training. Little has been done about their integration. Nothing has been dome for the rural mentally retarded persons. Yet all the NGOs together could not bring even 1 percent of the total mentally retarded population under any of their programs. And the large majority of the Mentally Retarded persons of the country still remain deprived from the facilities of special education, training and other services.

Yet Bangladesh Government could not announce any policy program for the mentally retarded persons. Therefore, the NGOs are getting opportunities to do many trials and errors with the mentally retarded persons. A National Policy for the mentally retarded persons including their health, education, employment, housing and social security is needed in Bangladesh.

Psycho-Social Problem

The term psychosocial is employed with reference to social relations dependent on mental factors and functions (Drever, 1968). Psycho-social problems are those having conditions underlying the development of social groups, the mental life, so far as it of behavior of the individual in relation to his social environment or society. In fact all problems have both an individual and social aspect.

When the researcher explored the Dictionaries available in internet he found four definitions of psychosocial problems. These are:

- Problems involving both psychological and social aspects or relating social condition to mental health.
  www.effexor.com/resources/glossary.jhtml

- Problems faced by human beings in social situations which involve both psychological and social aspects, or relating social condition to mental health.
  www.yestolife.com.au/blue_site/8/8a.htm

- Problems pertainnig to the psychological and social aspects of human functioning.
  www.aascipsw.org/StandardsPSW/Vl.htm

- The problems which are of relating to the relationship between social factors and individual thought and behaviour.
  www.peel-hepc.ca/glossary/medical.htm

From the above definitions it is clear that psycho-social problems are those problems of human interpersonal relationships which include both psychological and social aspects.

When sociologists consider social problems they make basic assumptions about why things happen the way they do. These assumptions or premises are starting points for studying some very complicated problems. The following are some of the basic premises of sociologists who study social problems (Julian & Kornblum, 1974).

1. Social problems are, to some extent, a result of indirect and unexpected effects of acceptable patterns of behavior.
2. A certain social structure and culture induce most people to conform but can cause some to deviate.
3. Every social structure, or society, is composed of different categories of people who are similar in income, education ethnic background, and

occupation; these various groups constitute "Strata" or layers of society. People in different strata experience the same problems differently and therefore are likely to understand them differently.

Psychologists also agree that the above mentioned aspects of life are factors of many psycological problems. These psychological problems may be mild or severe in the life of human beings. These factors are again related to intelligence, personality, motivation, memory, aptitude, attitude, socialization and many other psychological phenomenons. It can be said that all these inert psychological phenomenons lead a person to perceive a particular problem of social life differently from another person.

The behaviour pattern of a neighbour or a colleague may constantly irritate a person which may be totally ignored by others of the same community or workplace. The behaviour of a member or members when create psychological problems in the social interaction of another member may be termed as psycho-social problem.

In Bangladeshi urban life, the parents of severe mentally retarded children face some unexpected social interactions which create lot of stress to some parents and siblings of the mentally retarded children. These situations directly affect their coping pattern.

Every human being has to learn to cope with various situations from time to time in order to survive. However how well one copes will vary from one individual to another, depending on the internal strengths and external resources. Having a child with mental retardation in the family demands a lot of adjustments and coping on the part of parents. The impact of this on each parent may be quite individualized, and it can affect their personal, family and social lives in varying degrees. The adjustment in families with a mentally retarded child has been investigated in the wider content of the child, specially the family and resources available within the social environment. The ability of the individual to cope with this situation depends on his internal resources such as faith, energy, self determination and perception of the situation. Also the external resources, such as support from family members, relatives, friends, neighbors, professionals, community, government, policies and programs. Families who are successful in coping with having a mentally retarded child are able to effectively mobilize their internal and external resources to deal with the special needs of their child.

Most of the factors of effective coping, have been derived from the research on facilitators to effective coping. For example, better marital satisfaction, support from the spouse, are important facilitators to effective coping by

mothers and fathers. Conversely, a less satisfactory marriage and less support from the spouse would be inhibitors to effective coping. Social scientists also identified some inhibitors to effective coping, namely, additional financial hardships, stigma, extraordinary demands on time, difficulties in care given tasks like feeding, diminished time for sleeping, social isolation, less time for recreational pursuits and difficulties in managing behaviour problems.

While we may pity them and feel some sympathy for their plight, most of us tend to view the disabled and handicapped as deviants. People who are blind, lame, deaf, or otherwise physically disabled or handicapped make most of us uncomfortable, self-conscious, or angry. We stigmatize them as freaks, losers, partial persons, and the like. It is assumed, for example, that they are childlike and innately incapable, and they are discriminated against at every turn.

In the past the handicapped were literally a forgotten people. They were excluded from work, school, and society both by active discrimination and by barriers imposed by a world, school, and society both by active discrimination and by barriers imposed by a world designed for the able-bodied. Steps, curbs, narrow doorways and aisles- impassable obstacles to many of the disabled- are but a few of the aspects of everyday life that still impede the physically handicapped (Julian & Kornblum, 1974).

The purpose of social organization whether in society as a whole or in a small group like the family, is collective action to achieve mutual goals. Since the most clearly necessary function of the family by how well it appears to be performing this task. Only recently have the emotional health and happiness of the adult members of a family come to be regarded as perhaps equal in importance to the welfare of the children. Even now, if the two appear to be in conflict, society usually takes the children's side. There is good reason for this, since children, especially young children, need care and protection if they are to survive in a world in which death by starvation, exposure, disease, or physical abuse is quite possible. They also need proper education if they are to be assets to society and not liabilities. Because adults have more strength, knowledge, and experience, they are expected to be better able to defend for themselves and adjust to unfavorable circumstances (Julian & Kornblum, 1974).

Psychosocial problems include many important aspects of Psychology and Sociology. Psycho-social problems can be viewed from different angles. Psycho-social problems are different for different persons. The psycho-social problems of a community or a person may not be a problem at all in another community or person. The psycho-social problems of a father or

mother of a mentally retarded child may not be a problem to the parents of another mentally retarded child. But there can be many common problems if these problems are related to their social interactions and related to their overt & covered behaviour, then those problems are their psycho-social problems.

There can be numerous psycho-social problems of the parents of the mentally retarded children. In Bangaladeshi urban areas the mentally retarded children, especially the severe and profoundly retarded children remain confined inside their houses. Such confinements of the handicapped children inside the houses create some stress to the parents. The stress is a psychological problem. When the parents are criticized by the neighbours that they are not trying best treatments for their handicapped children then it becomes a psycho-social problem, as all parents do their best. When the marriage prospect of a sibling of a severely retarded child is disturbed, the parents face psycho-social problems.

When a close relative invite the whole family of a severely handicapped child to a family party and when guests start to show sympathy to the parents, the sympathy turns to a psycho-social problem to the parents.

If the children of the nieghbourhood disturbs or humiliate a severely handicapped child, the parents feel some special feelings within themselves which are psycho-social problems.

In this way thousands of social stimulus create thousands of psycho-social problems to the parents of the mentally retarded children. It is really very difficult to generalize these psycho-social problems. But obviously such problems are related to home, health, economy, personality and self improvement of the parents.

Review of Literature

Many scientific investigations on mental retardation are being carried out throughout the world. These investigations are concerned mainly with the prevalence and assessment of mental retardation, the etiology and treatment of mental retardation, and rehabilitational programs for the mentally retarded persons.

The most recent work on the etiology of mental retardation was done by Pornswan Wasant at the Faculty of Medicine. Siriraj Medical School, Mahidol University of Thailand. Wasant (1989) found that the etiologies of mental retardation can be divided into genetic and non genetic categories. The genetic causes are chromosomal. Nongenetic etiologies are those that occur in prenatal, perinatal and postnatal period. The clinical evaluation of a child with mental retardation include detailed pregnancy history, developmental and family history and the clinical examination of the child. Thus the multidisciplinary approach is often necessary. The outstanding recent advances in the field of molecular biology, biochemistry and molecular genetics (gene mapping, recombinant DNA technology) and prenatal diagnosis of chromosomal and biochemical genetic disorders give much hope in the prevention and treatment of mental retardation.

Marfo, Walker and Charles, (1986) have concluded that children in developing countries are extremely vulnerable to many adverse biological and environmental factors which cause handicapping conditions. The principal causes of childhood disability in these countries are related to such factors as malnutrition, poor medical care and preventive measure that adversely affect children and pregnant mothers.

Assessment of people with mental retardation is one of the big problem for the persons engaged in the services for the mentally retarded persons form the very beginning. Different authors have given Lot of recommendations and proposals. Hogg and Raynes (1987) have mentioned that four broad classes of approach to assessing people with mental handicap can be suggested : (i) norm referenced ; (ii) assessment of adaptive behaviour ; (iii) criterion referenced ; (iv) techniques of behavioral observation.

Oura, T. (1989) of the Osaka city rehabilitation centre of Japan in his study entitled Early diagnosis and treatment said that Chorionic villi sampling offers several advantages over amniocentesis in terms of early diagnosis at 9 gestational weeks in comparison to 16 weeks in amniocentesis, chromosome analysis without culture, sufficient amount of samples for DNA analysis. Indication of prenatal diagnosis still is a centre of hot

debates, because positive result leads to artificial termination of pregnancy in most case.

Social factors of Mental Retardation attracted interest of many researchers in the western countries. Baratz and Baratz (1970), Herzog and Lewis (1970), and Hurley (1969) have investigated the relationship between poverty and Mental Retardation. The American Presidents committee on Mental Retardation (1970) pointed out the existence of a large number of Mentally Retarded children who live in the slums of USA. Eisenberg (1969) observed the effects of poor environment, lack of stimulation, etc. on Mental Retardation.

Recently some research studies on mental retardation have been carried out in Bangladesh. Synopses of some important studies are cited below.

Zaman & Afroze (1979) studied the risk factors related to Mental Retardation among children in Bangladesh. The research was a pilot study to find out pre-natal and post-natal physical and socio cultural causes of mental retardation among a small sample of children in Bangladesh. A total of 30 cases of mental retardates were examined. Analysis of the data revealed that 56% of the subjects were moderately retarded. Genetic factors and prolonged labour were found as the main causes of retardation among the subjects. The higher educational level and higher socio-economic status of parents of the sample indicated that the study used a biased sample. It was concluded that survey studies need to be done with larger representative samples of children to find out the prevalence of mental retardation in Bangladesh.

Zaman and Ferial, (1985) studied the Etiological factors of Mental Retardation in a rural area of Bangladesh. In this study 978 children and their mothers were interviewed belonging to 8 villages of Dhamrai Union of Dhaka district (24 miles from Dhaka City). Total number of household visited were 590. The study revealed that a number of disabilities and diseases such as night blindness, hearing problems, seizures, etc, were associated with mental retardation and there was a significant relation between levels of intelligence and nutritional status of the children in the rural areas of Bangladesh.

Zaman and Munir (1988) mentioned that birth asphyxia causes multiple disabilities among a large number of children in Bangladesh.

In another study Development of early intervention programme for the handicapped in Bangladesh, Zaman and Munir (1987) concluded that early intervention is, in fact, effective. The authors also recommended for the developments of clinic for early diagnosis, early intervention programmes,

portage guide to early education, WHO training manual for the disabled, self help group in rural area, distance training package for the outreach, etc. in Bangladesh.

Zaman and Akhtar (1984) in their study entitled Effects of early and late intervention among retarded children: Bangladesh experience mentioned that a handicapped child is still considered as a stigma in the family. Majority of the parents due to prevailing attitude, superstition and ignorance tend to either hide their retarded child or continue to have higher expectation and pressurize the child to behave normally and finally become frustrated when their children fail to meet their demands. In such a situation the need to discuss and evaluate the effects of early and late intervention is especially significant in Bangladesh.

Zaman and Akhtar (1990) in their study entitled A comparative study of attitudes of mothers of MR children who have been working as special education teachers and those who have not been working found that the mothers who were involved in teaching, taking care and mangement of retarded children in specical education classes had more positive attitude towards their own child by being more caring, loving, accepting and adhering to discipline etc. as compared to mothers who were not teachers. This study reveals a significant fact that mother's of retarded children if involved in the management of other retarded children understand mental retardation better and this help them in accepting their own child as well. This study also revealed that the teachers who were not mothers were slightly better in taking care, following curriculum, adhering to discipline and acquiring knowledge on mental retardation thus displaying more positive attitude as compared to teachers who were mothers. This study thus proves that counselling of the parents of mentally retarded children will be more effective, if the parents become involved in the management of other retarded children.

Zaman and Rahman (1982) in their study entitled A comparative study of attitudes and personality traits of mothers of mentally retarded children with and without intervention programmes revealed that the mothers of the mentally retarded with intervention have more liberal attitude even when compared to mothers of normals. It was also found that the mothers of Mentally Retarded Children without intervention significantly overestimated the ability of the children as compared to mothers of retarded children with intervention.

Zaman, Banu, Huq and Ilyas (1987) in their study Attitudes towards Mental Retardation in Bangladesh investigated the opinion of general people towards mental retardation. Results of the study indicated that the three categories or subjects (general public, specialists and parents of the

Mentally Retarded) differed significantly in their attitude towards, and knowledge about the mentally retarded persons. Persons of specialist group were found to have their most scientific attitude. It was interesting to note that the parents of Mentally Retarded were more scientific in their knowledge and ideas than the general public, Furthermore, the results revealed that the general public and parents of the MR from Urban areas had more positive attitude and awareness than that of the rural subjects.

Zaman and Ara (1989) in their study comparison of main streaming and special school system for mentally retarded children compared improvement of social behaviour of two matched groups of mentally retarded children attending a special school and a normal school. Gunzberg's Progress Assessment chart was administered to assess the social behaviour of both group before attending the school and after attending the school. The results indicated improvement in social behaviour of both the groups and no significant difference was found between the two groups.

Zaman (1990) carried out an investigation in five sites of Bangladesh with a view to validate the Ten Questions (TQ) with probes as a tool for screening childhood disabilities in communities where formal resources for disabled children are scarce, if available at all. The types of disability covered by the TQ are blindness, deafness, mental retardation, speech problems, epilepsy and movement disorders.

Play behaviour attracted attention of the professionals working in Bangladesh. Rumizuddin (1990) observed the play behaviour of the mentally retarded children for several years. He has mentioned two special sides of the games of the mentally retarded children. First, the mentally retarded children can not cope with the same age group and like to play with the younger children, Secondly, the mentally retarded children require help from others in constructive games they lack in innovative capacity.

Games and sports for the mentally retarded children and adults attracted interests of the parents. Professionals and the volunteers from the very beginning of the services for the mentally retarded in all the countries. The most challenging job of Special Olympics international was done by the United State's parents. Games and sports have special implications for Mentally Retarded children. The mentally retarded children obtain more benefit from games and sports than from special education classes. In games and sports the rate of concentration of the mentally retarded persons are much higher compared to the rate of concentration in special education. The rate is relatively higher in out door games compared to indoor games (Sufi, 1990).

The child's interaction and experiences with his mother, fathers and siblings provide the beginnings of the life-long process of socialization. However, father, siblings and other persons generally have not been given the credit mothers have for influencing the child's cognitive, emotional, social, and personality development. Psychologists agree that parent's attitude towards child rearing or perception of her abilities for raising children is the first criteria for a child's success in life (Banu and Ara, 1990).

Like any other human being, the retarded child does not live in a vacuum. He needs, as do all persons, close emotional relationships with others and these relationships must be satisfying and strss reducing if he has to achieve maximum potentialities. The relationships between the retarded child and parents are of great importance. If the parents manifest negative feelings towards child's deficient abilities, then it becomes more difficult for healthy relationships. The greater the negative feelings of the parents, the less likely that the child will achieve the desired level of maturity he is capable of attaining. Negative reactions of the parents, thus, can adversely affect the full maturational development of the mentally retarded child. Studies have shown that parent's perception of abilities for setting child rearing goals are largely determined by the social norms (Banu & Ara, 1990). Bell (1961) pointed out that parent's attitudes, perceptions and beliefs about child rearing variables were greatly influenced by the attitudes and values of their parents. In addition to this some parents evaluate his/her child's behaviour in terms of standard followed by other parents of the social group to which he or she belongs. But it has also been found that some families disagree with this common viewpoint and follow different standards (Strom, et.al, 1981).

However, these families were found to be small in number and parents, in general, are in favour of accepting the collective viewpoint for making any decision or perceiving their abilities in raising children. Studies on parental attitudes toward child rearing almost always involve families consisting of normal, healthy children for identifying strength and weaknesses inherent in perceived parental duties and responsibilities. Psychologists have become concerned to the damaging effects of the traditional child rearing expectations mentally retarded child's attempt to master various skills as those expectations are based on normal young population. The absence of knowledge about the ineffectiveness of such expectations for a retarded child makes the parent socially isolated (Banu & Ara, 1990).

Many studies have shown that when a child behaves according to the demands made by the parents, both of them enjoy mutual relationships and develop self-confidence. Conversely, if the child fails to meet unrealistic parental demands, the likely result is mutual frustration and insecurity (Goldman, 1968; Goldman and Goldman, 1982 as quoted by Strom, R.D.,

1984). In a family where all the children are normal the affectionate relationships between mother and child, mutual trust, confidence and security remain undisturbed. Sometimes balance between parent's demands and child's behavior may be disturbed but soon they are resolved and both become happy and satisfied. But the birth of a handicapped child disrupt such a bond between parent and child. Due to lack of understanding of special need of a mentally handicapped child the parent expects similar behavior usually shown by normal children to occur. But due to deficient capacities the child fails to meet parental expectations (Webster, 1970).

Some studies found that parents of handicapped children in Australia and America expressed essentially same child rearing expectations (Strom, Rees, Slaughter, and Wurster, 1981), (Strom, Rees, and Wurster, 1983). But the studies did not reveal as to how parents of mentally retarded children differ from parents of non-handicapped children. Rees's (1982) findings as quoted by Strom (1984) also did not suggest any significant difference in expectations of parents of mentally retarded children with brain damage or Down's Syndrome. Results of another study, however, showed difference in child rearing expectations regarding control of behavior among parents of handicapped children in Germany, Italy, and Turkey (Daniels 1982).

The researcher did not find any study which investigated the specific psychological and social problems faced by the parents of the mentally retarded children. The researcher also did not find any report which compared the psycho-social problems of the parents of the mentally retarded and non-retarded children. However, Sufi (1992) reported that the rural mentally retarded people in Bangladesh enjoy more freedom to loiter in the community and possess better socialization compared to the urban mentally retarded person. From this report it is assumed that the parents of the rural mentally retarded persons are lesser worried about their children compared to the urban parents. Naturally it is expected that the urban parents of the mentally retarded children possess more psychosocial problems than the parents of the rural mentally children. Again the question comes whether the parents of the mentally retarded children of urban areas possess more psychosocial problems compared to the parents of the non-retarded children? And what is the magnitude of such problems? To find suitable answers of these questions, this study is designed.

Objectives of the study

The main objective of the study is to find out the number, nature and seriousness of the psycho- social problems of the parents of the mentally retarded children living in Rajshahi city.

The Specific objectives are to -

1) Identify the psycho-social problems faced by the parents of the mentally retarded children.
2) Compare the psycho-social problems of the parents of the mentally retarded children with the parents of the non- retarded children.
3) Find out the most important psycho-social problems of the parents of the mentally retarded children.
4) Compare the psycho-social problems of the mothers and fathers of the mentally retarded children with the problems of the mothers and fathers of the non-retarded children
5) Identify the Health problems of the parents of the mentally retarded and non-retarded children.
6) Identify the Economic Security problems of the parents of the mentally retarded and non-retarded children.
7) Identify the Self Improvement problems of the parents of the mentally retarded and non-retarded children.
8) Identify the Personality problems of the parents of the mentally retarded and non-retarded children.
9) Identify the Home-Family problems of the parents of the mentally retarded and non-retarded children.
10) Compare the general and severe psycho-social problems of the mothers of the mentally retarded and non-retarded children.
11) Compare the general and severe psycho-social problems of the fathers of the of the mentally retarded and non-retarded children.
12) Suggest ways and means to alleviate the psycho-social problems of the parents of the mentally retarded children.

Significance of the Study

The effect of rearing a Mentally Retarded child by the family appear to be complex. Many studies and personal observation agree that the families are faced with many peculiar problems in such situations which include management, finance, lack of rest, lower leisure periods,etc. of the parents. Some families may cope very well and remain cohesive and creative units in which other children may grow up normally and happily. But some families may get overstrained by the presence of a Mentally Retarded child and eventually disintegrate.

It is seen that though many of them possess potentials, the parents of the mentally retarded children are not being able to contribute significantly at home and community as they keep themselves confined at home with their mentally retarded children. If they can accept the reality and interact properly, they could lead a different life. In Bangladesh. counselors do not possess enough information and data in the related field. Sometimes they ignore many important problem areas which should be given importance.

The findings of this study will help the counselors and concerned professionals to provide better counseling to the parents of the mentally retarded children.

It is assumed that the findings will help the Social Welfare Department of the Government to decide whether residential homes for the severe mentally retarded children are necessary or not in the urban areas of the country.

Yet Bangladesh Government could not announce any Policy Program for the mentally retarded persons. The findings of this study will help the concerned Government officials to draft the proposed policy.

CHAPTER II
METHOD AND PROCEDURE

This research was designed to identify the psychosocial problems of the parents of the mentally retarded children and to compare these with the psychosocial problems of the parents of the non-retarded children of Rajshahi City. Following is the description of the sample, instrument used and procedure.

The subjects and their selection

The subjects of this study are purposively selected groups of parents of the mentally retarded children and the non-retarded children living in Rajshahi City. First of all, the researcher visited two Day Centers for the mentally retarded children of Rajshahi City. These Day Centers are run by The Society for the Welfare of the Intellectually Disabled (SWID) and The SIVUS Institute. The researcher spent several days in each Day Center and observed the children. He had discussion with the special teachers and he read the case history files of the children. He purposively selected 30 mentally retarded children from about 150 mentally retarded children affiliated with these two organizations. The selection criteria were as follows.

- All the 30 were severely retarded. They need help of others in Toilets, Eating and Clothing.
- Out of these 30 children, 10 are of middle class, 10 of lower middle class and 10 of poor families.
- Both parents are alive, live together in Rajshahi City.
- Mothers are housewives. Not engaged in any other profession.
- The age range of these mentally retarded children is between 6 and 16 years.

With the permission of the concerned organizations, the researcher established contact with the families of these children. He met the parents and requested whether they will answer some of his questions. Some families agreed with interest. Some families did not agree, did not show enough interest or one of the parents were out of station, etc. Therefore, the researcher had to consult the relevant organizations again and to change the children. Finally he succeeded to get 30 mentally retarded children who suited the selection criteria. The mothers and fathers of all these 30 children are considered as the respondents from the mentally retarded group.

Then the researcher purposively found out 30 non-retarded children of Rajshahi City who are students of different schools. All these children are of such intelligence that they can cope well with their curriculum and in all social interactions. These children are practically a well-matched counter group of the 30 mentally retarded children in respects of the following:

- Age and sex.
- Both parents are alive and live together in Rajshahi City.
- Mothers are housewives. Not engaged in any other profession.
- Possess same number of siblings, sex and the rank of the children are same as the mentally retarded child counterpart.
- Age of the parents
- Education of the parents.
- Profession of the parents.
- Total number of family members.
- Of same socioeconomic background of the counterpart mentally retarded child. Out of these 30 children, 10 are of middle class, 10 of lower middle class and 10 of poor families.
- Similar standard and facilities of the residential houses.

The researcher established contact with the families of these non-retarded children and had primary discussion with the parents of these children whether they will answer his detail questions. Similarly some of the families agreed and some families did not show enough interest. However, finally the researcher could succeed to select the 30 children and their parents. All the 60 parents are the respondents of this study who are described as parents of the non-retarded children.

Criteria of social class

To classify the families in Middle Class, Lower Middle Class and Poor Class families, the researcher first calculated the total income of all the family members from all sources, per month. Then divided the family income by the total number of family members. If it was more than Tk. 1250 per family member, the family was considered as Middle Class. Tk. 750 to Tk. 1250 per family member was considered as Lower Middle Class. If the amount is below Tk. 750 per family member, the families ware considered as Poor.

The above income – expenditure pattern and criteria of classification of the respondents in three different groups were done after consulting two teachers of Rajshahi University Economics Department. They considered

different Economic Indicators and facilities available in the city for classification of the families as Middle Class, Lower Middle Class and Poor.

Instrument used

In this study the following instruments were used.

1. A Case study form to assess the mentally retarded children.
2. Information Blank for the parents.
3. Mooney Problem Check List Form A
4. An attitude measuring scale.

Case study form to assess the mentally retarded children

The Case study form to assess the mentally retarded children, used during this research work is a part of the case study form which was originally developed by the research supervisor for his own doctoral research during 1988. The original form was used to study about 800 mentally retarded children and adults during 1988- 1992 at different places of the country. A panel of experts made little amendment of the original form for this study. The panel of experts comprised

1. The research supervisor
2. One Teacher of Rajshahi Medical College with long experience on mental retardation
3. Two teachers of Rajshahi University Psychology Department.
4. One special teacher of a day center.

There are many items in the contents of this form. The researcher read each item of the form and the guardians gave their opinion. In the present study the guardians responded on the basis of their own observation and rated the mentally retarded person's functional levels. The items included were mainly related to sensory levels, eating, dressing, walking, playing, social interactions, aggression, emotion, memory, personality, motivation, etc. of the children.

Though it is a short case study form but the form helps quick assessment of a case. The background basis of amendment and editing of the form by the researcher and the panel of experts were observation of the behavioral aspects of the mentally retarded children at home and special education schools; informal interviews with several parents of mentally retarded children in Rajshahi City; discussion with some special education teachers, counselors, welfare staff, etc. who worked with the mentally retarded persons.

Information Blank for the parents

The information blank for the parents that was used in this study contained several sections. The sections included items like name, address, age, educational level, income, source of income, ownership of residence, number of children, education level of the children, expenditure pattern, etc.

Parents of both mentally retarded and non-retarded children filled-up this information blank. Both the mothers and fathers filled-up individual information blank. However, they were given options that they may not write their names and addresses in the information blank. Secondly they were assured that the researcher will keep all given information as secret and maintain their privacy.

Mooney Problem Check List Form A

Psycho-social problems of the parents of the mentally retarded and non-retarded children of Rajshahi city were measured by the Bengali version of 'The Mooney Problem CheckList, form-A' translated by Assistant Professor Md. Mozibul Haq Azad Khan and Professor Monzur Ahmed of Rajshahi University Psychology Department.

The purpose of the Mooney Problem CheckList is to help individuals express their personal problems. The usefulness of the CheckList approach lies in its economy in bringing the problems of the individual into the open and in appraising the major concerns of the group. The Problem Check Lists are used as aid in counseling, in surveys and research (Gordon and Mooney, 1950). A review of psychological literature reveals a lack of reliable tools in Bangladesh for identifying personal problems. Although a number of checklist are available form western countries, yet they are unlikely to be appropriate in Bengali culture, which is obviously different form the culture in which the checklists were developed. Therefore, there is a dire need to develop appropriate checklist for identifying personal problems of Bengali speaking people, specially in Bangladesh (Khan and Ahmed, 1996).

Although the Mooney Problem CheckLists were developed in the USA. Many researchers have used the problem CheckList for identifying personal problems and for collecting data form individuals of both developed and developing countries (Pflieger, 1947; Hibler and Larsen, 1944; Hasan, 1985; Khan et al, 1995-96). But the CheckList are in English and some of the items are culturally inappropriate. Hence the authors of the Bengali version of the Mooney Problem CheckList feel that there is a need for translating and adapting this widely-used CheckList to make it suitable for

identifying personal problems of the people of Bangladesh (Khan and Ahmed, 1996).

The original Mooney Problem CheckList was developed during the early 1940s in the USA by Leonard V. Gordon and Ross L. Mooney at Ohio State University. There are six forms of the CheckList. e.g. the Adult Form, The College Form, the High School Form. The Junior High School Form, the Nursing School Form and the Rural Youth Form.

The Adult Form of the Mooney Problem CheckList was developed for use with the late adolescents and adults who are mainly of non-student status. The purpose of the CheckList is to help individuals express their personal problems. But the responses do not yield scores on traits or permit any direct statements about he adjustment status of the respondents, Rather, the problem CheckList is a form of simple communication between researchers, counselors and the respondents to accelerate the process of identifying their real problems.

Adult form of the Mooney Problem CheckList consists of 288 problems concerning personal lives of the adolescents and adults. These problems are divided into nine problem areas. The areas of the problems and total number of problems in each area are as follows;

Health (36)
Economic Security (36)
Self-improvement (36)
Personality (72)
Home and family (36)
Courtship (18)
Sex (18)
Religion (18), and
Occupation (18).

The problem CheckList is self-administering and all the needed instructions are given on the cover page of the booklet. The procedure of answering is simple. Respondents read through the CheckList and underline the problems which are of concern to them, circle the ones which are of most concern, and finally write a summary in their own words.

Scoring of the CheckList is very simple. Responses are computed in two ways. First the total number of marked and encircled (underlined and encircled) problems in each area are counted independently. Second, the total number of encircled problems of a particular problem are of the CheckList are counted. The marked or underlined problems are treated as simple problems which are of concern to the respondents. The encircled

problems are treated as severe problems which bother the respondents very much.

Rationale of selecting Mooney Problem CheckList From A

Other than the Mooney Problem CheckList Form-A there is no other Problem CheckList with which the psychosocial problems of the adults can be quickly assessed. Though this CheckList is developed in USA and in English language, it is being used in many countries.

The researcher used the Bengali translated and adapted version of the Mooney Problem CheckList. Many researchers in Bangaldesh used the Bengali version since 1980. Secondly, the answering and scoring system of the CheckList is relatively simple and easy. Literate respondents can easily read the instruction and can answer by themselves. Secondly, the Mooney Problem CheckList contains such items as problems which really projects the psychosocial problems face by the adults, specially the parents of children in Bangladesh. Mainly for all these reasons the Mooney Problem CheckList Form -A was selected for this research work.

Thou there are nine problem areas in CheckList only the problems of Health, Economic Security, Self-improvement, Personality, and Home Family areas were considered as psychosocial problems of the parents of the children in Bangladesh. The selection was done by the same panel of experts who reviewed the short case study form as mentioned earlier in this chapter. The panel of experts also considered that the problems of Courtship, Sex, Religion and Occupation areas are not suitable for Bangladeshi culture and for this research. Therefore, the researcher finally selected the 216 problems of five specific areas out of all the 288 problems contained in the CheckList.

Attitude measuring scale

The researcher used and attitude measuring scale in this study. Both the parents of the mentally retarded and the non-retarded children were given the same scale. There are 25 question in this scale and each question had five given answers. If any respondent score 125, it means he/she possess highly satisfactory condition in relation to psychosocial problems. Score 25 means very unsatisfactory condition in relation to psychosocial problems.

The scale was designed by the researcher himself. The panel of experts mentioned earlier in this chapter finalized these 25 items from a draft of about 100 items.

The scale was finalized in Likert scale format. The items were selected considering the problems of the Mooney Problem Check List, personal observation of the researcher, discussion with the parents, opinion of the experts, etc.

This attitude measuring scale is not a standardized scale. This is purposively designed to meet the needs of the present research work only.

Methods used

The researcher mainly followed Interview method in this study. In addition, observation and free discussions were extensively done during the case studies. In order to have reliable information, interview technique associated with observation was used. He also had free and informal discussions with the parents in relation to problems and prospects of their children. Field notes were maintained, too.

Procedure

The researcher made contact with the parents of the mentally retarded and non-retarded children at their home through personal visits. Before formal interviewing of the parents of the mentally retarded children, he first observed the mentally retarded children. He allowed the parents to express their own feelings about their children. All the information given by the parents in the case-study forms were checked by the researcher through questioning them. Besides some additional information were also gathered where necessary.

The questionnaire and the Mooney Problem CheckList were administered to each of the parents in individual session at their home. Literate parents were asked to follow the standard instructions printed on the top of the Questionnaire and Mooney Problem Check List. In case of problems faced by the respondents, the researcher offered necessary explanations. Parents were also assured that the information given by them would be kept secret.

It was mentioned earlier that in addition to Interview Method the researcher had to follow some other sub methods, such as,

- Observation,
- Question and answer, and
- Free Discussion.

As in all other sciences, the bedrock, of psychological knowledge is observation, and what psychologists observe is the behaviour of organisms. The focus of such observation is variable and includes the overt actions of an organism, certain of its measurable internal behaviours (e.g., its physiological processes), and at the human level verbal reports about inner processes or events. It is by far the most troublesome and yet often the most interesting and potentially useful. Of course, all of us observe our own overt behaviour and certain of our inner events, such as thoughts and feelings. But self- observation of one's inner processes has distinct limits as a database for psychological science, in part because much important mental activity is carried on automatically, so to speak, outside of the range of a person's awareness (Nisbett & Wilson, 1977).[1] In addition, mental events are in their fundamental nature private events, forever inaccessible to confirmation by anyone else. Science normally demands such confirmation (inter-subjective reliability) by others as a means of assuring accuracy in the observations made. This constraint has been a source of considerable difficulty for the discipline of psychology throughout its history.

Scientific observational methods employ systematic techniques by which observers are trained to watch and record behaviour without bias. Such methods have helped to ensure the scientific integrity of observational research, but obstacles still remain.[2]

Direct behavioural observations should be considered a primary method of evaluating particular critical responses in the mentally retarded child's repertoire. It is generally believed by behaviour therapists that nothing substitutes for behavioural observations because they can be used to pinpoint target behaviours and to identify antecedent and consequent events that may influence the occurrence or non-occurrence of specific responses (Matson & Beck, 1981)[3]

The major strength of behavioural observations is that they entail direct observation and recording of responses as they occur naturally in everyday settings. Moreover, direct observations are often continuous over a period of time and, thus, can provide a larger sample of behaviour than assessments that occur during limited and perhaps contrived therapy sessions or environmental contexts. For example, if a child's interaction with peers on the playground is a problem area, then that child can be observed directly in that setting for several days. Responses that can be

[1] R. E., Nisbett & T. D. Wilson, "Telling more than we can know: Verbal reports on mental processes", *Psychol. Rev.*, 84, 1977, 231-59.

[2] R. C. Carson, J. N. Butcher, and S. Mineka, *Abnormal Psychology and Modern Life*, 10th ed., (N. Y.: Harper Collins, 1996), p. 19

[3] J. L. Matson and S. Beck, "Assessment of Children in inpatient settings", In M. Hersen & A. S. Bellack (Eds.), *Behavioural assessment*, (New York: Pergamon Press), 1981.

recorded include the duration of time the child can successfully interact with others, the number and characteristics of peers, teacher reactions to responses, the specific activities engaged in, and the frequency and intensity of undesired behaviour such as physical outbursts. Gottlieb (1978)[4] stresses the interactive nature of behaviour in the examination of the mentally retarded child's social adaptation to school; hence, the child's observable behaviour is expressed within a context of peer and teacher characteristics and responses. An unanswered question is the degree to which the mentally retarded child's behaviour is similar across settings and in the responses it elicits from other persons (Gottlieb, 1978)[5].

Comprehensive behavioural observations in school include attention to academic responding. For example, the frequency, accuracy, and duration of oral and written responses in the various content areas can be measured in order to gain an understanding of the child's daily academic functioning. Knowledge of a child's actual performance in the curriculum used in his/her school is likely to be more revealing than a score on a standardized achievement test. For instance, an observational analysis of a child's math skills may show a greater proficiency in math facts when the response mode is oral than it is written or when certain reinforcement contingencies are in effect. This type of information is especially helpful to the classroom teacher, as it carries programmatic implications. In the case of the math example, then, the child who has difficulty writing numbers can more efficiently memorize math facts through the use of flashcards. Instruction in writing skills can proceed in a way that does not confound with other skills (Bormnstein and Kazdin, 1995).[6]

In this research observation method was used mainly to study the behavioural aspects of the mentally retarded cases. The parents, guardians and the family members reported the behavioural aspects to the researcher on the basis of their observation. The researcher himself studied the behaviour of the mentally retarded children mainly at day centres, too. The researcher also visited most of the houses of the mentally retarded persons to observe them while they are engaged in different activities. He also observed how the parents handle them, nurse them in Daily Living Activities at home.

The researcher's main interest was to compare the problems of the parents of the mentally retarded children with the problems of the non-retarded

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[4] J. Gottlieb, "Observing Social Adaptation in School", In G. P. Sackett (Ed.), *Observing behaviour, Vol I, Theory and Applications in mental retardation*, (Baltimore: University Perk Press), 1978.

[5] Ibid.

[6] Philip H. Bornstein and Alan E. Kazdin ed., *Handbook of Clinical Behavior Therapy with Children*, (Homewood, Illinois: The Dorsey Press, 1985): pp. 134 - 35.

children. The main focus was to find out the psychosocial problems faced by the parents of the mentally retarded children. The researcher also observed the behaviour of the parents related to the items of questionnaire and the CheckList. He tried to observe the emotion, stress, conflicts and confusions present among the parents.

Data Collection and analysis

The researcher visited the day centres at first. The staff members, teachers introduced him to the mentally retarded subjects. The researcher observed some of the activities of the subjects at the day centres. He was given an opportunity to read their personal files and detail case histories. He obtained the home addresses of the subjects from the Day centres, too. Then he established contact with the guardians of the subjects and wanted them to answer his questions.

The researcher mainly interviewed the parents at their own home. The researcher tried to establish some rapport before starting the interview. He had free discussion with the respondents to know their family problems and prospects. The mothers usually spend more time than the fathers during Interview sessions. In most of the cases he did not open the questionnaire or CheckList during the first visit. The researcher used to talk as informally as possible. The respondents were given the opportunity to talk more. The researcher used to keep note in his diary. The parents of the mentally retarded children told him about the birth, illnesses, treatment patterns, behavioural aspect, problems and prospects of the children. Then in the next visits the researcher obtained answers of the questionnaire and the problem CheckList. First, the parents had an impression that case studies of their mentally retarded children are being done. But later they understood that their own problems and feelings are being studied. This created lot of interest among them. They were someway happy to see that their problems are being given importance, too which were ignored by others.

The researcher used to record all his observation in his notebook as descriptively as possible. Finally, the researcher compiled the information from questionnaire, CheckList, case history and observation in the tabulation sheets in numerical figures.

Important findings from the questionnaire and the problem CheckList are shown in different tables in Chapter III of this dissertation. Some of the observations, which were recorded in the notebook, are discussed in chapter IV of this thesis.

In this study, the researcher plotted data from the responses of the questionnaire and CheckList. The researcher both analyzed the data manually and through SPSS. The researcher then coded the responses of the questionnaire and CheckList. The researcher opened a file in SPSS (Statistical Package for Social Sciences) 7.5 version. The researcher then defined all the variables in SPSS. Then he completed data entry in SPSS. After completion of data entry the researcher obtained selected statistical analysis. For analyzing the data, t-test was used.

CHAPTER - III
RESULTS

It was mentioned earlier in the preceding chapter that the researcher used the Bengali translation of Form–A of the Mooney Problem Checklist and a Questionnaire in this study in addition to the Information Blank. The parents identified the problems of the Checklist, which bother them. The average number of problems identified by them are shown in Tables 3.2 to Table 3.16 in the following pages. Some of these problems are their general problems and some of the problems are their severe problems.

Then in Tables 3.18 to Table 3.20, including some sub-tables, the researcher tried to show the average score of the respondents to the 25 questions asked to them. If any respondent score 125, it means he or she possess highly satisfactory condition in relation to Psychosocial conditions. If the respondent score only 25, it means he or she is in serious psychosocial problems.

While plotting data in tables, the researcher tried to compare the responses given by different groups of parents. The groups and sub-groups include parents of mentally retarded and non-retarded children, different socioeconomic status and mother-father sub-groups, etc. However, the following tables are self explanatory with table headings, column headings and row headings.

Problems identified from the Mooney Problem Checklist

The researcher gave the Bengali translation of Adult Form of the Mooney Problem Check List to all the parents and requested them to identify the problems which bother them. They were also asked to circle the problems which are of most concern to them. These problems are of **Personality, Self-improvement, Health, Economic Security,** and **Home – family** problem areas of the checklist.

Table 3.1

Mean and standard deviation of average problems identified by the parents of different groups and sub-groups.

Socio economic groups	Problem areas	Parents of mentally retarded children		Parents of non-retarded children		t
		Mean	Standard Deviation	Mean	Standard Deviation	
Middle	Health	09	4.54	09	2.57	0
	Economic Security	06	6.98	06	3.05	0.572
	Self Improvement	10	4.13	08	3.39	1.63
	Personality	19	11.66	15	7.003	1.28
	Home and Family	08	4.23	07	3.89	0.758
Lower Middle	Health	12	3.15	08	2.59	4.04 **
	Economic Security	10	4.12	10	2.73	0
	Self Improvement	11	2.40	12	3.90	1.13
	Personality	23	5.61	18	6.62	2.37 **
	Home and Family	09	3.27	06	3.37	1.75*
Poor	Health	11	3.97	08	2.35	2.15 **
	Economic Security	14	8.35	13	3.11	0.37
	Self Improvement	10	5.02	08	3.28	1.106
	Personality	22	6.21	17	4.63	2.14 **
	Home and Family	08	2.77	08	2.48	0

* Significant at level 0.01
** Significant at level 0.05

It is seen in the table above that on the average the middle class parents of both the mentally retarded and non-retarded children identified more or less similar member of problems in all the five problem areas. Standard deviations of all the Mean was calculated and t-test was done. It was found that there is no significant difference in any problem area.

Similarly t-test was done for the findings of the problems identified by the parents of the lower middle class families. It was found that

significant difference exist in Health, Personality and Home-Family areas between the parents of the mentally retarded and the non-retarded children.

t-test was also done for the findings of the poor parents. It was found that there are significant differences in Health and Personality problems of the poor parents of the mentally retarded and non-retarded children.

Average number of problems identified by different categories of subjects are shown in the following tables. In the following tables the first column shows the problem areas of the checklist. The second column shows the total number of problems of the Check List in that particular problem area. The third and fourth columns show the average number and percentage of problems identified by the parents of the mentally retarded children. The fifth & six columns show the average number and percentage of problem identified by the parents of the non-retarded children. The tables are self-explanatory with headings indicating the comparison groups of parents.

Table No. 3.2

Number and percentage of General problems identified by the parents of the mentally retarded and non-retarded children in selected areas of the Mooney Problem Check List

Problem areas	Area wise total problems in Check List	Parents of Mentally Retarded Children		Parents of Non - Retarded Children	
		N	%	N	%
Personality	72	21	29.17	17	23.61
Self improvement	36	10	27.78	9	25.00
Health	36	11	30.55	8	22.22
Economic Security	36	10	27.78	9	25.00
Home and family	36	8	22.22	7	19.44
Total	**216**	**60**	**27.78**	**50**	**23.15**

In the table above it is seen that the parents of the mentally retarded children identified more problems in all the five problem areas compared to the parents of the non-retarded children. Considering the percentage, the parents of the mentally retarded children identified more problems in the Health area. It is also seen that the parents of the mentally retarded children identified 60 problems (27.78%) and the parents of the non-mentally retarded children identified 50 problems (23.15%) out of 216 selected problems as their General problems which bother them.

Graph No. 3.2.1 –Average number of problems identified by the parents of the mentally retarded and non- retarded children

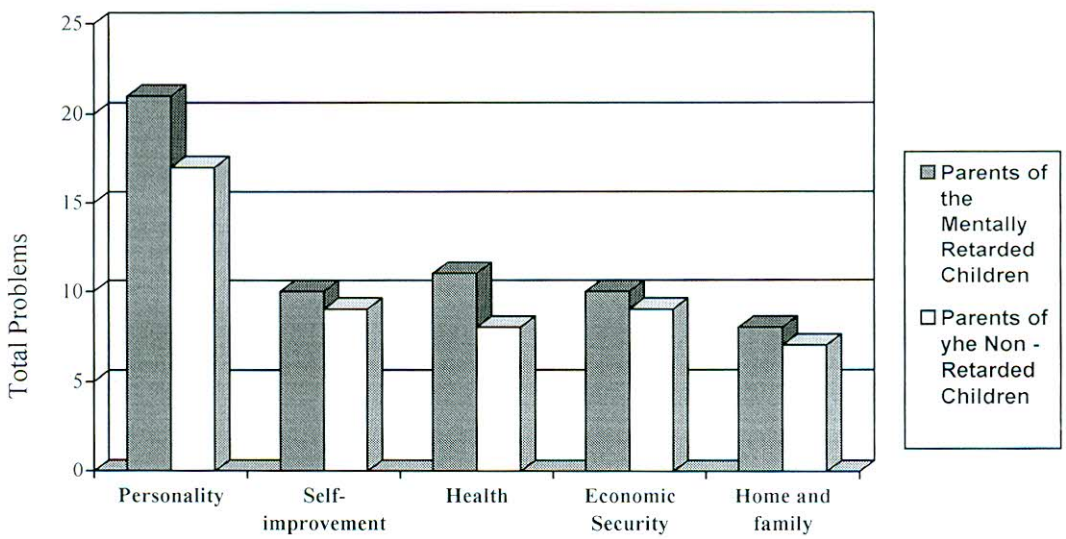

Table No. 3.3

Number and percentage of Severe problems identified by the parents of the mentally retarded and non-retarded children in selected areas of the Mooney Problem Check List

Problem areas	Area wise total problems in Check List	Parents of Mentally Retarded Children		Parents of Non - Retarded Children	
		N	%	N	%
Personality	72	5	6.94	3	4.16
Self improvement	36	3	8.33	1	2.77
Health	36	4	11.11	3	8.33
Economic Security	36	3	8.33	4	11.11
Home and family	36	3	8.33	2	5.55
Total	**216**	**18**	**8.33**	**13**	**6.01**

In the table above the Number and Percentage of Severe problems identified by the parents of the mentally retarded and non-retarded children in five problem areas of the Mooney Problem Check List are shown. If the percentages are considered it is seen that the differences in Self Improvement area of the mentally retarded and the Economic Security of the non-retarded group come into consideration. The parents of the mentally retarded children possess more severe problems in Self Improvement area compared to the parents of the non-retarded children. On the other hand the parents of the non-retarded children possess more severe problems in Economic Security area compared to the parents of the mentally retarded children.

It is also seen that out of 216 selected problems, the parents of the mentally retarded children identified 18 (8.33%) problems as their severe problems. On the other hand the parents of the non-retarded children identified 13 (6.01%) problems as their severe problems. It is believed that existence of only one severe problem in life sometimes jeopardizes the family, work and all other situations.

Table No. 3.4

Number and Percentage of General Problems identified by the parents of different socioeconomic groups of the mentally retarded children.

Problem areas	Area wise Total problems in checklist	Socioeconomic Groups					
		Middle		Lower Middle		Poor	
		N	%	N	%	N	%
Personality	72	19	26.38	23	31.94	22	30.55
Self Improvement	36	10	27.77	11	30.55	10	27.77
Health	36	09	25.00	12	33.33	11	30.55
Home & Family	36	08	22.22	09	25.00	08	22.22
Economic Security	36	06	16.66	10	27.77	14	38.88
Total	216	52	24.07	65	30.09	65	30.09

In the table above Number and Percentage of general problems identified by the parents of the mentally retarded children of different socio-economic group in all the five problem areas are shown. Considering the percentage, the parents of the mentally retarded children of the lower middle class group identified more problems in the Health area. It is also seen that the parents of the mentally retarded children of both the lower middle class and poor groups identified 65 problems (30.09%) out of 216 selected problems.

Table No. 3.5

Number and Percentage of General Problems identified by the parents of different socioeconomic groups of the non- retarded children.

Problem areas	Area wise total problems in checklist	Socioeconomic Groups					
		Middle		Lower Middle		Poor	
		N	%	N	%	N	%
Personality	72	15	20.83	18	25.00	17	23.61
Self Improvement	36	08	22.22	12	33.33	08	22.22
Health	36	09	25.00	08	22.22	08	22.22
Home & Family	36	07	19.44	06	16.66	08	22.22
Economic Security	36	06	16.66	10	27.77	13	36.11
Total	216	45	20.83	54	25.00	54	25.00

In the table above Number and Percentage of general problems identified by the parents of the non- retarded children of different socio-economic groups in all the five problem areas are shown. Considering the percentage, the parents of the non- retarded children of the lower middle class group identified more problems in the Self Improvement area. It is also seen that the parents of the non- retarded children of both the lower middle class and poor groups identified 54 problems (25%) out of 216 selected problems.

Table No. 3.6

Number and Percentage of Severe Problems identified by the parents of different socioeconomic groups of the mentally retarded children.

Problem areas	Area wise total problems in checklist	Socioeconomic Groups					
		Middle		Lower Middle		Poor	
		N	%	N	%	N	%
Personality	72	04	5.55	07	9.72	03	4.16
Self Improvement	36	02	5.55	04	11.11	02	5.55
Health	36	03	8.33	05	13.88	03	8.33
Home & Family	36	02	5.55	04	11.11	03	8.33
Economic Security	36	02	5.55	04	11.11	03	8.33
Total	216	13	6.01	24	11.11	14	6.48

In the table above Number and Percentage of Severe problems identified by the parents of the mentally retarded children of different socio-economic groups in all the five problem areas are shown. Considering the percentage, the parents of the lower middle class group identified more problems in the Health problem area. It is also seen that the parents of the lower middle class identified 24 severe problems (11.11%) out of 216 selected problems.

Table No. 3.7

Number and Percentage of Severe Problems identified by the parents of different socioeconomic groups of the non-retarded children.

Problem areas	Area wise total problems in checklist	Socioeconomic Groups					
		Middle		Lower Middle		Poor	
		N	%	N	%	N	%
Personality	72	03	04.16	03	4.16	03	4.16
Self Improvement	36	02	5.55	02	5.55	01	2.77
Health	36	02	5.55	01	2.77	03	8.33
Home & Family	36	01	2.77	01	2.77	02	5.55
Economic Security	36	02	5.55	03	8.33	04	11.11
Total	216	10	4.63	10	4.63	13	6.01

In the table above it is seen that the parents of the poor group identified more severe problems in the Economic Security area. It is also seen that the parents of the poor group identified 13 severe problems (6.01%) out of 216 selected problems.

Table No. 3.8

Total Problems identified by the mothers & fathers of the mentally retarded children

Problem Areas	Area wise total problems in checklist	Mother		Father	
		N	%	N	%
Personality	72	25	34.72	17	23.61
Self Improvement	36	12	33.33	08	22.22
Health	36	14	38.88	08	22.22
Home & Family	36	13	36.11	07	19.44
Economic Security	36	09	25.00	07	19.44
Total	216	73	33.79	47	21.75

In the table above it is seen that the mothers of the mentally retarded children identified more problems in all the five problem areas compared to the fathers of the mentally retarded children. Considering the percentage, the mothers of the mentally retarded children identified more problems in the Health area. It is also seen that the mothers of the mentally retarded children identified 73 problems (33.798%) and the fathers of the mentally retarded children identified 47 problems (21.75%) out of 216 selected problems as their General problems which bother them.

Table No. 3.9

Total Problems identified by the mothers & fathers of the non-retarded children

Problem Areas	Area wise total problems in checklist	Mother		Father	
		N	%	N	%
Personality	72	19	26.38	15	20.83
Self Improvement	36	10	27.77	08	22.22
Health	36	09	25.00	07	19.44
Home & Family	36	10	27.77	08	22.22
Economic Security	36	08	22.22	06	16.66
Total	216	56	25.92	44	20.37

In the table above it is seen that the mothers of the non-retarded children identified more problems in all the five problem areas compared to the fathers of the non-retarded children. Considering the percentage, the mothers of the non-retarded children identified more problems in the 'Self Improvement' and 'Home-Family' areas. It is also seen that the mothers identified 56 problems (25.92%) and the fathers identified 44 problems (20.37%) out of 216 selected problems as their General problems which bother them.

Table No. 3.10

Severe Problems identified by the mothers & fathers of the mentally retarded children

Problem Areas	Area wise total problems in checklist	Mother		Father	
		N	%	N	%
Personality	72	06	8.33	04	5.55
Self Improvement	36	04	11.11	02	5.55
Health	36	05	13.88	03	8.33
Home & Family	36	03	8.33	03	8.33
Economic Security	36	04	11.11	02	5.55
Total	216	22	10.18	14	6.48

In the table above it is seen that the mothers of the mentally retarded children identified more severe problems in all the five problem areas compared to the fathers of the mentally retarded children. Considering the percentage, the mothers identified more problems in the Health area. It is also seen that the mothers identified 22 severe problems (10.18%) and the fathers identified 14 severe problems (6.48%) out of 216 selected problems.

Table No. 3.11

Severe Problems identified by the mothers & fathers of the non-retarded children

Problem Areas	Area wise total problems in checklist	Mother		Father	
		N	%	N	%
Personality	72	04	5.55	02	2.77
Self Improvement	36	02	5.55	02	5.55
Health	36	04	11.11	02	5.55
Home & Family	36	04	11.11	04	11.11
Economic Security	36	01	2.77	01	2.77
Total	216	15	6.94	11	5.09

In the table above it is seen that the mothers of the non-retarded children identified more severe problems in all the five problem areas compared to the fathers of the non-retarded children. Considering the percentage, the mothers identified more problems in the 'Health' and 'Home-Family' areas. It is also seen that the mothers identified 15 severe problems (6.94%) and the fathers identified 11 severe problems (5.09%) out of 216 selected problems.

Table No. 3.12

Total problems identified by the mothers of the mentally retarded and non-retarded children.

Problem Areas	Area wise total problems in checklist	Mothers of mentally retarded children		Mothers of non-retarded children	
		N	%	N	%
Personality	72	25	34.72	19	26.38
Self Improvement	36	12	33.33	10	27.77
Health	36	14	38.33	09	25.00
Home & Family	36	13	36.11	10	27.77
Economic Security	36	09	25.00	08	22.22
Total	216	73	33.79	56	25.92

In the table above it is seen that the mothers of the mentally retarded children identified more problems in all the five problem areas compared to the mothers of the non-retarded children. Considering the percentage, the mothers of the mentally retarded children identified more problems in the Health area. It is also seen that the mothers of the mentally retarded children identified 73 problems (33.79%) and the mothers of the non-retarded children identified 56 problems (25.92%) out of 216 selected problems as their General problems which bother them.

Table No. 3.13

Total problems identified by the fathers of the mentally retarded and non-retarded children.

Problem Areas	Area wise Total problems in checklist	Fathers of mentally retarded children		Fathers of non-retarded children	
		N	%	N	%
Personality	72	17	23.61	15	20.83
Self Improvement	36	08	22.22	08	22.22
Health	36	08	22.22	07	19.44
Home & Family	36	07	19.44	08	22.22
Economic Security	36	07	19.44	06	16.66
Total	216	47	21.75	44	20.37

In the table above it is seen that the fathers of the mentally retarded children identified more problems compared to the fathers of the non-retarded children. Considering the percentage, the fathers of the mentally retarded children identified more problems in the Personality area. It is also seen that the fathers of the mentally retarded children identified 47 problems (21.75%) and the fathers of the non-retarded children identified 44 problems (20.37%) out of 216 selected problems as their General problems which bother them. It is also seen that the number of problems identified by the fathers of the non-retarded children are slightly more than the father of the mentally retarded children in home family problem area.

Table No. 3.14

Severe problems identified by the mothers of the mentally retarded and non-retarded children.

Problem Areas	Area wise total problems in checklist	Mothers of mentally retarded children		Mothers of non-retarded children	
		N	%	N	%
Personality	72	06	8.33	04	5.55
Self Improvement	36	04	11.11	02	5.55
Health	36	05	13.88	04	11.11
Home & Family	36	03	8.33	04	11.11
Economic Security	36	04	11.11	01	2.77
Total	216	22	10.18	15	6.94

In the table above it is seen that the mothers of the mentally retarded children identified more severe problems in four problem areas compared to the mothers of the non- retarded children. Considering the percentage, the mothers of the mentally retarded children identified more severe problems in the Health area. On the other hand the mothers of non-retarded children identified more severe problems in Home & Family and Health area compared to the mother of the mentally retarded children. It is also seen that the mothers of the mentally retarded children identified 22 severe problems (10.18%) and the mothers of the non-retarded children identified 15 severe problems (6.94%) out of 216 selected problems.

Table No. 3.15

Severe problems identified by the fathers of the mentally retarded and non-retarded children.

Problem Areas	Area wise total problems in checklist	Fathers of mentally retarded children		Fathers of non-retarded children	
		N	%	N	%
Personality	72	04	5.55	02	2.77
Self Improvement	36	02	5.55	02	5.55
Health	36	03	8.33	02	5.55
Home & Family	36	03	8.33	04	11.11
Economic Security	36	02	5.55	01	2.77
Total	216	14	6.48	11	5.09

In the table above it is seen that the fathers of the mentally retarded children identified more severe problems in four problem areas compared to the fathers of the non- retarded children. Considering the percentage, the fathers of the mentally retarded children identified more severe problems in the Health and Home & family area. On the other hand severe problems of the fathers of non-retarded children are more in home-family area. It is also seen that the fathers of the mentally retarded children identified 14 severe problems (6.48%) and the fathers of the non-retarded children identified 11 severe problems (5.09%) out of 216 selected problems.

Table 3.16

Fifty percent or more parents of the Mentally Retarded Children identified the following problems.

SL. NO.	Problem areas & Number		Problem	% of respondents
	area	number		
1	HF	35	Worried about a member of my family	100
2	HF	32	Member of my family in poor health	90
3	SI	15	Wanting worthwhile discussions with people	72
4	P	165	Disliking certain persons	72
5	P	24	Taking things too seriously	70
6	SI	13	Wanting to develop a hobby	68
7	P	72	Not doing anything well	66
8	P	216	Feelings too easily hurt	66
9	P	78	Not really having any friends	58
10	P	212	Constantly Worrying	58
11	SI	255	Missing my former social life	58
12	H	1	Feeling tired much of the time	56
13	ES	58	Having too many financial dependents	54
14	H	100	Allergies(asthma, hay fever, hives, etc.)	54
15	SI	209	Wanting very much to travel	54
16	ES	108	Having too many financial problems	54
17	SI	61	Having a poor memory	54
18	SI	113	Forgetting the things I learned in school	54
19	P	213	Too easily moved to tears	54
20	P	74	Avoiding someone I don't like	52
21	P	121	Being disliked by someone	52
22	ES	154	Unsure of future financial support	52
23	P	168	Trying to forget an unpleasant experience	52
24	ES	200	Not having a systematic savings plan	52
25	HF	223	Mother or father not living	52
26	P	261	Bothered by thoughts running through my head	52
27	H	3	Too much underweight or overweight	50
28	H	54	Feet hurt or tire easily	50
29	H	193	Having considerable trouble with my teeth	50
30	P	211	Mind constantly wandering	50
31	SI	64	Too few opportunities for meeting people	50
32	H	198	Not getting enough rest or sleep	50
33	P	172	People finding fault with me	50
34	HF	131	Wanting love and affection	50

HF = Home and Family
P = Personality
SI = Self Improvement
ES = Economic Security
H = Health

Table 3.17

Fifty percent or more parents of the Non-Retarded Children identified the following problems.

SL. NO.	Problem areas and Number		Problem	% of respondents
	Area	Number		
1	P	24	Taking things too seriously	66
2	ES	154	Unsure of future financial support	58
3	H	50	Stomach trouble (indigestion, ulcers, etc)	56
4	SI	162	Wanting to read worthwhile books more	54
5	P	214	Too nervous or high strung	54
6	SI	63	Not using my leisure time well	52
7	SI	113	Forgetting the things I learned in school	52
8	ES	106	Not having enough money for necessities	50
9	SI	109	Wanting to improve my mind	50
10	SI	209	Wanting very much to travel	50
11	P	74	Avoiding someone I don't like	50

Table 3.17.1

Problems common to both groups of parents

Problem areas and Number	Problem	% of respondents	
		Parents of the mentally retarded children	Parents of the Non-retarded children
P 24	Taking things too seriously	70%	66%
SI 209	Wanting very much to travel	54%	50%
SI 113	Forgetting the thing I learned in school	54%	52%
P 74	Avoiding someone I don't like	52%	50%
ES 154	Unsure of future financial support	52%	58%

HF = Home and Family
P = Personality
SI = Self Improvement
ES = Economic Security
H = Health

Table No. 3.18

Mean and Standard Deviation of attitude score of the parents of the mentally retarded and non-retarded children

Group	N	X	SD	t
Parents of mentally retarded children	60	85.8	9.95	1.81 not significant
Parents of non-retarded children	60	82.06	10.22	

The findings shown in the above table indicate that the two groups of parents do not differ significantly in relation to their psychosocial problems, attitude and expectations. However, the parents of the mentally retarded children scored little better compared to the parents of the non-retarded children.

Mean and Standard Deviation of attitude score of the parents of the mentally retarded and non-retarded children for each item of the questionnaire. For each question 5 is the highest & positive score and 1 is the lowest score.

Table 3.18.1.

How do you evaluate your present family life?

Group	N	X	SD	t
Parents of mentally retarded children	60	3.68	0.81	0.35 not Significant
Parents of non-retarded children	60	3.76	1.38	

Table 3.18.2.

How do you evaluate the relationship with your spouse?

Group	N	X	SD	t
Parents of mentally retarded children	60	3.92	1.18	0.85 not Significant
Parents of non-retarded children	60	3.96	1.07	

Table 3.18.3.

What is your evaluation about your relationship with all your children?

Group	N	X	SD	t
Parents of mentally retarded children	60	4.56	0.57	1.76 not Significant
Parents of non-retarded children	60	4.26	1.07	

Table 3.18.4.

How do you evaluate your relationship with your friends?

Group	N	X	SD	t
Parents of mentally retarded children	60	3.60	0.89	0.74 not Significant
Parents of non-retarded children	60	3.76	1.20	

Table 3.18.5.

How much can you concentrate to your work?

Group	N	X	SD	t
Parents of mentally retarded children	60	3.94	0.93	1.19 not Significant
Parents of non-retarded children	60	3.68	1.21	

Table 3.18.6.

How do you feel about your present life compared to previous life?

Group	N	X	SD	t
Parents of mentally retarded children	60	3.60	0.80	0.41 not Significant
Parents of non-retarded children	60	3.52	1.12	

Table 3.18.7.

How do you feel about your life compared to others?

Group	N	X	SD	t
Parents of mentally retarded children	60	3.42	0.92	0.37 not Significant
Parents of non-retarded children	60	3.50	1.20	

Table 3.18.8.

Do you think that most of the members of your family is very close to each other?

Group	N	X	SD	t
Parents of mentally retarded children	60	4.00	0.77	1.81 not Significant
Parents of non-retarded children	60	3.68	0.97	

Table 3.18.9.

Do you feel that your family members will look after you when you will be sick?

Group	N	X	SD	t
Parents of mentally retarded children	60	4.18	0.95	1.47 not Significant
Parents of non-retarded children	60	3.92	0.79	

Table 3.18.10.

Do you think that your family will take responsibility of any member of your family if she/he is in critical condition (for example, if anyone becomes handicapped)?

Group	N	X	SD	t
Parents of mentally retarded children	60	3.08	0.96	1.26 not Significant
Parents of non-retarded children	60	3.36	1.23	

Table 3.18.11.

Do you sometimes feel worried by thinking that none will take responsibility of your family if you become handicapped?

Group	N	X	SD	t
Parents of mentally retarded children	60	3.48	1.08	3.02 Significant
Parents of non-retarded children	60	2.76	1.27	

Table 3.18.12.

Are you worried about your about future?

Group	N	X	SD	t
Parents of mentally retarded children	60	2.90	1.18	1.27 not Significant
Parents of non-retarded children	60	2.60	1.15	

Table 3.18.13.

Do you think that your life is useless?

Group	N	X	SD	t
Parents of mentally retarded children	60	2.24	1.56	0.43 not Significant
Parents of non-retarded children	60	2.16	1.19	

Table 3.18.14.

Do you believe that your friends and relatives will come forward to help you when you will be in real problem ?

Group	N	X	SD	t
Parents of mentally retarded children	60	3.28	1.00	2.17 Significant
Parents of non-retarded children	60	2.88	0.82	

Table 3.18.15.

Do you think that your life is monotonous or joyless?

Group	N	X	SD	t
Parents of mentally retarded children	60	2.82	1.24	1.24 not Significant
Parents of non-retarded children	60	2.54	0.96	

Table 3.18.16.

Can you accomplish what you want to do?

Group	N	X	SD	t
Parents of mentally retarded children	60	3.86	0.87	17.03 Significant
Parents of non-retarded children	60	3.36	0.81	

Table 3.18.17.

How much opportunity do you get to participate in different social activities?

Group	N	X	SD	t
Parents of mentally retarded children	60	3.20	1.06	1.69 not Significant
Parents of non-retarded children	60	2.86	0.93	

Table 3.18.18.

How much do you expect from al of your children ?

Group	N	X	SD	t
Parents of mentally retarded children	60	4.08	0.93	0.28 not Significant
Parents of non-retarded children	60	4.02	1.19	

Table 3.18.19.

Do you think that you are performing enough responsibilities to of all your children ?

Group	N	X	SD	t
Parents of mentally retarded children	60	3.90	0.83	0.91 not Significant
Parents of non-retarded children	60	3.70	1.30	

Table 3.18.20.

What is the possibility of fulfillment of your expectations?

Group	N	X	SD	t
Parents of mentally retarded children	60	3.58	0.91	0.00 not Significant
Parents of non-retarded children	60	3.58	0.86	

Table 3.18.21.

Do you feel that you are alone?

Group	N	X	SD	t
Parents of mentally retarded children	60	2.62	1.13	18.15 Significant
Parents of non-retarded children	60	2.00	0.63	

Table 3.18.22.

Can you spend your leisure satisfactorily?

Group	N	X	SD	t
Parents of mentally retarded children	60	3.04	1.11	0.36 not Significant
Parents of non-retarded children	60	3.12	1.07	

Table 3.18.23.

Do you think that it will be better if one of your children is send to Day-Care Centre?

Group	N	X	SD	t
Parents of mentally retarded children	60	2.68	1.74	0.87 not Significant
Parents of non-retarded children	60	2.42	1.13	

Table 3.18.24.

Do you feel that now you are successful enough?

Group	N	X	SD	t
Parents of mentally retarded children	60	3.02	0.70	16.29 Significant
Parents of non-retarded children	60	3.52	1.00	

Table 3.18.25.

Considering your whole life pattern do think that this is the life that you wanted to lead?

Group	N	X	SD	t
Parents of mentally retarded children	60	3.12	0.80	0.17 not Significant
Parents of non-retarded children	60	3.14	1.04	

Table 3.19

It was found that out of 25 questions, in 5 questions the parents of the mentally retarded and non-retarded children possess significant differences in attitude. The following 5 tables show the detail of the findings.

Table 3.19.1.

Do you believe that your friends and relatives will come forward to help you when you will be in real problem?

Response	Parents of mentally retarded children		Parents of Non-retarded children	
	N	%	N	%
Very much	10	16.67	2	3.33
Much	12	20.00	10	16.67
Moderate	24	40.00	32	53.33
Not so	14	23.33	10	16.67
Not at all	00	00.00	6	10.00
Total	60	100	60	100

It is seen that 40% parents of mentally retarded children moderately believe that their friends and relatives will help them when they will be in trouble. On the other hand 53.33% parents of non-retarded children believe so. It is also seen that 23.33% parents of mentally retarded children and 16.67% parents of non- retarded children are doubtful. However, 16.67% parents of the mentally retarded children very much expect that their friends and relatives will come forward to help them. Whereas only 3.33% of the parents of the non-retarded children believe so.

Table 3.19.2

Do you sometimes feel worried by thinking that none will take responsibility of your family if you become handicapped?

Response	Parents of mentally retarded children		Parents of Non-retarded children	
	N	%	N	%
Very much	14	23.33	8	13.33
Much	10	16.67	10	16.67
Moderate	30	50.00	10	16.67
Not enough	2	3.33	24	40.00
Not at all	4	6.67	8	13.33
Total	60	100	60	100

From the findings shown in the table above it is seen that 40% parents of the non-retarded children believe that none will take responsibility of their family if they become handicapped. Whereas, only 3.33% parents of the mentally retarded children have similar belief.

Again 50% parents of the mentally retarded children moderately believe that friends and relatives will take responsibility of their families.

From the above findings it is assumed that the parents of the mentally retarded children are more optimistic compared to the parents of the non-retarded children.

Table 3.19.3.

Do you feel that you are alone?

Response	Parents of mentally retarded children		Parents of Non-retarded children	
	N	%	N	%
Very much	6	10	0	0
Much	7	11.67	0	0
Fair	11	18.33	12	20
Not so	30	50.00	36	60
Not at all	6	10.00	12	20
Total	60	100	60	100

It is seen that nearly 22% of the mentally retarded children feel that they are alone. Whereas, none of the parents of the non-retarded children feel so. There are differences in all five levels of answers to this question of the two groups of parents.

Table 3.19.4.

Can you accomplish what you want to do?

Response	Parents of mentally retarded children		Parents of Non-retarded children	
	N	%	N	%
Very much	16	26.67	10	16.66
Much	24	40.00	24	40.00
Sometimes	17	28.33	12	20.00
Not always	3	5.00	07	11.67
Not at all	0	0.00	07	11.67
Total	60	100.00	60	100.00

It is seen that 26.67% parents of the mentally retarded children answered very much compared to 16.66% parents of non-mentally retarded children. On the other hand none of the parents of the mentally retarded children answered 'No'. About 12% parents of non-mentally retarded children answered that they 'Not at all' can accomplish what they want.

Table 3.19.5.

Do you feel that now you are successful enough?

Response	Parents of mentally retarded children		Parents of Non-retarded children	
	N	%	N	%
Very much	0	0.00	12	20.00
Much	16	32.00	14	23.33
Moderate	32	53.33	30	50.00
Not much	10	16.67	0	0.00
Not at all	2	4.00	4	6.67
Total	60	100.00	60	100.00

All the parents were asked how they rate themselves as successful or not in life. It was found that none of the parents of the mentally retarded children answered that they are very much successful. In other ratings of 'Much', 'Moderate', 'Not much' and 'Not at all', there are differences in the level of answers of the two groups of parent.

Table 3.20.1
Comparison on overall attitude of fathers and mothers of mentally retarded children.

Group	N	Mean Score	SD	t
Fathers of the mentally retarded children	30	82.9	9.61	2.20 Significant at 0.05 Level
Mothers of the mentally-retarded children	30	88.7	10.28	

Table 3.20.2
Comparison on overall attitude of fathers and mothers of non-retarded children.

Group	N	Mean Score	SD	t
Fathers of the non- retarded children	30	80.36	10.00	1.26 Not Significant
Mothers of the non-retarded children	30	83.76	10.43	

Table 3.20.3
Comparison on overall attitude of mothers of mentally retarded and non-retarded children.

Group	N	Mean score	SD	t
Mothers of the mentally retarded children	30	88.7	10.28	1.82 Not Significant
Mothers of the non-retarded children	30	83.76	10.43	

Table 3.20.4.
Comparison on overall attitude of fathers of mentally retarded and non-retarded children.

Group	N	Mean Score	SD	t
Fathers of the mentally retarded children	30	82.90	9.61	0.98 Not significant
Fathers of the non-retarded children	30	80.36	10.00	

CHAPTER - IV
DISCUSSION

The main objectives of the present study were to study the number nature and seriousness of the psychosocial problems faced by the parents of the mentally retarded children and to compare the problems with the parents of the non-retarded children of Rajshahi City.

It is not exactly known how many mentally retarded children are there in Rajshahi City. The population of Rajshahi City is approximately 600,000 and if WHO (1968) report (3% of total population) is considered there should be 18,000 mentally retarded persons. But it is sure that now 3% of Bangladeshi population are not mentally retarded. Dr Quamruzzaman, former Head of Psychiatry of Dhaka Medical College conducted a sample survey in Nangolkot of Comilla in 1988 and found 0.68% of the population is mentally retarded. Dr Anwarul Sufi of Rajshahi University Psychology Department studied all the households in a village known Bandaikhara of Naogaon District in 1995 and found only 19 mentally retarded persons out of 4436 villagers. Dr Sufi estimated 0.43% of the population are mentally retarded. Mr Saiful Islam Khan, Lecturer of Psychology of Hatgangopara Degree College of Bagmara Rajshahi studied all the households of Auchpara Union in 2002 and found 117 (0.48%) mentally retarded persons out of 24,201 total population. A team of some students and teachers of Rajshahi University Psychology Department is conducting door to door survey in all the 30 wards of Rajshahi City since 2001 and until very recently identified 739 mentally retarded persons. Though the present findings indicate that only 0.12% of Rajshahi City's population are mentally retarded, the team members assume that about 0.25% of the total population of Rajshahi City are mentally retarded and the total number will be around 1500 persons.

Whatever the number and percentage is in Rajshahi City, the birth of a mentally retarded child in a family jeopardize the social life of the parents, specially the mothers. If the degree of retardation is severe or profound, the problem increases for all the family members. While the researcher was an undergraduate student of Rajshahi University Psychology Department and was a SIVUS Volunteer, he personally visited some families of severely retarded children. In these families he observed that not only the mentally retarded child, the parents, specially the mothers, lead a miserable life. The families sometimes face stigma of the society, either of the parents are always at home to attend the child, marriage prospects of the siblings face difficulties, extra financial burden occurs, and above all, the parents suffer

some psychological stress and complex which are absent in the families without mentally retarded children.

During close interviews, the parents mentioned to the researcher that if the Government could establish some Residential Institutions for the mentally retarded children, they could leave their children there for short periods in emergency situations to go outside the city. As a SIVUS Volunteer the researcher observed the situation is not so severe in the rural areas around Rajshahi. In the rural areas, no doubt the families have a different feeling but the parents are not under so much stress, complex and anxiety like the urban parents. Comparing the urban and rural situations, the researcher understood that more the life is mechanized, more psychosocial problems occur for the parents of the mentally retarded children.

As SIVUS Volunteer, the researcher attended some conferences on Mental Retardation and listened speeches of some foreign delegates. In 1998, the Japanese delegates mentioned that before the Second World War, the quality of life of the Japanese mentally retarded persons were similar like the Bangladeshi mentally retarded persons. In 1999, the Swedish delegates mentioned that in the decade of fifties of the last century when Sweden had massive industrialization in the country, the mothers of the severe mentally retarded persons faced the problem how to maintain their severe or profound mentally retarded children. Then Swedish Government established large-scale residential institutions for such handicapped persons. It was found that such establishments were of great help to the parents of the handicapped children. They were left behind in such institutions under the care of the medical and nursing people. Gradually the frequency of visits of the parents and siblings started reducing to such institutions. Ultimately, the handicapped children became adults and old persons in such institutions without the warmth of the family members. Now, in the Scandinavian countries, the Governments are closing such residential institutions and providing community based support. In Britain, the government policy now is to provide extra pension or social welfare grants to the family members, if they take care of the handicapped persons inside the family.

The experiences of the developed countries indicate that families are the best places of living of the mentally retarded persons. In Bangladesh all the mentally retarded persons live in their families, not at residential institutions. But we do not know the real psychological problems and the social problems faced by the parents and the siblings of such persons.

Psychosocial problems cover a wide range of problems. The interaction among the parents themselves, among the family members and members outside the family are strong variables of the nature, number and

seriousness of the psychosocial problems. Again the nature, number and seriousness varies in individual cases. The socioeconomic status of the families, education of the family members, profession of the parents, living places, community, etc. play important role in the nature, number and seriousness of the psychosocial problems. Knowledge about mental retardation, perception of the global situation, availability of health care facilities, support from inside and outside the family, etc. are important factors, too.

The researcher understands from casual interviews and discussions with the parents of the mentally retarded children that interaction with family members, community members, colleagues, etc. are included in psychosocial problems. The number, nature and seriousness of the psychosocial problems of a mother or a father varies in different degrees. A particular problem may be very simple problem to a person, whereas the same problem may become a very serious problem to another person. There can be thousands of psychosocial problems related to thousands of variables. In the preceding chapter the important psychosocial problems which bother 50% or more of the respondents are shown in two different tables. But these are not all, there can be many more problems.

Here, in this chapter, the researcher attempts to discuss the psychosocial problems in five broad areas. These are:

- Personality
- Self improvement
- Health
- Economic Security, and
- Home & Family.

The discussion in the following sections of this chapter is an attempt of the researcher to analyze the findings shown in the preceding chapter and an attempt to evaluate the findings on the basis of obtained data, secondary data, discussion and observation.

Personality Problems

Personality is relatively a wide concept in Psychology. The personality pattern of a mother or a father before and after the birth of a mentally retarded child may become different. What changes take places depend on many variables. Yet there is no study report, which indicate what changes take place. The major concern of this research was not to study the changes of personality pattern of the parents. The major concern was to get hints about the personality problems of the parents.

The researcher found Mooney Problem Check List Adult Form as an excellent tool to identify the personality problems of the parents. There are 72 specific problems. All these problems bother adult people all over the world in all culture. The researcher asked the parents to identify those problems which bother them. It was found that different persons gave emphasis to different specific problems. Each case was found as an unique case. Therefore, the researcher tried to generalize the cases and the nature of personality problems.

It was found that out of 72 problems, the Middle Class parents of the mentally retarded children identified 19 personality problems on the average. The lower middle class parents identified 23 personality problems on the average. The poor parents identified 22 personality problems. The findings show that lower middle class parents of the mentally retarded children of Rajshahi City possess the highest number of personality problems.

When compared with the personality problems of a matched group of parents of non-retarded children, it was found that the middle class parents have 15 personality problems on the average. This average number is significantly lower than the middle class parents of the mentally retarded children. Similarly the lower middle class and poor parents of the mentally retarded children possess significantly more personality problems compared to lower middle class and poor parents of the mentally retarded children of Rajshahi City.

The researcher segregated the personality problems, which were identified by 50% or more parents of the mentally retarded children. It was found that 72% parents 'Dislike Certain Persons'. On the other hand about 48% parents of non-retarded children reported that it is a problem for them. Why they dislike certain persons? Whom they dislike? During close interview large majority of them told the researcher that their own relatives, friends and neighbors who are not sympathetic to their children and them are the persons they dislike.

'Taking things too seriously' was identified as a problem by 70% parents of the mentally retarded children. During interview the parents mentioned that before birth of their handicapped children this was not a serious problem. Now they feel that they are taking things too seriously. They also mentioned that this feeling is leading them to new psychosocial problems. On the other hand, 66% parents of the non-retarded children also identified this problem as one of their personality problems.

'Not doing anything well' is a personality problem identified by 66% parents of the mentally retarded children. The researcher observed that the parents can do things pretty well. It is sure that they have or had certain expectations which were not fulfilled or can not be fulfilled in the way they expected because of the birth of the handicapped children. So, they now feel that they are not doing anything well.

'Feelings too easily hurt' was also identified by 66% parents of the mentally retarded children. Many of them informed that this particular problem has developed in them after the birth of their handicapped children. Many of them also informed that with the gradual aging of their handicapped children they are gradually overcoming this particular problem. But they feel shocked and hurt when close relatives and neighbors can't perceive the handicapped condition of their children. Some of them also blame their fate. During interview the researcher understood that economic condition of the family is not related to the feeling of this problem by the parents. Rather education and knowledge of the parents are important factors behind feelings of this particular personality problem.

'Not really having any friends' and 'constantly worrying' were identified by 58% parents of the mentally retarded children. 'Too easily moved to tears' was identified by 54% parents. The problems, 'Avoiding someone I don't like', 'Being disliked by someone', 'Trying to forget an unpleasant experience' and 'Bothered by thoughts running through my head' were identified by 52% parents of the mentally retarded children.

'Mind constantly wandering' and 'People finding fault with me' were identified by 50% parents of the mentally retarded children.

During close interview the researcher understood that all these problems center around their handicapped children. In Bangladesh, yet people have many misconceptions about mental retardation, its causes, problems and prospects. The misconceptions are prevailing more among the uneducated and the poor. For all these misconception or faulty ideas sometimes the parents are blamed by their relatives, friends and neighbors. When the parents listen to such false blames they suffer stress, conflict and many other psychological problems.

It was found that 50% or more of the parents of the mentally retarded children identified 13 problems of the Personality area of the Adult Form of the Mooney Problem Check List. These problems and the percentage of respondents are shown in Table 3.16 of the preceding chapter. These problems are:

- Disliking certain persons,
- Taking things too seriously,
- Not really having any friends,
- Not doing anything well,
- Feelings too easily hurt,
- Constantly worrying,
- Too easily moved to tears,
- Bothered by thoughts running through my head,
- Trying to forget and unpleasant experience,
- Avoiding someone i don't like,
- Being disliked by some one,
- People finding fault with me, and
- Mind constantly wandering.

It was mentioned earlier that there are 72 problems in the personality area of the Mooney Problem Check List. The above mentioned problems were identified by 50% or more of the parents of the mentally retarded children. But the following specific personality problems were also identified by a large number of parents of the mentally retarded children.

- Lacking self-confidence
- Being timid or shy
- Feeling ill at ease with other people
- Not getting along well with people
- Being rude or tactless
- Sometimes acting childish or immature
- Being treated unfairly by others
- Having feelings of extreme loneliness
- Not knowing the kind of person I want to be
- Confused as to what I really want
- Feeling no one cares for me
- Having difficulty in making decisions
- Sometimes afraid of going insane
- Sometimes feeling forced to perform certain acts
- Having a troubled or guilty conscience
- Sometimes being dishonest

Detail of the findings shown in page 103-104 in Appendix - I

Problems related to Self-improvement

Self-improvement problems are social problems. There are 36 problems related to self-improvement in the Mooney Problem Checklist Adult Form. The researcher requested the respondents to identify the problems that bother them and circle the problems that are of most concern to them.

The parents of the mentally retarded children identified 10 and the parents of the non-retarded children identified 9 problems on the average from the self-improvement area, which are of concern to them. The parents of the mentally retarded children identified 4 problems on the average as their serious problems and the parents of the non-retarded children identified 3 problems as serious problems.

The middle class, lower middle class and poor parents of the mentally retarded children respectively identified 10, 11 and 10 problems out of 36 problems on the average. On the other hand the middle class, lower middle class and poor parents of the non-retarded children respectively identified 8, 12 and 8 problems out of 36 problems on the average. It was found that the middle class and poor parents of the non-retarded children have lesser problems compared to their counterpart parents of the mentally retarded children. Surprisingly the lower middle class parents of the non-retarded children identified highest number of self-improvement problems.

When the same parents were requested to rethink and identify the problems which are of serious nature to them in self improvement area, the middle class, lower middle class and poor parents of the mentally retarded children respectively identified only 2, 4 and 2 problems on the average as serious problems. On the other hand the middle class, lower middle class and poor parents of the non-retarded children respectively identified only 2, 2 and 1 problems. This finding indicates that self-improvement problems are not necessarily related to the birth and care of the mentally retarded children. It also indicates that the parents of lower middle class socioeconomic group possess more self-improvement problems compared to the other socio-economic groups.

It was found that mothers of the mentally retarded children possess 12 and the fathers possess 8 problems on the average in self-improvement area. Whereas the mothers of the non-mentally retarded children possess 10 and the fathers possess 8 problems on the average in self-improvement area. When asked to identify the severe problems in self-improvement area the mothers of the mentally retarded children identified only 4 and the fathers identified 2 problems on the average as serious problems. Both the mothers and fathers of the non- retarded children identified only 2 problems on the

average as serious problems. This finding indicates that there is no difference in the possession of self-improvement problems among the fathers of the mentally retarded and non-retarded children.

'Wanting worthwhile discussions with people' was identified by 72% parents of the mentally retarded children. This problem was not identified by majority of the parents of the non-retarded children. This finding clearly indicates that the parents of the mentally retarded children in Rajshahi City are in urgent need of counseling and guidance.

'Wanting to develop a hobby' was identified by 68% parents of the mentally retarded children which again was not identified by majority of the parents of the non-retarded children. This created interest to the researcher and he during close discussion understood that this is some sort of Defense Mechanism, the parents of the mentally retarded children want to adopt.

'Missing my former social life' was identified by 58% parents of the mentally retarded children which again was not identified by majority of the parents of the non-retarded children. This finding indicate that the parents of the mentally retarded children are either pre-occupied with their handicapped children or are withdrawing themselves from social interactions.

'Wanting very much to travel' was identified by 54% parents of the mentally retarded children and 50% of the parents of the non-retarded children. This is a common self-improvement problem to majority of the parents of both categories.

'Having a poor memory' was identified by 54% parents of the mentally retarded children which was not identified by majority of the parents of the non-retarded children.

'Forgetting the things I learned in school' was identified by 54% parents of the mentally retarded children and 52% of the parents of the non-retarded children. This is a common self-improvement problem to majority of the parents of both categories.

'Too few opportunities for meeting people' as a self-improvement problem was identified by 50% parents of the mentally retarded children which was not identified by majority of the parents of the non-retarded children.

Among other self-improvement problems 'Wanting to improve myself culturally', 'Not being as efficient as I would like', 'Trouble keeping up a conversation', 'Wanting to improve my mind', 'Wanting to improve my manners or etiquette', 'Wanting more personal freedom', 'Wanting more chance for self- expression', 'Not having enough time for recreation', 'Needing a vacation', 'Not having enough social life', 'Being alone too

much', 'Spending too many evenings at home', 'Not living a well-rounded life', etc are the problems which bother the parents of the mentally retarded children in Rajshahi City relatively more compared to the parents of the non-retarded children. To some parents one or two of these problems are their serious problems.

Health Problems

According to WHO (World Health Organization) health includes complete physical, mental and social wellbeing, and not merely the physical condition. The Adult Form of the Mooney Problem Checklist was so developed that include such items which projects not only the physical health problems but also the relationship to psychosocial conditions.

The respondents of this research, the parents of the mentally retarded and the non-retarded children of Rajshahi City, were asked to identify the health problems which bother them, from 36 selected problems of the checklist. They identified which problems are general problems to them and then segregated the problems which are of severe nature and are of most concern to them.

It was found that on the average the parents of the mentally retarded children identified 11 problems and the parents of the non-retarded children identified 8 problems. Respectively they also identified 4 and 3 problems are of severe concern to them.

Middle class parents of both mentally retarded and non-retarded children identified 9 problems. Lower Middle Class parents of the mentally retarded children identified 12 and the parents of the non-retarded children identified 8 problems. The Poor parents of the mentally retarded children identified 11 and the parents of the non-retarded children identified 8 health problems on the average.

The Mean differences of health problems identified by the parents of the mentally retarded and the non-retarded children were found highly significant. The results are shown in Table 3.1 of the preceding chapter.

The mothers of the mentally retarded children on the average possess 14 health problems and the fathers possess 8 problems. Among these 14 and 8 problems, 5 and 3 problems respectively are of severe nature. On the other hand the mothers of the non-retarded children possess 9 and the fathers possess 7 health problems on the average. And among these 9 and 7 problems of the parents of the non-retarded 4 and 2 problems are respectively of severe nature. The findings clearly indicate that the parents of the mentally retarded children are having more general and severe health problems compared to the parents of the non-retarded children.

'Feeling tired much of the time' and 'Allergies' as health problems were identified by 54% parents of the mentally retarded children. These two

problems were not identified by majority of the parents of the non-retarded children.

'Too much underweight or overweight', 'Feet hurt or tire easily', 'Having considerable trouble with my teeth' and 'Not getting enough rests or sleeps' are four of the health problems which were identified by 50% of the parents of the mentally retarded children. Majority of the parents of the non-retarded children did not identify these as their problems. It was also found that the health problems of the parents of the mentally retarded and the non-retarded children are not of common nature. And all the six specific problems mentioned above are someway related to the psychosocial condition of the parents. Some of these problems are indicators of psychosomatic diseases, too.

'Sleeping poorly', 'Poor appetite', 'Having a permanent illness or disability', 'Troubled by headaches', 'Glandular disorders', 'Muscular aches and pains', 'High blood pressure', 'Occasionally feeling faint or dizzy', 'Troubled by swelling of the ankles', 'Occasional pressure or pain in my head', 'Bothered by shortness of breath', 'Having heart trouble', and 'Needing another climate for my health', are some of the problems which were identified by a large number of parents of the mentally retarded children.

If a mother or a father can't get enough sleep, he or she can't interact well in social situations. Poor appetite is a clear symptom of some psychosomatic illnesses. If headaches or an experience of occasional pressure or pain in head troubles someone, he or she should get immediate medical attention. Bothered by shortness of breath means something serious. If someone feels the need of another climate for health, at least should be given some relieve from his or her monotonous work loads.

Economic Security Problems

Economy and economic security are important aspects of adult life. To the parents, the economic security is a serious matter to run the family smoothly. In Bangladesh, yet there is no well-developed social security system. Also health insurance and other pension schemes are inadequate or practically nil. People of fixed income groups, specially the fathers, always remain worried about financial matters. If there is an emergency and not enough fund in hand people sometimes face extensive psychological stress.

Economic security problems can be considered as social problems that ultimately may lead to many psychological problems, too. There are 36 problems in the Mooney Problem Checklist Adult Form related to economic security. The researcher requested the two groups of respondents, who are the parents of the mentally retarded and the non-retarded children, to mark the Economic Security problems, which bother them. They identified the specific problems as of simple and of severe nature.

It was found that the parents of the mentally retarded children identified 10 problems of simple nature and 3 problems of severe nature, on the average from the list of 36 selected problems related to Economic Security. On the other hand the parents of the non- retarded children identified 9 problems of simple nature and 4 problems of severe nature in economic security problem area.

The middle class parents of the mentally retarded children identified 6 problems as simple and 2 problems as severe problems. The Lower Middle Class parents identified 10 simple and 4 severe problems. The Poor parents identified 14 simple and 3 severe problems, on the average.

On the other hand the Middle class parents of non-retarded children identified 6 simple and 2 severe problems in the economic security area. The Lower Middle Class parents of the non-retarded children identified 10 simple and 3 severe problems. The Poor parents of the non-retarded children identified 13 simple and 4 severe problems in the economic security area, on the average.

The mothers of the mentally retarded children identified 9 simple and 4 severe problems. The fathers of the mentally retarded children identified 7 and simple 2 severe problems. On the other hand, the mothers of the non-retarded children identified 8 simple and 1 severe problems. On the average, the fathers of the non-retarded children identified 6 simple and 1 severe problems, in economic security problem area.

It was also found that 50% or more parents of the mentally retarded children identified four specific problems in the economic security area. Following are the four problems.

- Having too many financial dependents (54%)
- Having too many financial problems (54%)
- Unsure of future financial support (52%)
- Not having a systematic savings plan (52%)

The problem 'Unsure of future financial support' was also identified by 52% parents of the non-retarded children.

Among other problems of economic security area, the following 11 problems were identified by more than 35% parents of the mentally retarded and the non-retarded children.

- Living in an undesirable location
- Lacking privacy in my living quarters
- Unfair landlord or landlady
- Disliking financial dependence on others
- Getting into debt
- Needing financial assistance
- Not having enough money for necessities
- Too little money for recreation
- Not budgeting my money
- Having to spend all my savings
- Worried about security in old age

Though there are Mean Differences of the problems identified by different groups and sub-groups of parents, these differences were not found statistically significant. Therefore, it is concluded that economic security problems of the parents are not related to the mentally retarded condition of their children.

Home & Family Problems

The effects of rearing a handicapped child on the family appear to be complex. Many studies and personal observations agree that the families are faced with many problems including those of management, finance, deprivation of rest and leisure to the parents. Some families may cope very well and remain cohesive and creative units in which other children may grow up normally and happily. But some families may get over strained by the presence of a handicapped child and eventually disintegrate.

Home and family problems are basically social problems but having some psychological impacts. There are 36 problems in the checklist related to home and family.

It was found that the parents of the mentally retarded children identified 8 problems of simple nature and 3 problems of severe nature, on the average from the list of 36 selected problems related to Home-Family area. On the other hand the parents of the non- retarded children identified 7 problems of simple nature and 2 problems of severe nature in Home-Family problem area.

Middle class parents of mentally retarded children identified 8 simple and 2 severe problems in the Home-Family area. The Lower Middle Class parents of the mentally retarded children identified 9 simple and 4 severe problems. The Poor parents of the mentally retarded children identified 8 simple and 3 severe problems in the Home-Family area, on the average.

On the other hand the middle class parents of the non-retarded children identified 7 problems as simple and 1 problem as severe problems. The Lower Middle Class parents identified 6 simple and 1 severe problems. The Poor parents identified 8 simple and 2 severe problems, on the average, in Home-Family problem area.

The mothers of the mentally retarded children identified 13 simple 3 severe problems in Home-Family problem area. The fathers of the mentally retarded children identified 7 simple 3 severe problems in Home-Family problem area. On the other hand, the mothers of the non-retarded children identified 10 simple 4 severe problems. The fathers of the non-retarded children identified 8 simple 4 severe problems, on the average, in Home-Family problem area.

It was also found that 50% or more parents of the mentally retarded children identified four specific problems in the Home-Family area. Following are the four problems.

- Worried about a member of my family (100%)
- Member of my family in poor health (90%)
- Mother or father not living (52%)
- Wanting love and affection (50%)

None of these four problems was identified by majority of the parents of the non-retarded children.

Among other problems of Home-Family area, the following eight problems were identified by more than 40% parents of both the mentally retarded and the non-retarded children.

- Members of my family working too hard
- Home untidy and ill kept
- Too much nagging and complaining at home
- Not really having a home
- Not being understood by my family
- Too much interference by relatives
- Unable to discuss certain problems at home
- Needing advice about raising children

Though there are Mean Differences of the problems identified by different groups and sub-groups of parents, the differences of the middle class and poor parents were not found statistically significant. Only the Mean Differences of different sub-groups of the Lower Middle Class are statistically significant.

The problem, 'worried about a member of my family' was identified by 100% of the parents of mentally retarded children.

The problem, 'member of my family in poor health' has been identified by 90% of the parents of the Mentally Retarded children, (94% Lower middle class, 100% Poor economy and 80% middle class). During interview most of the parents reported that their Mentally retarded children is in poor health.

Conclusions

Though this research was designed mainly to study the number, nature and seriousness of the psychosocial problems of the parents of the mentally retarded children of Rajshahi City and to compare their problems with the problems of the parents of non-retarded children, the researcher concludes the following on the basis of primary data, secondary sources, free discussion with the parents and his personal observation.

1. The parents of the mentally retarded children face more psychosocial problems compared to the parents of the non-retarded children.

2. Mothers of the mentally retarded children possess more psychosocial problems compared to the fathers of the mentally retarded children.

3. Parents of the mentally retarded children of lower middle class socioeconomic group possess more psychosocial problems compared to the middle class and poor socioeconomic groups.

4. Large majority of the parents of the mentally retarded children, specially the mothers, do not possess scientific knowledge related to the factors of mental retardation, prospects of special education and other therapies in Rajshahi city.

5. Large majority of the lower middle class severely retarded children are being given psychotropic drugs which are creating more problems to the children and their parents.

Recommendations

On the basis of his observation, the researcher strongly recommends the following to alleviate the psychosocial problems faced by the parents of the mentally retarded children in Rajshahi city.

1. The health wing of the City Corporation must undertake an appropriate measure to identify the mentally retarded children living in all the 30 wards of the city.

2. At least one Special Education School or Day Care Center are needed in all the 30 wards of Rajshahi city where these mentally retarded children should spend some time of the day. During absence of these children from home in such schools or Day Centers, the mothers can take a break.

3. Both institutional and home based counseling programs are urgently needed for the parents to help them realize the exact condition of their handicapped children and plan what to do for them.

4. Some social welfare benefit or monthly pension from the Government for the mentally retarded persons will increase the social status of the mentally retarded persons and their parents.

5. A National Policy for the Mentally Retarded persons is urgently needed in Bangladesh that the NGOs can not do trials and errors with them and their families.

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Appendix - I

The following 6 pages show the percentage of respondents in all the 216 problems in the areas of Mooney problem checklist. These are the findings of the main study

Percentage of respondents in the Health (H) area

Problem. Number.	Parents of mentally retarded children				Parents of Non-retarded child			
	Socio economic group			TOTAL	Socio economic group			TOTAL
	Middle	Lower Middle	Poor		Middle	Lower Middle	Poor	
1	25	61	100	56	30	16	42	28
2	30	33	83	44	70	39	25	48
3	20	72	67	50	30	33	8	26
4	15	61	0	28	15	17	0	12
5	0	33	0	18	20	17	8	16
6	15	61	67	58	25	44	25	32
49	15	33	25	24	15	22	42	24
50	30	17	16	22	60	61	42	56
51	15	33	0	18	45	11	8	24
52	25	33	42	32	15	17	25	18
53	50	33	0	32	5	11	0	6
54	50	56	42	50	35	33	0	26
97	30	27	67	38	15	11	8	12
98	15	17	0	12	20	17	42	24
99	25	44	25	32	30	11	8	18
100	50	56	58	54	20	66	83	44
101	40	56	25	42	35	11	25	24
102	0	44	25	22	10	6	8	8
145	30	28	0	22	10	22	83	32
146	15	0	0	6	10	6	25	12
147	15	33	0	18	15	17	8	14
148	15	0	41	16	0	22	8	10
149	30	44	0	28	45	6	16	24
150	50	33	0	32	25	22	25	24
193	40	72	33	50	30	22	25	26
194	0	0	16	4	5	6	8	6
195	0	17	0	6	20	0	16	12
196	55	17	0	28	30	50	44	46
197	25	33	75	40	45	27	16	32
198	55	44	50	50	45	50	25	42
241	25	61	16	36	15	33	8	20
242	15	17	41	18	15	0	25	12
243	15	17	0	22	15	11	25	16
244	15	28	0	16	15	17	0	12
245	15	17	0	12	30	55	25	38
246	0	0	0	0	5	6	8	6

Percentage of respondents in the Economic Security(ES) area.

Problem. Number.	Parents of mentally retarded children				Parents of Non-retarded child			
	Socio economic group			TOTAL	Socio economic group			TOTAL
	Middle	Lower Middle	Poor		Middle	Lower Middle	Poor	
7	15	44	0	22	5	22	42	20
8	0	28	0	10	35	44	16	34
9	15	44	75	40	20	33	25	26
10	25	17	25	22	15	33	25	24
11	0	33	25	18	15	6	0	8
12	0	28	25	16	20	38	8	24
55	15	33	42	28	15	17	39	26
56	0	44	0	16	15	28	8	18
57	15	44	42	32	20	28	16	22
58	45	50	75	54	20	50	66	42
59	25	33	91	44	35	22	58	36
60	15	33	41	28	15	55	25	32
103	30	33	58	38	10	22	42	22
104	30	33	66	40	5	33	16	18
105	0	17	66	22	5	11	33	14
106	25	61	25	38	5	77	83	50
107	0	0	25	6	5	22	25	16
108	30	61	83	54	10	55	83	44
151	25	44	58	40	15	11	8	12
152	15	27	41	26	10	22	25	18
153	0	17	25	12	15	11	8	12
154	30	56	83	52	45	66	66	58
155	15	28	83	36	15	22	16	18
156	15	0	25	12	10	6	16	10
199	30	33	41	34	15	33	44	34
200	25	72	66	52	15	28	50	28
201	15	17	41	22	15	11	66	26
202	30	0	0	12	10	11	38	22
203	15	0	41	16	10	39	16	22
204	40	0	41	26	20	11	25	18
247	15	44	0	22	10	6	8	8
248	15	33	66	34	15	22	25	20
249	0	0	25	6	10	22	66	28
250	0	0	0	0	10	22	8	14
251	0	0	25	6	10	55	50	36
252	40	17	41	32	30	44	50	40

Percentage of respondents in the Self Improvement (SI) area.

Problem Number	Parents of mentally retarded children				Parents of Non-retarded child			
	Socio economic group			TOTAL	Socio economic group			TOTAL
	Middle	Lower Middle	Poor		Middle	Lower Middle	Poor	
13	40	89	83	68	40	44	41	38
14	40	61	25	44	20	28	8	20
15	65	61	100	72	20	28	41	28
16	15	33	50	30	10	17	8	12
17	40	17	25	28	5	33	0	24
18	15	44	25	28	15	33	33	24
61	30	72	66	54	20	28	25	24
62	40	33	0	28	20	50	25	32
63	25	33	25	28	35	72	50	52
64	15	56	100	50	15	38	0	20
65	25	50	25	34	10	28	0	14
66	15	44	50	34	15	28	16	20
109	40	17	41	32	35	55	66	50
110	30	28	0	12	15	33	8	20
111	15	0	25	12	20	61	58	44
112	0	28	0	10	10	44	8	24
113	60	44	58	54	65	44	41	52
114	30	17	25	24	15	17	8	14
157	40	28	0	26	30	17	16	22
158	40	28	25	32	20	39	41	32
159	30	28	0	22	10	44	41	30
160	0	0	25	6	15	28	8	18
161	30	17	25	18	15	39	41	30
162	25	44	41	36	65	50	41	54
205	15	17	0	12	15	11	0	0
206	0	17	25	12	20	6	8	12
207	0	17	41	16	20	44	41	34
208	25	17	0	16	10	11	8	10
209	40	78	41	54	30	66	58	50
210	25	17	16	20	50	38	25	40
253	0	17	58	20	15	44	0	22
254	0	17	16	10	10	11	0	8
255	65	89	0	58	20	28	25	24
256	15	17	0	12	10	17	16	14
257	25	17	25	22	20	17	8	16
258	40	33	16	32	10	6	25	12

Percentage of respondents in the Personality (P) area.

Problem. Number.	Parents of mentally retarded children				Parents of Non-retarded child			
	Socio economic group			TOTAL	Socio economic group			TOTAL
	Middle	Lower Middle	Poor		Middle	Lower Middle	Poor	
19	15	44	25	28	25	39	41	34
20	15	61	16	32	30	11	92	38
21	30	78	25	46	20	50	8	28
22	15	33	41	28	10	39	8	20
23	25	61	50	38	10	17	16	14
24	75	72	58	70	80	67	41	66
25	30	28	25	28	35	17	8	22
26	25	33	75	40	20	28	41	28
27	0	56	66	36	10	28	33	22
28	25	44	0	26	10	6	0	6
29	40	44	0	32	15	6	0	8
30	0	28	0	10	10	22	8	14
67	30	72	0	38	35	33	8	28
68	15	28	25	22	10	6	25	12
69	15	28	0	16	5	39	66	32
70	25	28	25	26	15	28	25	22
71	25	33	0	22	15	28	25	22
72	60	72	66	66	25	67	41	44
73	0	33	41	22	10	11	25	14
74	65	44	41	52	75	39	25	50
75	15	44	50	34	10	22	8	14
76	40	33	50	40	15	17	41	22
77	15	33	41	28	15	11	25	16
78	25	78	83	58	10	17	25	16
115	15	28	25	22	5	50	16	24
116	15	0	0	6	10	11	8	10
117	40	33	58	42	50	22	66	44
118	25	28	41	30	45	61	25	46
119	15	17	0	12	15	17	8	14
120	25	0	25	16	15	33	17	22
121	50	61	41	52	10	39	41	28
122	40	28	0	26	5	11	8	8
123	15	0	25	12	15	6	8	10
124	50	17	25	32	10	44	25	26
125	0	0	0	0	10	17	8	12
126	25	17	25	22	15	6	17	12
163	15	0	50	18	15	11	17	12
164	15	17	41	22	15	17	16	16
165	65	88	58	72	50	61	25	48

Percentage of respondents in the Personality (P) area.

Problem. Number.	Parents of mentally retarded children				Parents of Non-retarded child			
	Socio economic group			TOTAL	Socio economic group			TOTAL
	Middle	Lower Middle	Poor		Middle	Lower Middle	Poor	
166	30	28	0	22	15	22	25	20
167	40	33	0	28	20	17	25	20
168	30	33	91	52	35	33	17	30
169	15	0	0	6	10	17	8	12
170	25	0	0	10	10	17	8	12
171	25	0	0	10	15	22	8	16
172	50	39	66	50	15	17	8	14
173	15	39	25	26	15	6	33	16
174	30	28	25	28	15	22	8	16
211	25	72	58	50	25	33	17	26
212	65	61	41	58	20	28	8	20
213	65	44	50	54	40	28	25	32
214	25	33	41	32	75	28	58	54
215	15	28	50	28	15	6	8	10
216	40	78	91	66	15	50	83	44
217	15	0	0	6	20	28	25	24
218	25	0	25	16	25	28	8	22
219	25	28	41	30	45	44	41	44
220	40	28	25	32	35	11	25	24
221	25	33	41	32	20	28	8	20
222	40	56	25	42	20	33	8	22
259	15	39	58	34	15	11	16	14
260	15	0	25	12	15	17	25	18
261	40	55	66	52	35	28	50	36
262	15	17	25	18	20	17	8	16
263	0	0	0	0	20	17	25	20
264	25	17	41	26	60	44	8	42
265	15	50	0	24	15	33	17	22
266	15	0	0	6	15	11	25	16
267	25	0	25	16	20	11	25	18
268	15	0	0	6	15	11	8	12
269	15	0	25	12	5	6	25	10
270	0	17	0	6	20	22	50	28

Percentage of respondents in the Home & Family (HF) area.

Problem. Number.	Parents of mentally retarded children				Parents of Non-retarded child			
	Socio economic group			TOTAL	Socio economic group			TOTAL
	Middle	Lower Middle	Poor		Middle	Lower Middle	Poor	
31	25	28	25	26	50	6	8	24
32	80	94	100	90	10	17	25	16
33	15	72	0	32	20	33	41	30
34	30	56	50	44	20	17	33	26
35	100	100	100	100	35	6	8	18
36	0	17	0	6	20	22	25	22
79	15	28	0	16	20	33	8	22
80	25	61	50	44	35	11	33	26
81	0	33	0	12	25	28	25	26
82	25	33	25	28	10	6	8	8
83	25	44	25	32	10	17	25	16
84	0	17	25	6	15	28	41	26
127	55	33	0	34	15	22	25	20
128	40	17	0	22	15	6	17	12
129	25	0	0	10	15	6	17	12
130	25	17	0	16	5	17	25	14
131	25	50	91	50	15	50	25	30
132	25	0	0	0	15	11	25	16
175	25	28	25	26	5	17	8	10
176	0	0	0	0	15	28	0	16
177	15	28	66	32	25	11	25	20
178	30	17	0	18	35	17	25	26
179	25	44	50	38	15	28	25	22
180	15	0	25	12	15	11	8	12
223	50	50	58	52	15	39	75	38
224	15	17	0	12	20	11	8	14
225	15	0	0	6	15	39	8	22
226	30	0	0	12	10	28	25	20
227	0	0	0	0	20	11	25	18
228	25	17	0	16	10	6	25	12
271	0	0	0	0	15	6	8	10
272	30	17	0	18	10	11	8	10
273	0	0	0	0	25	22	25	24
274	25	17	0	16	15	11	8	12
275	0	0	41	10	15	11	50	22
276	0	0	25	6	10	17	8	12

Appendix- II

MOONEY PROBLEM CHECK LIST, FORM - A

(1950 revised edition)

Leonard V. Gordon and **Ross L. Mooney**
Bureau of Educational Research
Ohio State University

INSTRUCTIONS

"This contains a list of problems frequently faced by people concerning their health, work, family, temperament, etc. Please go through the list and select the statement which refers to your problems.

Remember, it is not a Psychological test and there is nothing right or wrong here. This questionnaire is applied for the purpose of research and for getting information about general problems of human existence. If you mark the list honestly and sincerely, then we may get a valid sample list of human problems. If a statement of this booklet seems to be related to your problem, then underline the serial number of that statement in the answer sheet.

You may be assured that, the confidentiality of the answer given by you will be maintained by all means.

Here you will have to work in three steps:-

First step: Read the list slowly and underline in the answer sheet, the serial number of each problem that troubled you. Suppose the first statement of the list, "1. feeling tired much of the time", is a problem for you, then underline the serial No. 1 in the answer sheet like this '1'.

Second step: After you have gone through the entire list, look once again the problems that you have underlined. This time encircle the serial numbers of those problems which appear to you to be of most concerned to you. Suppose the first statement of the list, i.e., "1. Feeling tired much of the time," is of most concerned to you, then encircle the serial No. (1) in this way '(1)' in the answer sheet.

Third step: Answer to the summarizing statements on the opposite page of the answer sheet. 'Thank you'

First Step: Read the list slowly, and as you come to a problem which troubles you, underline it.

1. Feeling tired much of the time
2. Sleeping poorly
3..Too much underweight or overweight
4. Gradually losing weight
5. Frequently bothered by a sore throat
6. Catching a good many colds

7. Living in an undesirable location
8. Transportation or commuting problem
9. Lacking modern conveniences in my home
10. Lacking privacy in my living quarters
11. Unfair landlord or landlady
12. Poor living conditions

13. Wanting to develop a hobby
14. Wanting to improve myself culturally
15. Wanting worthwhile discussions with people
16. Wanting to learn how to dance
17. Lacking skill in sports or games
18. Not knowing how to entertain

19. Lacking leadership ability
20. Lacking self-confidence
21. Not really being smart enough
22. Being timid or shy
23. Lacking courage
24. Taking things too seriously

25. Wanting a more pleasing personality
26. Awkward in meeting people
27. Daydreaming
28. Being too tall or too short
29. Being physically unattractive
30. Wishing I were the other sex

31. Being away from home too much
32. Member of my family in poor health
33. Death in my family
34. Member of my family working too hard
35. Worried about a member of my family
36. Drinking by a member of my family

49. Poor appetite
50. Stomach trouble (indigestion, ulcers, etc.)
51. Intestinal trouble
52. Poor complexion or skin trouble
53. Poor posture
54. Feet hurt or tire easily

55. Needing a job
56. Needing part-time work
57. Disliking financial dependence on others
58. Having too many financial dependents
59. Getting into debt
60. Fearing future unemployment

61. Having a poor memory
62. Not being as efficient as I would like
63. Not using my leisure time well
64. Too few opportunities for meeting people
65. Trouble keeping up a conversation
66. Not mixing well with the opposite sex

67. Being lazy
68. Lacking ambition
69. Being influenced too easily by others
70. Being untidy
71. Being too careless
72. Not doing anything well

73. Feeling ill at ease with other people
74. Avoiding someone I don't like
75. Finding it hard to talk before a group
76. Worrying how I impress people
77. Not getting along well with people
78. Not really having any friends

79. Having to live with relatives
80. Irritated by habits of member of my family
81. Home untidy and ill kept
82. Too much quarreling at home
83. Too much nagging and complaining at home
84. Not really having a home

97. Having a permanent illness or disability
98. Frequent nose or sinus trouble
99. Having trouble with my ears or hearing
100. Allergies (asthma, hayfever, hives, etc.)
101. Having trouble with my eyes
102. Having a serious illness or disease

103. Needing financial assistance
104. Can't seem to make ends meet
105. Not getting a satisfactory diet
106. Not having enough money for necessities
107. Never being able to own a home of my own
108. Having too many financial problems

109. Wanting to improve my mind
110. Wanting to improve my appearance
111. Wanting to improve my manners or etiquette
112. Having trouble with my speech
113. Forgetting the things I learned in school
114. Having trouble understanding what I read

115. Speaking or acting without thinking
116. Being rude or tactless
117. Being stubborn or obstinate
118. Sometimes acting childish or immature
119. Being envious or jealous
120. Tending to exaggerate too much

121. Being disliked by someone
122. Being left out of things
123. Being made fun of or teased
124. Being treated unfairly by others
125. Suffer form racial or religious prejudice
126. Having feelings of extreme loneliness

127. Not being understood by my family
128. Not being trusted by my family
129. Feeling rejected by my family
130. Having an unhappy home life
131. Wanting love and affection
132. Being an only child

145. Troubled by headaches
146. Glandular disorders (thyroid, lymph, etc.)
147. Menstrual or female disorders
148. Kidney or bladder trouble
149. Muscular aches and pains
150. High blood pressure

151. Not enough money for medical expenses
152. Too little money for recreation
153. Needing money for education or training
154. Unsure of future financial support
155. No steady income
156. Work too irregular or unsteady

157. Needing more exercise
158. Needing more outdoor air and sunshine
159. Wanting more personal freedom
160. Wondering if further education is worth while
161. Wishing I had a better educational background
162. Wanting to read worthwhile books more

163. Too self-centered
164. Getting into arguments or fights
165. Disliking certain persons
166. Sometimes lying without meaning to
167. Feeling blue and moody
168. Trying to forget an unpleasant experience

169. Not knowing the kind of person I want to be
170. Confused as to what I really want
171. Feeling I am too different
172. People finding fault with me
173. Feeling no one cares for me
174. Sometimes feeling life is hardly worth while

175. Too much interference by relatives
176. Having too many decision made for me
177. Unable to discuss certain problems at home
178. Not getting along with a member of my family
179. Educational level different form my family's
180. Wishing I had a different family background

193. Having considerable trouble with my teeth
194. Occasionally feeling faint or dizzy
195. Troubled by swelling of the ankles
196. Trouble with my scalp
197. Occasional pressure or pain in my head
198. Not getting enough rests or sleeps

199. Not budgeting my money
200. Not having a systematic savings plan
201. Buying too much on the installment plan
202. Being too extravagant and wasteful
203. Living far beyond my means
204. Having to spend all my savings

205. Wanting more chance for self- expression
206. Little chance to enjoy art or music
207. Little opportunity to enjoy nature
208. Not having enough time for recreation
209. Wanting very much to travel
210. Needing a vacation

211. Mind constantly wandering
212. Constantly worrying
213. Too easily moved to tears
214. Too nervous or high strung
215. Having a bad temper
216. Feelings too easily hurt

217. Unable to express myself well in words
218. Feeling inferior
219. Not reaching the goal I've set for myself
220. Having difficulty in making decisions
221. Feeling I am a failure
222. Wanting to be more popular

223. Mother or father not living
224. Parents separated or divorced
225. Having clashes or opinion with my parents
226. Parents sacrificing too much for me
227. Parents having a hard time of it
228. Not seeing parents often enough

241. Bothered by shortness of breath
242. Having heart trouble
243. Having a persistent cough
244. Needing an operation or medical treatment
245. Needing another climate for my health
246. "Change of life" (menopause)

247. Needing legal advice
248. Needing to make a will
249. Needing an insurance program
250. Needing advice about investments
251. Wanting to have a business of my own
252. Worried about security in old age

253. Not having enough social life
254. Being alone too much
255. Missing my former social life
256. Not entertaining often enough
257. Spending too many evenings at home
258. Not living a well-rounded life

259. Unhappy too much of the time
260. Sometimes feeling things are not real
261. Bothered by thoughts running through my head
262. Sometimes afraid of going insane
263. Bothered by thoughts of suicide
264. Sometimes feeling forced to perform certain acts

265. Having a troubled or guilty conscience
266. Afraid of being found out
267. Sometimes being dishonest
268. Having a certain bad habit
269. Wanting to break a bad habit
270. Giving in to temptation

271. Worrying whether my marriage will succeed
272. Having different interests form husband or wife
273. Marriage breaking apart
274. Needing advice about a marriage problem
275. Needing advice about raising children
276. Wanting to have a child

Second Step: Look back over the items you have underlined and circle the numbers in front of the problems which are troubling you most.

ANSWER SHEET
MOONEY PROBLEM CHECK LIST, Form-A
(1950 revised edition)

Sl. Number of the problems

1	49	97	145	153	241
2	50	98	146	154	242
3	51	99	147	155	243
4	52	100	148	156	244
5	53	101	149	157	245
6	54	102	150	198	246
7	55	103	151	199	247
8	56	104	152	200	248
9	57	105	153	201	249
10	58	106	154	202	250
11	59	107	155	203	251
12	60	108	156	204	252
13	61	109	157	205	253
14	62	110	158	206	254
15	63	111	159	207	255
16	64	112	160	208	256
17	65	113	161	209	257
18	66	114	162	210	258
19	67	115	163	211	259
20	68	116	164	212	260
21	69	117	165	213	261
22	70	118	166	214	262
23	71	119	167	215	263
24	72	120	168	216	264
25	73	121	169	217	265
26	74	122	170	218	266
27	75	123	171	219	267
28	76	124	172	220	268
29	77	125	173	221	269
30	78	126	174	222	270
31	79	127	175	223	271
32	80	128	176	224	272
33	81	129	177	225	273
34	82	130	178	226	274
35	83	131	179	227	275
36	84	132	180	228	276

TOTAL...

Cir	Tot
H	
Es	
SI	
P	
HF	
Cir.	Tot.

Third step : Reply to the following .

SUMMARY

1. Use the space below to add any additional problems that you may have .

2. Write a brief summary of what you to be your chief problems.

3. Would you like to talk to someone about some of your problems ? (yes/no)

MOONEY PROBLEM CHECK LIST, FORM – A

(Bengali version of 1950 revised edition)

নির্দেশনা

স্বাস্থ্য, কাজ-কর্ম, পরিবার, মন-মেজাজ ইত্যাদি বিষয়ে মানুষ প্রায়ই যে সমস্যাগুলোর সম্মুখীন হয়, তারই একটি তালিকা এখানে রয়েছে। আপনি তালিকাটি পড়বেন এবং যে বক্তব্যগুলো আপনার সমস্যাকে উল্লেখ করে, সেগুলো নির্বাচন করবেন।

মনে রাখবেন, 'এ'টি কোন মনস্তাত্ত্বিক অভীক্ষা' নয় এবং ভুল বা সঠিক বলে এখানে কিছু নেই। মানুষের জীবন ধারণের সাধারন সমস্যাগুলো সম্পর্কে তথ্য সংগ্রহ ও গবেষণার উদ্দেশ্যেই এ'প্রশ্নমালাটি প্রয়োগ করা হ'চ্ছে। আপনি যদি সততা ও আন্তরিকতার সাথে এ' তালিকাটি চিহ্নিত করেন, তবে মানুষের সমস্যাগুলোর একটি যথার্থ নমুনা তালিকা পাওয়া যাবে। তালিকায় বর্ণিত যে বক্তব্যগুলোর সাথে আপনার সমস্যা জড়িত বলে মনে হয়, উত্তর পত্রে সেগুলোর ক্রমিক নম্বরের নীচে একটি দাগ দিবেন।

আপনি এ'ব্যাপারে নিশ্চিত থাকতে পারেন যে, আপনার প্রদত্ত উত্তরের গোপনীয়তা সর্বোতভাবে রক্ষা করা হবে।

এখানে, তিনটি ধাপে আপনাকে কাজটি শেষ করতে হবে -

প্রথম ধাপঃ ধীর-স্থিরভাবে তালিকাটি পড়ুন এবং আপনাকে অসুবিধায় ফেলেছে এমন প্রতিটি সমস্যার ক্ষেত্রে উত্তর পত্রে উক্ত ক্রমিক নম্বরের নীচে দাগ দিন। ধরুন, তালিকার প্রথম বক্তব্যটি "অর্থাৎ ১, বেশীরভাগ সময় ক্লান্তিবোধ করি" আপনার জন্য সমস্যা হলে - উত্তর পত্রে ক্রমিক নম্বর '১' এর নীচে '১' এ'ভাবে দাগ দিন।

দ্বিতীয় ধাপঃ পুরো তালিকাটি এ'ভাবে একবার পড়া শেষ হ'লে উত্তর পত্রে যে ক্রমিক নম্বরগুলোর নীচে দাগ দিয়েছেন, সেগুলো আরেকবার লক্ষ্য করুন। এ'বার যে সমস্যাগুলো আপনার কাছে গুরুতর মনে হবে, সেই ক্রমিক নম্বরগুলোর চার-পাশে একটি গোল চিহ্ন দিন। ধরুন, তালিকার প্রথম বক্তব্যটি 'অর্থাৎ, ১. বেশীরভাগ সময় ক্লান্তিবোধ করি' আপনার জন্য গুরুত্বর সমস্যা হলে- উত্তরপত্রে বক্তব্যটির ক্রমিক নম্বরে অর্থাৎ উত্তর পত্রে ক্রমিক নম্বর '১' কে (১) এভাবে গোল চিহ্ন দিন।

তৃতীয় ধাপঃ উত্তর পত্রের অপর পৃষ্ঠায় বর্ণিত বিষয়গুলোর উপর সংক্ষিপ্ত বিবৃতি দিন।

প্রথম ধাপঃ ধীর-স্থিরভাবে তালিকাটি পড়ুন এবং আপনাকে সমস্যায় ফেলেছে এমন সমস্যাগুলোর জন্য উত্তর পত্রে ক্রমিক নম্বরের নীচে দাগ দিন।

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১. বেশীর ভাগ সময় ক্লান্তি বোধ করি

২. অপর্যাপ্ত ঘুম

৩. শরীরের ওজন অস্বাভাবিক কম বা বেশী

৪. শরীরের ওজন ক্রমশঃ কমে যাচ্ছে

৫. প্রায়শঃই গলায় ঘা জনিত অস্বস্তি অনুভব করি

৬. প্রায়শঃই সর্দি-কাশিতে ভুগি

৭. অস্বস্তিকর পরিবেশে বাস করি

৮. পরিবহন বা যাতায়াত সমস্যা আছে

৯. বাড়ীতে আধুনিক সুযোগ-সুবিধার অভাব

১০. আবাস স্থলে গোপনীয়তার অভাব

১১. বাড়ীর মালিকের আচার-ব্যবহার অসৌজন্যমূলক

১২. বসবাসের পরিবেশ নিম্নমানের

১৩. একটা সখ (hobby) -এর প্রসার ঘটাতে চাই

১৪. কৃষ্টিগত দিক থেকে সম্বৃদ্ধ হতে চাই

১৫. মানুষের সাথে গুরুত্বপূর্ণ বিষয়ে আলোচনা করতে চাই

১৬. নাচ-গান শিখতে চাই

১৭. খেলা-ধুলায় দক্ষতা নেই

১৮. কিভাবে মানুষের মনোরঞ্জন করতে হয় জানিনা

১৯. নেতৃত্বদানে যোগ্যতার অভাব

২০. আত্ন-বিশ্বাসের অভাব

২১. যথেষ্ট বিচক্ষণ (smart) নই

২২. ভীরু ও লাজুক স্বভাবের

২৩. সাহসের অভাব

২৪. সব কিছুতে অতিরিক্ত গুরুত্ব আরোপ করি

২৫. অধিক সন্তোষজনক ব্যক্তিত্বের অভাব
২৬. অন্যের সাথে মেলা-মেশায় অপ্রস্তুত বা অপ্রতিভ বোধ করি
২৭. দিবাস্বপ্ন দেখি (কল্পনারাজ্যে বাস করি)
২৮. বড্ড বেশী লম্বা বা খাটো
২৯. সুদর্শন নই
৩০. আমি যদি পুরুষ/মহিলা হ'তাম

৩১. অধিকাংশ সময় বাড়ী থেকে দুরে থাকতে হয়
৩২. পরিবারের একজন অসুস্থ
৩৩. পরিবারের কারো মৃত্যু হয়েছে
৩৪. পরিবারের কেউ কঠোর পরিশ্রম করছে
৩৫. পরিবারের একজনকে নিয়ে উদ্বিগ্ন
৩৬. পরিবারের একজন মদ্যাসক্ত

৪৯. ক্ষুধামন্দা
৫০. পাকস্থলীর অসুস্থতা (বদহজম, আলসার ইত্যাদি)
৫১. অন্ত্রের (অন্ত্রনালী) অসুস্থতা
৫২. গায়ের রং ভালো নয় অথবা চর্মরোগ যুক্ত
৫৩. অসুন্দর দৈহিক গড়ন
৫৪. সজেই পা দুটোতে আঘাত পাই বা ক্লান্তি বোধ করি

৫৫. কাজ (চাকরি) চাই
৫৬. খন্ডকালীন কাজ চাই
৫৭. অর্থনৈতিক ব্যাপারে অন্যের উপর নির্ভরশীলতা ভালো লাগছে না
৫৮. অর্থনৈতিক ভাবে আমার উপর অনেকেই নির্ভরশীল
৫৯. ঋণগ্রস্ত
৬০. ভবিষ্যত বেকারত্ব সম্বন্ধে ভীত

৬১. স্মৃতি শক্তি দুর্বল
৬২. কাঙ্খিত দক্ষতা অর্জনে ব্যর্থ
৬৩. অবসর সময়ের সদ্ব্যবহার হচ্ছে না
৬৪. অন্যের মেলা-মেশার সুযোগ কম
৬৫. আলাপ-চারিতায় অস্বাচ্ছন্দ্য বোধ করি
৬৬. পুরুষদের/মহিলাদের সাথে সহজে মিশতে পারি না

৬৭. আলসেমী লাগে

৬৮. উচ্চাকাঙ্খার অভাব

৬৯. অন্যের দ্বারা অতি সহজেই প্রভাবিত হই

৭০. পরিপাটী থাকতে পারি না

৭১. অতিমাত্রায় অসতর্ক

৭২. কোন কিছুই ভালো করে করতে পারছি না

৭৩. অন্যের সংস্পর্শে সহজেই বিব্রত (অস্বস্তি) বোধ করি

৭৪. একজনকে পছন্দ করি না, তাকে এড়িয়ে চলছি

৭৫. আমার পক্ষে একসাথে অনেক মানুষের সামনে কথা বলা কঠিন

৭৬. আমার সম্পর্কে অন্যেরা কেমন ধারণা পোষণ করে তা'নিয়ে উদ্বেগ বোধ করি

৭৭. অন্যের সাথে মানিয়ে চলতে পারি না

৭৮. প্রকৃত পক্ষে কোন বন্ধু নেই

৭৯. আত্নীয়-স্বজনের সাথে বাস করতে হচ্ছে

৮০. পরিবারের একজনের আচরণে বিরক্ত বোধ করি

৮১. ঘর-বাড়ী অপরিচ্ছন্ন ও অগোছালো

৮২. বাড়ীতে বড্ড বেশী ঝগড়া-ঝাটি

৮৩. বাড়ীতে একে অন্যের দোষ খোঁজা ও অভিযোগ আনার প্রবণতা রয়েছে

৮৪. প্রকৃত পক্ষে কোন বাড়ী নেই

৯৭. চিরস্থায়ী কোন অসুস্থ্যতা বা পঙ্গুঁত্ব

৯৮. প্রায়শঃই নাকের অসুখ বা 'সাইনাসে' ভুগি

৯৯. কানের অসুখ বা শ্রবণজনিত অসুবিধা আছে

১০০. এলার্জি (সর্দি-কাশি, মাথাধরা, আমবাত ইত্যাদি) আছে

১০১. চোখের অসুখ আছে

১০২. বড় কোন অসুস্থতা বা অসুখ

১০৩. আর্থিক সাহায্য দরকার
১০৪. মনে হচ্ছে, আর খরচ কুলাতে পারছি না
১০৫. প্রয়োজন মত খাদ্যের অভাব
১০৬. প্রয়োজন মেটাবার জন্য পর্যাপ্ত অর্থের অভাব
১০৭. নিজস্ব বাড়ীর মালিক হবার সামর্থ নেই
১০৮. নানাবিধ অর্থনৈতিক সমস্যা আছে

১০৯. মনের উন্নতি ঘটাতে চাই/চিত্তবৃত্তির বিকাশ ঘটাতে চাই
১১০. সুদর্শন হতে চাই
১১১. শিষ্টাচার আয়ত্ব করতে চাই
১১২. কথা-বলার সমস্যা আছে
১১৩. স্কুলে অর্জিত শিক্ষা ভুলে যাচ্ছি
১১৪. যা' পড়ি তা' ঠিকমত বুঝিনা

১১৫. না ভেবেই কথা বলি বা কাজ করে ফেলি
১১৬. আমি অমার্জিত ও বোকা
১১৭. আমি জেদী বা একগুঁয়ে
১১৮. মাঝে-মাঝে শিশুসুলভ আচরণ বা কাঁচা কাজ করে ফেলি
১১৯. ঈর্ষাপরায়ন বা পরশ্রীকাতর
১২০. অতিরিক্ত বাড়িয়ে বলার প্রবণতা আছে

১২১. এমন কেই আছে যে আমাকে পছন্দ করে না
১২২. সব কিছুতেই আমাকে নগন্য করে রাখা হচ্ছে
১২৩. আমাকে উপহাসের পাত্র বানান হয়
১২৪. অন্যেরা আমার প্রতি অন্যায় করে
১২৫. জাতিগত বা ধর্মীয় ব্যাপারে কুসংস্কারাচ্ছন্ন
১২৬. ভীষণ একাকী বোধ করি

১২৭. পরিবারের অন্যেরা আমাকে বোঝে না
১২৮. পরিবারের অন্যেরা আমাকে বিশ্বাস করে না
১২৯. নিজেকে পারিবারিকভাবে প্রত্যাখ্যাত বলে মনে হয়
১৩০. পারিবারিক ভাবে অসুখী
১৩১. স্নেহ ভালোবাসা চাই
১৩২. নিজে একমাত্র সন্তান

১৪৫. মাথা ব্যাথায় ভুগছি
১৪৬. গ্রন্থি (থাইরয়েড, লিম্ফ ইত্যাদি) সংক্রান্ত অসুস্থ্যতা
১৪৭. ঋতুস্রাব বা স্ত্রীরোগজনিত সমস্যা আছে
১৪৮. কিডনি অথবা মুত্রাশয়ের অসুস্থতা
১৪৯. পেশীতে দীর্ঘস্থায়ী যন্ত্রণা এবং ব্যাথা
১৫০. উচ্চ রক্তচাপ

১৫১. চিকিৎসার জন্য প্রয়োজনীয় অর্থের অভাব
১৫২. বিনোদনের অর্থের প্রচন্ড অভাব
১৫৩. শিক্ষা বা প্রশিক্ষণের জন্য অর্থের অভাব
১৫৪. ভবিষ্যত অর্থনৈতিক নিরাপত্ত অনিশ্চিত
১৫৫. স্থায়ী উপার্জন নেই
১৫৬. অনিয়মিত বা স্থায়ী ধরনের কাজে নিয়োজিত

১৫৭. অধিক ব্যায়াম করা প্রয়োজন
১৫৮. অধিক মুক্ত আলো-বাতাসের প্রয়োজন
১৫৯. আরো বেশী ব্যক্তিগত স্বাধীনতা চাই
১৬০. আরো শিক্ষা গ্রহণ লাভজনক হবে কি না ভাবছি
১৬১. আমার শিক্ষাগত যোগ্যতা যদি অপেক্ষাকৃত ভালো হতো
১৬২. বেশী করে উপযোগী বই পড়তে চাই

১৬৩. বড্ড আত্মকেন্দ্রিক

১৬৪. দ্বন্দ্বে জড়িয়ে পড়ি

১৬৫. বিশেষ কাউকে-কাউকে অপছন্দ করি

১৬৬. মাঝে-মাঝে অনর্থক মিথ্যা বলি

১৬৭. বিমর্ষ ও বিষন্ন বোধ করি

১৬৮. একটা অস্বস্তিকর অভিজ্ঞতা ভুলবার চেষ্টা করি

১৬৯. আমি কি হতে চাই জানিনা

১৭০. আসলে আমি কি চাই সে ব্যাপারে স্বচ্ছ ধারণা নেই

১৭১. নিজেকে বড্ড বিসদৃশ মনে হয়

১৭২. অন্যেরা আমার দোষ ধরে বেড়ায়

১৭৩. আমাকে কেউ গ্রহ্য করে না বলে মনে হয়

১৭৪. মাঝে-মাঝে মনে হয় জীবনের খুব একটা মূল্য নেই

১৭৫. আমার ব্যাপারে আত্নীয়-স্বজনরা বড্ড বেশী হস্তক্ষেপ করে

১৭৬. আমার উপর অনেক সিদ্ধান্ত চাপিয়ে দেয়া হচ্ছে

১৭৭. কিছু কিছু সমস্যা আছে যেগুলো নিয়ে বাড়ীতে আলোচনা করতে পারি না

১৭৮. পরিবারের কোন এক সদস্যের সাথে সদ্ভাব নেই

১৭৯. পরিবারের অন্যান্যদের থেকে আমার শিক্ষাগত যোগ্যতা ভিন্ন

১৮০. যদি অন্য পরিবারের জন্মাতাম ভালো হতো

১৯৩. অতিমাত্রায় দাঁতের সমস্যায় ভুগছি

১৯৪. কোন-কোন সময় জ্ঞান হারাবার উপক্রম হয়

১৯৫. গোড়ালী ফোলা থেকে কষ্ট পাই

১৯৬. মাথার ত্বক ও চুলের সমস্যা আছে

১৯৭. মাঝে-মাঝে মাথায় যন্ত্রণা ও চাপ অনুভূত হয়

১৯৮. যথেষ্ট নিদ্রা ও বিশ্রাম নিতে পারি না

১৯৯. আয়-ব্যয়ের কোন পরিকল্পনা নেই

২০০. সঠিক সঞ্চয় পরিকল্পনা নেই

২০১. ধারে বেশী কেনা-কাটা করি

২০২. বেহিসেবী খরচ এবং অপচয় করি

২০৩. আমার জীবন যাপনের মান সামর্থকে ছাড়িয়ে গেছে

২০৪. সমস্ত সঞ্চয় খরচ করতে হচ্ছে

২০৫. আত্ন-প্রকাশের অধিক সুযোগের অভাব

২০৬. শিল্পকলা ও সঙ্গীত উপভোগের সুযোগ খুব কম

২০৭. প্রকৃতিকে উপভোগ করার সুযোগ সুবিধা খুব কম

২০৮. বিনোদনের জন্য পর্যাপ্ত সময়ের অভাব

২০৯. খুব বেশী বেড়াতে চাই, যদি পারি

২১০. দীর্ঘ অবকাশ প্রয়োজন

২১১. মনটা প্রতিনিয়ত অস্থির

২১২. প্রতিনিয়ত উদ্বিগ্ন

২১৩. অতি সহজেই কান্না পায়

২১৪. অতিশয় "নার্ভাস" ও উত্তেজিত

২১৫. বদমেজাজী

২১৬. অতি সহজে মনে আঘাত পায়

২১৭. কথা - বার্তায় নিজেকে প্রকাশ করতে অপারগ

২১৮. নিজেকে অযোগ্য মনে হয়

২১৯. কাঙ্খিত লক্ষ্যে পৌছুতে পারছি না

২২০. সিদ্ধান্ত গ্রহণে অসুবিধা বোধ করি

২২১. নিজেকে ব্যর্থ বলে মনে হয়

২২২. অধিকতর জনপ্রিয় হতে চাই

২২৩. মা কিংবা বাবা বেঁচে নেই

২২৪. মা - বাবা আলাদা থাকেন বা তাঁদের বিবাহ বিচ্ছেদ হয়েছে

২২৫. বাব-মার সাথে নিজের মতবিরোধ রয়েছে

২২৬. বাবা-মা আমার জন্য যথেষ্ট ত্যাগ স্বীকার করছেন

২২৭. মা-বাবার খুব দুঃসময় যাচ্ছে

২২৮. প্রায়ই মা-বাবা কে দেখতে পাই না

২৪১. শ্বাস প্রশ্বাসের কষ্টে ভুগছি

২৪২. হৃদরোগ আছে

২৪৩. দীর্ঘ স্থায়ী কাশিতে ভুগছি

২৪৪. অপারেশন বা চিকিৎসার প্রয়োজন

২৪৫. স্বাস্থ্য রক্ষার জন্য বায়ু পরিবর্তন করা দরকার

২৪৬. "জীবন ধারার পরিবর্তন" (স্বাভাবিক বয়স জনিত কারনে ঋতস্রাব বন্ধ হয়ে গেছে)

২৪৭. আইনগত পর্রামর্শের প্রয়োজন

২৪৮. উইল করা দরকার

২৪৯. বীমা করা দরকার

২৫০. বিনিয়োগের ক্ষেত্রে পরামর্শ প্রয়োজন

২৫১. নিজস্ব পুঁজিতে একটা ব্যবসা চাই

২৫২. বৃদ্ধ বয়সে নিরাপত্তার ব্যপারে উদ্বিগ্ন

২৫৩. সামাজিক মেলা মেশার সুযোগ কম

২৫৪. বড্ড বেশী একা

২৫৫. পূর্বের সামাজিক জীবন হারাচ্ছি

২৫৬. তেমন কাউকেই আপ্যায়ন করিনা

২৫৭. সংসার আমার সমস্ত সময় নিয়ে নেয়

২৫৮. জীবনের পরিপূর্নতা এলো না

২৫৯. অধিকাংশ সময়ই খুব অসুখী মনে হয়

২৬০. মাঝে মাঝে মনে হয় কিছুই যেন সত্যি নয়

২৬১. মাথায় যে সব চিন্তা ঘুরে বেড়ায় সেগুলো আমাকে পীড়া দেয়

২৬২. মাঝে - মাঝে মনে হয় পাগল হয়ে যাব

২৬৩. মাঝে-মাঝে আত্মহত্যার চিন্তা পেয়ে বসে

২৬৪. কখনও কখনও কিছু কিছু কাজ না করে থাকতে পারি না

২৬৫. নিজেকে অপরাধী মনে হয় ও বিবেকের দংশন বোধ করি

২৬৬. ধরা পড়ার ভয়ে ভীত

২৬৭. মাঝে- মাঝে অসাধু আচরন করি

২৬৮. কোন একটা বিশেষ বদ অভ্যাস আছে

২৬৯. একটা বদ অভ্যাস ত্যাগ করতে চাই

২৭০. প্ররোচনা বা প্রলোভনের ফাঁদে জড়িয়ে পড়ি

২৭১. বিয়ে স্বার্থক হবে কি না সে দুশ্চিন্তা আছে

২৭২. স্বামী-স্ত্রীর মধ্যে আগ্রহের পার্থক্য আছে

২৭৩. দাম্পত্য জীবন ভেঙ্গে যাচ্ছে

২৭৪. দাম্পত্য সমস্যার সু-পরামর্শের প্রয়োজন

২৭৫. শিশু পালনের বিষয়ে উপদেশ চাই

২৭৬. সন্তান চাই

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Sl. Number of the problems

১	৪৯	৯৭	১৪৫	১৫৩	২৪১
২	৫০	৯৮	১৪৬	১৫৪	২৪২
৩	৫১	৯৯	১৪৭	১৫৫	২৪৩
৪	৫২	১০০	১৪৮	১৫৬	২৪৪
৫	৫৩	১০১	১৪৯	১৫৭	২৪৫
৬	৫৪	১০২	১৫০	১৯৮	২৪৬
৭	৫৫	১০৩	১৫১	১৯৯	২৪৭
৮	৫৬	১০৪	১৫২	২০০	২৪৮
৯	৫৭	১০৫	১৫৩	২০১	২৪৯
১০	৫৮	১০৬	১৫৪	২০২	২৫০
১১	৫৯	১০৭	১৫৫	২০৩	২৫১
১২	৬০	১০৮	১৫৬	২০৪	২৫২
১৩	৬১	১০৯	১৫৭	২০৫	২৫৩
১৪	৬২	১১০	১৫৮	২০৬	২৫৪
১৫	৬৩	১১১	১৫৯	২০৭	২৫৫
১৬	৬৪	১১২	১৬০	২০৮	২৫৬
১৭	৬৫	১১৩	১৬১	২০৯	২৫৭
১৮	৬৬	১১৪	১৬২	২১০	২৫৮
১৯	৬৭	১১৫	১৬৩	২১১	২৫৯
২০	৬৮	১১৬	১৬৪	২১২	২৬০
২১	৬৯	১১৭	১৬৫	২১৩	২৬১
২২	৭০	১১৮	১৬৬	২১৪	২৬২
২৩	৭১	১১৯	১৬৭	২১৫	২৬৩
২৪	৭২	১২০	১৬৮	২১৬	২৬৪
২৫	৭৩	১২১	১৬৯	২১৭	২৬৫
২৬	৭৪	১২২	১৭০	২১৮	২৬৬
২৭	৭৫	১২৩	১৭১	২১৯	২৬৭
২৮	৭৬	১২৪	১৭২	২২০	২৬৮
২৯	৭৭	১২৫	১৭৩	২২১	২৬৯
৩০	৭৮	১২৬	১৭৪	২২২	২৭০
৩১	৭৯	১২৭	১৭৫	২২৩	২৭১
৩২	৮০	১২৮	১৭৬	২২৪	২৭২
৩৩	৮১	১২৯	১৭৭	২২৫	২৭৩
৩৪	৮২	১৩০	১৭৮	২২৬	২৭৪
৩৫	৮৩	১৩১	১৭৯	২২৭	২৭৫
৩৬	৮৪	১৩২	১৮০	২২৮	২৭৬

TOTAL...

Cir	Tot
H	
Es	
SI	
P	
HF	
Cir.	Tot.

তৃতীয় ধাপ: নীচের প্রশ্ন গুলোর উত্তর দিন।

সার সংক্ষেপ

১। তালিকার বাইরে আপনার অতিরিক্ত কোন সমস্যা থাকলে সেগুলো এখানে লিখুন-

২। আপনার কাছে যে সমস্যাগুলো প্রধান বলে মনে হয় , এখানে সেগুলোর একটি সংক্ষিপ্ত বিবরণী দিন।

৩। আপনি কি আপনার সমস্যা গুলো সম্পর্কে কারো সাথে আলোচনা করতে ইচ্ছুক?
হ্যাঁ/ না-

Appendix- III

Attitude Measuring Scale

People live in different environments. Besides this, there is a gulf of difference among them. So the feelings about life and own field is not the same to all. It needed to know what they think about the daily matters that are related to health, family, work etc. It is essential to gather knowledge about it to develop / to modify / to enhance the life style / living pattern of the people.

This questionnaire is prepared to know about what you think about some particular aspects of life and the life as a whole. Read every question attentively and mark ( ) to the relevant answer among the given answers that you consider as your own. Sometimes you may think that none of the given answers is matching perfectly to your feelings, in that case, mark the answer that you think the closest to your answer.

You need not to mention your name, address, etc. on the answer sheet. Privacy of your information will be strictly maintained and it will be used for research only. So answer honestly and frankly to accomplish our effort.

QUESTIONS

1. How do you evaluate your present family life?
   a)Very good b) Good c) Moderate d) Bad e) Very bad .
2. How do you evaluate the relationship with your spouse?
   a)Very good b) Good c) Moderate d) Bad e) Very bad.
3. What is your evaluation about your relationship with all of your children?
   a) Very good b) Good c) Moderate d) Bad e) Very bad.
4. How do you evaluate your relationship with your friends?
   a) Very good b) Good c) Moderate d) Bad e) Very bad.
5. How much can you concentrate to your work?
   a) Very well b) Well c) Moderate d) Bad e) Not at all.
6. How do you feel about your present life compared to previous life?
   a) Very happy b) Happy c) Fair d) Not so happy e) Unhappy

7. How do you feel about your life compared to others ?
   a) Very happy b) Happy c) Fair d) Not so happy e) Unhappy .
8. Do you think that most of the members of your family is very close to each other ?
   a) Very much b) Much c) Moderate d) Not enough e) Not at all.
9. Do you feel that your family members will look after you when you will be sick ?
   a) Certainly b) Yes c) Not sure d) No e) Not at all
10. Do you think that your family will take responsibility of any member of your family if she/he is in critical condition (for example, if any one becomes handicapped)?
    a) Very much b) Much c) Moderate d) Doubtful e) Not at all.
11. Do you sometimes feel worried by thinking that none will take responsibility of your family if you become handicapped?
    a)Very much b) Much c) Moderate d) Not enough e) Not at all
12. Are you worried about your future?
    a) Very much b) Much c) Moderate d) Not so e) Not at all.
13. Do you think that your life is useless ?
    a) Very much b) Much c) Moderate d) Not so e) Not at all.
14. Do you believe that your friends and relatives will come forward to help you when you will be in real problem ?
    a) Very much b) Much c) Moderate d) Not so e) Not at all .
15. Do you think that your life is monotonous or joyless?
    a)Very much b) Much c) Moderate d) Not so e) Not at all.
16. Can you accomplish what you want to do ?
    a) Very much b) Much c) Sometimes d) Not always e) Not at all .
17. How much opportunity do you get to participate in different social activities?
    a) Very much b) Much c)fair d) Not so e) Not at all.
18. How much do you expect from all of your children ?
    a) Very much b) Much c) Fair d) Not so e) Not at all.
19. Do you think that you are performing enough responsibilities to of all your children?
    a) Very much b) Much c)Moderate d) Not e) Not at all.
20. What is the possibility of fulfillment of your expectation?
    a) Huge b) Enough c) Fair d) Not enough e) Not at all.
21. Do you feel that you are alone ?
    a) Very much b) Much c) Fair d) Not so e) Not at all.
22. Can you spend your leisure satisfactorily?
    a)Very much b) Much c) Sometimes d) Not always e)Not at all

23. Do you think that it will be better if one of your children is sent to Day-Care Centre ?
    a) Certainly yes b) Yes c) Moderate d) No e) Not at all.
24. Do you feel that now you are successful enough ?
    a) Very much b) Much c) Moderate d) Not much e) Not at all.
25. Considering your whole life pattern do you think that this is the life that you wanted to lead ?
    a) Certainly yes b) Yes c) Not sure d) No e) Not at all.

Attitude Measuring Scale Bengali Version

মানুষ বিভিন্ন পরিবেশে বাস করে। তাছাড়া তাদের মধ্যে বিস্তর পার্থক্য রয়েছে। তাই জীবন ও আপন জগৎ সম্বন্ধে সকলের অনুভুতি এক রকম হয় না। স্বাস্থ্য, পরিবার, কাজ-কর্ম ইত্যাদি প্রাত্যহিক বিষয়গুলো নিয়ে তাঁরা কি ভাবেন সে সম্বন্ধে জানা প্রয়োজন। জনগনের জীবন যাত্রার মান উন্নয়নের জন্য এ বিষয়ে জ্ঞানলাভের প্রয়োজনীয়তা অনস্বীকার্য।

জীবনের বিশেষ বিশেষ দিক এবং সার্বিক জীবন সম্বন্ধে আপনি কি মনে করেন সে সম্বন্ধে জানার জন্য এই প্রশ্নমালাটি প্রণয়ন করা হয়েছে। প্রতিটি প্রশ্ন মনোযোগ সহকারে পড়ুন এবং প্রদত্ত উত্তরের মধ্যে যেটি আপনার নিজের বলে বিবেচনা করেন সেটিকে (√) চিহ্ন দিন। অনেক সময় মনে হতে পারে প্রদত্ত উত্তরের কোন উত্তরই আপনার অনুভূতির সাথে পুরোপুরি মিলছে না। সে ক্ষেত্রে যেটি আপনার উত্তরের সবচেয়ে কাছাকাছি মনে হয় সেটিকে চিহ্নিত করুন।

আপনার দেয়া তথ্যের গোপনীয়তা সম্পূর্ণভাবে রক্ষা করা হবে এবং তা কেবল মাত্র গবেষণা কাজে ব্যবহার করা হবে। কাজেই সম্পূর্ণ খোলা মনে উত্তর দিয়ে আমাদের প্রচেষ্টাকে সাফল্য মণ্ডিত করে তুলুন।

প্রশ্নমালা

১. বর্তমানে, আপনি আপনার পারিবারিক জীবন কেমন মনে করেন?

ক) খুবই ভাল খ) ভাল গ) মোটামুটি ঘ) খারাপ ঙ) খুব খারাপ

২. আপনার সাথে আপনার স্বামী/স্ত্রীর সম্পর্ক কে কেমনভাবে দেখেন?

ক) খুবই ভাল খ) ভাল গ) মোটামুটি ঘ) খারাপ ঙ) খুব খারাপ

৩. আপনার সাথে আপনার সন্তানদের সম্পর্ক কেমন মনে করেন?

ক) খুবই ভাল খ) ভাল গ) মোটামুটি ঘ) খারাপ ঙ) খুব খারাপ

৪. আপনার সাথে আপনার বন্ধু বান্ধবদের সম্পর্ক কেমন বলে মনে করেন?

ক) খুবই ভাল খ) ভাল গ) মোটামুটি ঘ) খারাপ ঙ) খুব খারাপ

৫. আপনার কাজ কর্মে আপনি কতখানি মনোযোগী হতে পারেন?

ক) খুব বেশী খ) বেশী গ) কিছুটা ঘ) তেমন বেশী নয় ঙ) একেবারেই নয়

৬. অতীতের তুলনায় আপনার বর্তমান জীবনকে কেমন মনে করেন?

ক) খুবই সুখী খ) সুখী গ) মোটামুটি ঘ) তেমন সুখী নয় ঙ) অসুখী

৭. অন্যদের তুলনায় আপনার জীবনকে কেমন মনে করেন?

ক) খুবই সুখী খ) সুখী গ) মোটামুটি ঘ) তেমন সুখী নয় ঙ) অসুখী

৮. আপনি কি মনে করেন আপনার পরিবারের অধিকাংশ সদস্য ঘনিষ্ট ভাবে একে অপরের কাছাকাছি?

ক) খুব বেশী খ) বেশী গ) কিছুটা ঘ) তেমন বেশী নয় ঙ) একেবারেই নয়

৯. আপনি অসুস্থ হলে আপনার পরিবার কি আপনার দেখাশোনা করবে?

ক) হ্যাঁ অবশ্যই খ) হ্যাঁ গ) কিছুটা করবে ঘ) না করবে না ঙ) একদমই করবে না

১০. কোন সদস্যের সংকটাপন্ন অবস্থায়, যেমন কেউ যদি পঙ্গু হয়ে পড়ে, তাহলে আপনার পরিবার পুরোপুরি তার ভরণপোষণ করবে বলে আপনি মনে করেন?

ক) খুব বেশী খ) বেশী গ) কিছুটা ঘ) সন্দিহান ঙ) একেবারেই করবে না

১১. আপনি যদি কখনও অক্ষম হয়ে পড়েন তখন আপনার ছেলেমেয়েদেরকে যথার্থ সাহায্য করতে তেমন কেউ থাকবে না একথা ভেবে আপনি মাঝে মাঝে দুশ্চিন্তাগ্রস্থ হন কি?

ক) খুব বেশী খ) বেশী গ) কিছুটা ঘ) তেমন বেশী নয় ঙ) একেবারেই নয়

১২. আপনি কি আপনার ভবিষ্যত নিয়ে উদ্বিগ্ন?

ক) খুব বেশী খ) বেশী গ) কিছুটা ঘ) তেমন নয় ঙ) একেবারেই নয়

১৩. আপনার জীবনকে কি অপ্রয়োজনীয় বলে মনে করেন?

ক) খুব বেশী খ) বেশী গ) কিছুটা ঘ) তেমন নয় ঙ) একেবারেই নয়

১৪. আপনি কি মনে করেন আপনার বন্ধু-বান্ধব/আত্নীয়-স্বজন আপনার বিপদে সাহায্য করতে এগিয়ে আসবে?

ক) খুব বেশী খ) বেশী গ) কিছুটা ঘ) তেমন নয় ঙ) একেবারেই নয়

১৫. আপনার জীবন নিরানন্দময় বা একঘেয়েমিপূর্ণ বলে আপনি কি মনে করেন?

ক) খুব বেশী খ) বেশী গ) কিছুটা ঘ) তেমন নয় ঙ) একেবারেই নয়

১৬. আপনি যা করতে চান তা কি সম্পাদন করতে পারেন?

ক) খুব বেশী খ) বেশী গ) মাঝে মাঝে ঘ) কদাচিৎ ঙ) কখনই নয়

১৭. বিভিন্ন সামাজিক কর্মকান্ডে অংশগ্রহনের কেমন সুযোগ পান?

ক) খুব বেশী খ) বেশী গ) মোটামুটি ঘ) তেমন নয় ঙ) একেবারেই নয়

১৮. আপনি আপনার সন্তানদের কাছ থেকে কতখানি প্রত্যাশা করেন?

ক) খুব বেশী খ) বেশী গ) মোটামুটি ঘ) তেমন নয় ঙ) একেবারেই নয়

১৯. আপনি কি মনে করেন যে আপনি আপনার সবকটি সন্তান লালন-পালনের ক্ষেত্রে যথেষ্ট দায়িত্ব পালন করতে পারছেন?

ক) খুব বেশী খ) বেশী গ) কিছুটা ঘ) তেমন নয় ঙ) একেবারেই নয়

২০. আপনার প্রত্যাশা পূরণের সম্ভাবনা কতখানি?

ক) খুব বেশী খ) বেশী গ) মোটামুটি ঘ) তেমন নয় ঙ) একেবারেই নয়

২১. নিজেকে কি নিঃসঙ্গ বলে মনে করেন?

ক) খুব বেশী খ) বেশী গ) মোটামুটি ঘ) তেমন নয় ঙ) একেবারেই নয়

২২. অবসর সময় কি সন্তোষজনক ভাবে ব্যয় করতে পারেন?

ক) খুব বেশী খ) বেশী গ) মাঝে মাঝে ঘ) কদাচিৎ ঙ) কখনই নয়

২৩. আপনি কি মনে করেন যে আপনার সন্তানদের মধ্যে কোন একজনকে ডে-কেয়ার সেন্টারে রাখলে ভাল হবে?

ক) অবশ্যই খ) হ্যাঁ গ) কিছুটা ঘ) না ঙ) একেবারেই নয়

২৪. আপনার কি মনে হয় আপনি এখন যথেষ্ট কৃতকার্য?

ক) খুব বেশী খ) বেশী গ) কিছুটা ঘ) তেমন নয় ঙ) একেবারেই নয়

২৫. আপনার সার্বিক জীবনযাত্রাকে বিবেচনা করে আপনি কি মনে করেন যে এটাই সে জীবন যা আপনি চেয়েছিলেন?

ক) অবশ্যই খ) হ্যাঁ গ) কিছুটা ঘ) তেমন নয় ঙ) একেবারেই নয়

Appendix- IV

Case study Form

♦ Name and address of the organization with which the mentally retarded children is affiliated:

.....

.....

♦ Date of information: .....

General information of the mentally retarded children

♦ Name:.....

♦ Father's Name: .....

Age:.....

Educational qualification: .....

Profession: .....

♦ Mother's Name: .....

Age:.....

Educational qualification: .....

Profession: .....

♦ Full Residential address

.....

Special identity of the mentally retarded children

Date of birth: .....

Age:.....

Sex:.....

Birth order: .....

Place of birth: .....

Birth process: **Normal / Caesarean / Others**

Height:..... Weight:.....

Identification mark:.....

Assessment of Teacher / Counsellor / Researcher about the following:

Behavioural Aspects	4	3	2	1	0	Remarks
Toilet training						
Clothing						
Self eating						
Gesture						
Speech						
Hearing						
Vision						
Smell						
Taste						
Skin sensations						
Follow instructions						
Physical development						
Intelligence						
Memory						
Activity						
General knowledge						
Behaviour at school						
Behaviour at home						
Social behaviour						
Play behaviour						
Behaviour with music						
Behaviour in roads						
Behaviour when guests come						
Behaviour at other's house						
Behaviour in market						
Behaviour with teachers						
Behaviour with parents						
Behaviour with siblings						
Behaviour with known people						
Behaviour with unknown people						
Behaviour with same age group						
Cleanliness						
Behaviour with counsellor						

4: Very good, 3: Good, 2: Average, 1: Poor, 0: Very poor

Description of special problems of the mentally retarded (to be filled-upby the Teacher /Counsellor / Researcher)

a) Psychological problems: (i.e.intelligence, memory, learning, activity, etc)

b) Physiological prolems and diseases:

c) Social problems: (i.e. behaviour with friends, in road, play ground, etc.)

কেস স্টাডি ফরম

♦ প্রতিবন্ধী যে প্রতিষ্ঠানের সাথে সংযুক্ত সেই প্রতিষ্ঠানের নাম ও ঠিকানাঃ

.....

.....

♦ তথ্য সংগ্রহের তারিখঃ.....

প্রতিবন্ধীর সাধারণ পরিচয়

♦ নাম ঃ .....

♦ পিতার নামঃ .....

বয়সঃ.....

শিক্ষাগত যোগ্যতা ঃ .....

পেশাঃ .....

♦ মাতার নামঃ .....

বয়সঃ .....

শিক্ষাগত যোগ্যতা ঃ .....

পেশাঃ .....

♦ প্রতিবন্ধীর পূর্ণ ঠিকানাঃ

.....

.....

প্রতিবন্ধীর বিশেষ পরিচয়

জন্মতারিখঃ .....

বয়স ঃ .....

লিঙ্গ ঃ .....

জন্মক্রম ঃ .....

জন্মস্থানের নামঃ .....

জন্ম প্রক্রিয়া ঃ নরমাল / সিজারিয়ান / অন্যান্য

উচ্চতাঃ.....ওজনঃ.....

সনাক্তকরন চিহ্নঃ.....

শিক্ষক/ কাউন্সিলর/গবেষক এর মতে প্রতিবন্ধীর বর্তমান অবস্থা

প্রতিবন্ধীর সমস্যার বিবরণ	৪	৩	২	১	০	মন্তব্য
টয়লেট ট্রেনিং						
পোশাক পরিধান ক্ষমতা						
খাবার নিজে খেতে পারার ক্ষমতা						
বসা, দাড়ানো এবং হাটা						
শব্দ উচ্চারণ এবং কথা						
শ্রবণ শক্তি						
দৃষ্টি শক্তি						
ঘ্রাণ শক্তি						
স্বাদ সংবেদন						
ত্বক সংবেদন						
কোন নির্দেশ বুঝতে পারার ক্ষমতা						
সাধারন শারীরিক গঠন						
বুদ্ধি						
স্মৃতি শক্তি						
চঞ্চলতা						
সাধারন জ্ঞান						
স্কুলে সামগ্রিক আচরন						
বাড়িতে সামগ্রিক আচরন						
সামাজিক প্রেক্ষাপটে সামগ্রিক আচরন						
খেলাধুলার সময় আচরন						
গান গাওয়া অথবা শুনার সময় আচরন						
রাস্তা ঘাটে চলার সময় আচরন						
বাড়িতে অতিথি এলে আচরন						
অন্য আত্নীয়/ বন্ধুর বাড়িতে গেলে আচরন						
বাজারে বা দোকানে নিয়ে গেলে আচরন						
শিক্ষকদের সাথে আচরন						
বাবা-মার সাথে আচরন						
ভাই বোনদের সাথে আচরন						
পরিচিত জনদের সাথে আচরন						
অপরিচিত জনদের সাথে আচরন						
সম বয়সীদের সাথে আচরন						
পরিষ্কার -পরিচ্ছন্নতা						
কাউন্সিলর/গবেষক এর সাথে আচরণ						

৪ঃ খুব ভাল, ৩ঃ ভাল, ২ঃ মোটামুটি, ১ঃ খারাপ, ০ঃ খুব খারাপ

প্রতিবন্ধির বিশেষ সমস্যার বিবরণ (শিক্ষক/কাউন্সেলর/গবেষক পূরণ করবেন)

ক) মনস্তাত্বিক সমস্যাবলী (যেমন- বুদ্ধি, স্মৃতিশক্তি, শিক্ষণ প্রক্রিয়া, চঞ্চলতা ইত্যাদি)

খ) শারীরিক সমস্যাবলী ও রোগঃ

গ) সামাজিক সমস্যাবলী (যেমন- বন্ধুদের সাথে আচরণ, রাস্তাঘাট, খেলার মাঠে ইত্যাদিতে)

Appendix- V

INFORMATION BLANK FOR THE PARENTS

♦ Name of the father:.....

Age: .....

Educational qualification:.....

Profession: .....

♦ Name of the Mother:.....

Age: .....

Educational qualification: .....

Profession: .....

♦ Residential Address:

Name of the House: .....House No.:.....

Name of House owner:.....

Moholla.....Post:..... Dist.:.....

♦ Appx. monthly income of the family:.....

♦ Source of income: service/business/agriculture/ day labourer /others

♦ Ownership of residence: own /rent

♦ Category of residence: paka/ semi paka / kacha

♦ Number of children: .....

♦ Age and Education level of children:

Birth order	Age	Sex	Education level

♦ Age at the birth of first child: Father.....Mother.....

♦ Mentally retarded person in family?- yes/no

a) Number of mentally retarded children:

b) Birth order of the mentally retarded children:

INFORMATION BLANK FOR THE PARENTS BENGALI VERSION

♦ পিতার নামঃ .....

বয়সঃ .....

শিক্ষাগত যোগ্যতা ঃ .....

পেশাঃ .....

♦ মাতার নামঃ .....

বয়সঃ.....

শিক্ষাগত যোগ্যতা ঃ .....

পেশাঃ .....

♦ বাসস্থানের ঠিকানাঃ

বাড়ির নাম ঃ.....বাড়িরনম্বরঃ.....

বাড়ির মালিকের নামঃ .....

এলাকাঃ..... পোঃ..... জেলাঃ.....

♦ আনুমানিক মাসিক আয় ঃ.....

♦ আয়ের উৎস ঃ চাকুরী/ ব্যবসা/ কৃষি/ দিনমজুর /অন্যান্য

♦ বসত বাড়ি ঃ নিজস্ব / ভাড়া

♦ বসত বাড়ির প্রকৃতি ঃ পাকা/ সেমিপাকা/ কাচা

♦ পরিবারের মোট সন্তান সংখ্যাঃ .....

♦ সন্তানদের বয়স ও শিক্ষাগত যোগ্যতাঃ

জন্মক্রম	বয়স	লিঙ্গ	শিক্ষারস্তর

♦ প্রথম সন্তান জন্মের সময় বয়স ঃ

পিতা.....মাতা.....

♦ পরিবারে প্রতিবন্ধী সন্তান আছে কিনা? ঃ হ্যাঁ / না

ক) প্রতিবন্ধী সন্তান সংখ্যা ঃ খ) প্রতিবন্ধী সন্তানের জন্মক্রম ঃ

List of the Mentally Retarded Children with name, address and others information

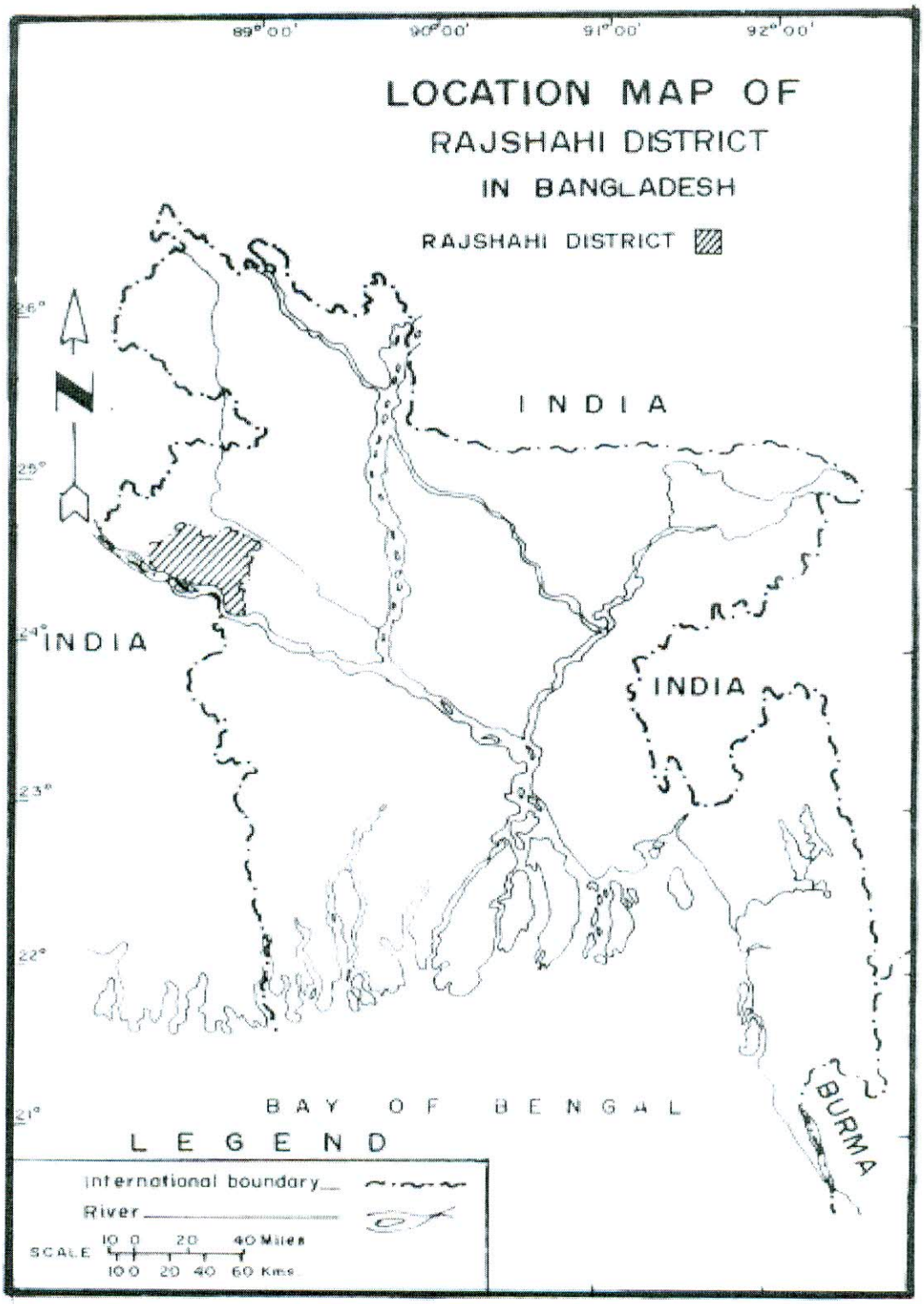
Sl. No	Information of the Mentally Retarded Children					Information of the Parents								Yearly Income (Thousand Tk.)	Catagroy of Residence (Paka/SemiPaka Kacha)	Residence (Own / Rent)
	Name	Sex	Age	Birth Order	Address	Age		Education		Occupation		Number of Siblings				
						Father	Mother	Father	Mother	Father	Mother	Son	Daughter			
01	Soriful Islam	Male	15	01	Uposhohor Sopura Rajshahi	42	33	B.A	S.S.C	Service	House Wife	2	2	105	Paka	Own
02	Tareque Hossain	Male	16	01	Uposhohor Sopura Rajshahi	45	38	M.A	H.S.C	Service	House Wife	2	2	110	Paka	Own
03	Khadaza Sultana	Female	06	01	Uposhohor Sopura Rajshahi	38	31	B.A	H.S.C	Buisness	House Wife	0	2	100	Paka	Own
04	Nahid Afirin	Female	13	01	Uposhohor Sopura Rajshahi	39	36	L.L.B	B.A	Buisness	House Wife	1	1	90	Paka	Own
05	Masud Rana	Male	14	01	Dori Khorbona Rajshahi	45	40	B.A	S.S.C	Service	House Wife	3	1	90	Paka	Rent
06	Mahmudun Nobi	Male	15	01	Ambagan Rajshahi	44	39	M.A	H.S.C	Service	House Wife	2	1	95	Paka	Rent
07	Roksana Sarmin	Female	14	01	Housing Estate Rajshahi	48	37	M.A	Primary	Service	House Wife	3	1	115	Paka	Own
08	Brishti	Female	11	01	Sosti Tala Rajshahi	35	29	B.A	S.S.C	Buisness	House Wife	1	1	95	Paka	Own
09	Akram Hossain	Male	10	01	Dori Khorbona Rajshahi	40	32	B.A	S.S.C	Buisness	House Wife	2	1	115	Paka	Own
10	Nawaz Sharif	Male	08	01	Salbagan Rajshahi	35	28	B.A	B.A	Buisness	House Wife	1	1	90	Paka	Rent
11	Ashiqur Rahman	Male	16	01	Uposhohor Rajshahi	46	40	B.A	S.S.C	Buisness	House Wife	2	2	75	Paka	Rent
12	Jabbar Hossain	Male	15	01	Bilsimla Rajshahi	47	40	B.A	S.S.C	Buisness	House Wife	3	1	60	Paka	Own
13	Moien Uddin	Male	08	01	Bilsimla Rajshahi	43	30	H.S.C	S.S.C	Buisness	House Wife	2	0	65	Paka	Own
14	Umma Kulsum	Female	15	01	Tikapara Rajshahi	41	38	H.S.C	S.S.C	Service	House Wife	1	2	70	Paka	Rent
15	Md. Yusuf Hosin	Male	16	01	Tarokadia Rajshahi	44	33	S.S.C	Primary	Service	House Wife	2	2	65	Paka	Own

Sl. No	Information of the Mentally Retarded Children					Information of the Parents								Yearly Income (Thousand Tk.)	Catagroy of Residence (Paka/SemiPaka Kacha)	Residence (Own / Rent)
	Name	Sex	Age	Birth Order	Address	Age		Education		Occupation		Number of Siblings				
						Father	Mother	Father	Mother	Father	Mother	Son	Daughter			
16	Abdur Rahman	Male	15	01	Kadirgong Rajshahi	46	39	B.A	Primary	Buisness	House Wife	2	1	60	Semi Paka	Rent
17	Musfique Shariar	Male	08	01	Uposhohor Rajshahi	34	31	B.A	S.S.C.	Buisness	House Wife	2	0	70	Paka	Rent
18	Md. Mizanur Rahman	Male	14	01	Tarokadia Rajshahi	43	39	S.S.C	Primary	Buisness	House Wife	2	1	60	Semi Paka	Own
19	Maya	Female	13	01	Sopura Rajshahi	40	32	H.S.C	S.S.C.	Service	House Wife	1	1	60	Semi Paka	Own
20	Nawshin	Female	07	01	Uposhohor Rajshahi	38	30	H.S.C	Primary	Buisness	House Wife	1	1	65	Semi Paka	Rent
21	Md. Milon	Male	16	01	Choto Bongram Rajshahi	40	34	Primary	Primary	Day Labourer	House Wife	2	2	35	Kacha	Own
22	Ms. Jesmin	Female	09	01	Asam Koloni Rajshahi	42	30	Primary	Primary	Day Labourer	House Wife	2	1	40	Semi Paka	Own
23	Sohel Rana	Male	07	01	Asam Koloni Rajshahi	35	26	Primary	Primary	Day Labourer	House Wife	1	1	35	Semi Paka	Rent
24	Md. Joy	Male	06	01	Asam Koloni Rajshahi	30	22	Primary	Primary	Day Labourer	House Wife	1	0	40	Kacha	Rent
25	Md. Tutul	Male	16	01	Sopura Rajshahi	45	40	Primary	Primary	Day Labourer	House Wife	2	2	33	Kacha	Rent
26	Atia Khatun	Female	14	01	Tarokhadia Rajshahi	43	35	Primary	Primary	Day Labourer	House Wife	2	1	35	Kacha	Rent
27	Jonab Ali	Male	15	01	Tarokhadia Rajshahi	42	35	Primary	Primary	Day Labourer	House Wife	3	1	37	Kacha	Rent
28	Md. Tareque	Male	08	01	Hetam Khan Rajshahi	35	25	Primary	Primary	Day Labourer	House Wife	1	1	35	Semi Paka	Rent
29	Md. Sakib	Male	08	01	Dori Khorbona Rajshahi	40	32	Primary	Primary	Day Labourer	House Wife	2	1	40	Semi Paka	Rent
30	Md. Tuhin	Male	15	01	Choto Bongram Rajshahi	44	38	Primary	Primary	Day Labourer	House Wife	2	2	37	Kacha	Rent

List of the Non-Retarded Children with name, address and others information

Sl. No	Information of the Non- Retarded Children					Information of the Parents								Yearly Income (Thousand Tk.)	Category of Residence (Paka/SemiPaka Kacha)	Residence (Own / Rent)
	Name	Sex	Age	Birth Order	Address	Age		Education		Occupation		Number of Siblings				
						Father	Mother	Father	Mother	Father	Mother	Son	Daughter			
01	Roman Ahsan	Male	16	01	Uposhohor Rajshahi	44	35	M.A	H.S.C	Service	House Wife	2	2	110	Paka	Own
02	Haresha Yasmin	Female	14	01	Housing Estate Rajshahi	48	37	M.A	Primary	Service	House Wife	3	1	115	Paka	Own
03	Monirul Huq	Male	15	01	Uposhohor Rajshahi	42	33	B.A	S.S.C	Service	House Wife	2	2	105	Paka	Own
04	Mst. Fatema Khatun	Female	13	01	Uposhohor Rajshahi	39	36	B.A	B.A.	Buisness	House Wife	1	1	90	Paka	Own
05	Jannatul Ferdous	Female	11	01	Ambagan Rajshahi	35	29	B.A	S.S.C	Buisness	House Wife	1	1	95	Paka	Own
06	Hemel Shakhawat	Male	10	01	Sopura Rajshahi	40	32	B.A	S.S.C	Buisness	House Wife	2	1	115	Paka	Own
07	Seiaum Rahman	Male	15	01	Bilsimla Rajshahi	44	39	M.A	H.S.C	Service	House Wife	2	1	95	Paka	Rent
08	Moktadir Rahman	Male	14	01	Housing Estate Rajshahi	45	40	B.A	S.S.C	Service	House Wife	3	1	90	Paka	Rent
09	Mounita Piali	Female	06	01	Terokhadia Rajshahi	38	31	B.A	H.S.C	Buisness	House Wife	0	2	100	Paka	Own
10	Shehab Soliman	Male	08	01	Ranibazar Rajshahi	35	28	B.A	B.A	Buisness	House Wife	1	1	90	Paka	Rent
11	Alima Pervin	Female	15	01	Uposhohor Rajshahi	41	38	H.S.C	S.S.C	Service	House Wife	1	2	70	Paka	Rent
12	Md. Narul Huda	Male	16	01	Jinna nagar Rajshahi	46	40	B.A	S.S.C	Buisness	House Wife	2	2	75	Paka	Rent
13	Shakhon	Male	15	01	Terokhadia Rajshahi	47	40	B.A	S.S.C	Buisness	House Wife	3	1	60	Paka	Own
14	Alvi Ali	Male	08	01	Hetamkha Rajshahi	43	30	H.S.C	S.S.C	Buisness	House Wife	2	0	65	Paka	Own
15	Md. Roni Reza	Male	16	01	Uposhohor Rajshahi	44	33	S.S.C	Primary	Service	House Wife	2	2	65	Paka	Own

Sl. No	Information of the Non-Retarded Children					Information of the Parents								Yearly Income (Thousand Tk.)	Category of Residence (Paka/Semi Paka Kacha)	Residence (Own / Rent)
	Name	Sex	Age	Birth Order	Address	Age		Education		Occupation		Number of Siblings				
						Father	Mother	Father	Mother	Father	Mother	Son	Daughter			
16	Jerin Afrin	Female	07	01	Uposhohor Rajshahi	38	30	H.S.C	Primary	Buisness	House Wife	1	1	65	Semi Paka	Rent
17	Afia Ahmed	Female	13	01	Ambagan Rajshahi	40	32	H.S.C	S.S.C	Service	House Wife	1	1	60	Semi Paka	Own
18	Md. Shalauddin	Male	08	01	Uposhohor Rajshahi	34	31	B.A	S.S.C	Buisness	House Wife	2	0	70	Paka	Rent
19	Abdul Hadi	Male	15	01	Bilsimla Rajshahi	46	39	B.A	Primary	Buisness	House Wife	2	1	60	Semi Paka	Rent
20	Saroware Jahan	Male	14	01	Laxmipur Rajshahi	43	39	S.S.C	Primary	Buisness	House Wife	2	1	60	Semi Paka	Own
21	Md. Rana Islam	Male	16	01	Bongram Rajshahi	40	34	Primary	Primary	Day Labourer	House Wife	2	2	35	Kacha	Own
22	Asha Khatun	Female	14	01	Bohorompur Rajshahi	43	35	Primary	Primary	Day Labourer	House Wife	2	1	35	Kacha	Rent
23	Muslima Khatun	Female	09	01	Hetamkha Rajshahi	42	30	Primary	Primary	Day Labourer	House Wife	2	1	40	Semi Paka	Own
24	Desh Ahmed	Male	07	01	Kadirgong Rajshahi	35	26	Primary	Primary	Day Labourer	House Wife	1	1	35	Semi Paka	Rent
25	Md. Shown	Male	16	01	Choto Bongram Rajshahi	45	40	Primary	Primary	Day Labourer	House Wife	2	2	33	Kacha	Rent
26	Mamun Reja	Male	06	01	Hatem kha Rajshahi	30	22	Primary	Primary	Day Labourer	House Wife	1	0	40	Kacha	Rent
27	Ratul Hossain	Male	15	01	Sopura Rajshahi	44	38	Primary	Primary	Day Labourer	House Wife	2	2	37	Kacha	Rent
28	Raja Ahmed	Male	08	01	Ghospara Rajshahi	35	25	Primary	Primary	Day Labourer	House Wife	1	1	35	Semi Paka	Rent
29	Mamun Ahmed	Male	08	01	Uposhohor Rajshahi	40	32	Primary	Primary	Day Labourer	House Wife	2	1	40	Semi Paka	Rent
30	Monir Hossain	Male	15	01	Ranibazar Rajshahi	42	35	Primary	Primary	Day Labourer	House Wife	3	1	37	Kacha	Rent


89°00'
90°00'
91°00'
92°00'
LOCATION MAP OF
RAJSHAHI DISTRICT
IN BANGLADESH
RAJSHAHI DISTRICT
26°
25°
24°
23°
22°
21°
INDIA
INDIA
INDIA
BURMA
BAY OF BENGAL
LEGEND
International boundary
River
SCALE
10 0 20 40 Miles
100 20 40 60 Kms

Location Map of Rajshahi city