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Strategies for Dealing with a Crisis When Mentally Retarded Child Within Family

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Abstract: The presence of mentally retarded child within the family cause many crises experienced by the family after receiving a shock that the child is mentally retarded so, the research going to develop Strategies for dealing with a crisis when mentally retarded child within family throwing statistical prescription of research sample, Recognizing volume of a mentally retarded child crisis within family and volume of each stage and defining most important variables which affect a mentally retarded child crisis within family. The research sample was conducted on (n=117) families of children with mentally retarded, the children aged between (newborn - 9 years). Research recommendations was a necessity of making social class aware id mental retardation, its cases and methods of prevention through various mass media and Necessity before civil community establishment to direct themselves towards mentally retarded children so as to provide care they need and allow them chance for rehabilitation with symbolic wages, especially with families having low economic standard.

Kay words: Strategies · Crisis · Mentally retarded child

INTRODUCTION

Mental retardation problem is considered one of most important problems which have imposed itself recently as a social issue, as it represents peak problem as it occupies highest percentage in total rate of handicap persons in Egypt [1]. Characteristic of mentally retarded children vary; This is why they are in need for receiving information with scientific value that helps to develop their self-esteem, recognition and evaluation of others, social acceptance and integration in group membership [2]. These characteristics pose a problem for the mentally retarded in society generally and particularly in family regarding adaptation and meeting demands which ultimately fall on surrounding people and not on the mentally retarded whose presence for most family members causes psychic and social crises, [3]. Which affect their stability and ability to perform their functions and obstruct them from playing their role of providing necessary care for such child whether medical psychic, social, rehabilitation or educational, etc., thus having impact of life of family members, [4]. This is reflected on family structure and adds unbearable burdens, [5] such as decreased financial resources as result of effect of child handicap circumstances on parent work [6]. Crisis originates from the difficult position to which family is Exposure as birth of a mentally retarded child, causing various reactions by parents limiting their care of child and educating it [7]. This is shown when family tries to accept such handicap and live with it [3].

Crisis gets worse when child mental retardation is severe or accompanied by other diseases such as epilepsy, inhibition or other organic diseases [8]. First reaction on part of family towards a mentally retarded baby is catastrophic as situation is fraught with fear, anxiety and non-belief [2].

Despite disparity of family reactions, most of these reactions pass through similar crisis stages starting with exposure to crisis stage (shock, refusal, denial, guilt, anger, pity, sadness, despair, gloom and rejection), then crisis activity stage (non-balance, event, sequences, pressure situations, anxiety, fear, withdrawal and accusation) and finally acceptance and crisis solution (accepting facts, adaptation, integration and call for help) [4, 7, 9, 10].

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Nature of crisis and accompanying problems cause obstacles which confront family of retarded child making solutions hard to find and could take years to overcome them. This leads to depriving child of many services which could have been available to it. Reaction shows in form of crisis specially with breaking news of child case to psychic, social and economic state of family resulting from crisis. Hence it is necessary to derive certain strategies to be used with families of mentally retarded children which could help to cope with crisis and offer assistance to related parties to enable them to keep their balance under charges of care and attention to the mentally retarded child and finally ways of handling to make child useful with suitable abilities to merge in social fabric [11].

Research Aims: The study aims at settling strategies for dealing with a mentally retarded child crisis within family through:

- Statistical prescription of research sample.
- Recognizing volume of a mentally retarded child crisis within family and volume of each stage.
- Defining most important variables which affect a mentally retarded child crisis within family.

Pilot Study: With aim of defining research problem objectively and in more depth than actual reality, following is undertaken:

First Pilot Study: It aims at studying and interpreting various statistics related to special cases in Egypt to recognize number and classes of handicaps. Findings showed conflict in statistics specially regarding categories (isolation - accompanying handicaps - emotional disturbance - communication disruption), but they agreed that mental retardation category is the most spread one according to predictive estimations of central authority for statistics and public mobilization.

Second Pilot Study: It aims at defining nature of crisis which faces family of mentally retarded child through disciplined personal interviews on (n=20) of family with mentally retarded children in a rehabilitation center for mentally retarded children (Montazah center for developing child capability and care for the mentally retarded). An open question was posed: (what are most crises that you faced when dealing with your child?). Findings showed that most families with mentally retarded children faced many crises such as:

- Symbolic death as result of shock on hearing that their child is mentally retarded. Many showed their wish for not having a baby at all instead of having an unacceptable one.
- Providing daily care in state inexperience regarding raising such child.
- Financial crises specially in case of accompanying illness to handicap and need for constant child presence in rehabilitation center to receive services (therapy, communication, early intervention).
- Non acceptance of its brothers and sisters and negative view of society.
- Fear over its destiny in future after death of its custodian.

MATERIALS AND METHODS

Methodology: Survey method was used for descriptive studies.

Research Sample: Research sample was composed of 117 mentally retarded children. Family with age of child between (newly born - 9 years). Selected in a simple random method from a number of centers, school and social societies specialized in mentally retardation, Alexandria Governorate.

Tools: Researchers developed a questionnaire following scientific method [12- 14] composed of two parts:

Part One: Defining some variables for gathering general data concerning family and its mentally retarded child.

Part Two: Defining stages of mentally retarded child crisis which are:

First Stage: Exposure to crisis (shock refusal, denial, guilt, anger, bitterness, grief, despair, depression and rejection).

Second Stage: Crisis activity (non-balance, event, sequences, pressure situations, anxiety, fear, withdrawal and blame projection).

Third Stage: Accepting and crisis solution (accepting matter as a state of fact, adaptation, merger and requesting assistance).

They were shown to academic and professional for taking their opinion in consideration then some

alterations were made and all stages were agreed on phrases were formulated to suit research goals, sample and distribution over various stages. Questionnaire form was designed in its preliminary form, then it was shown once again to The specialist academic experience and field and according to their views form. They used Tripartite Lickert balance (Yes/ somewhat/ No) to reply to stage phrases [12, 13].

Researchers were content with approval of the specialist academic experience and field on phrases which ranged between 60% and 100% and some phrases with lesser approval were omitted as shown in.

Empirical Criteria of Questionnaire Form:

First: Questionnaire Form Validity:

Arbitrator Validity: Questionnaire form in its final form was proposed to 10 experts, specialists with academic experience in the field of the study to verify correlation of various variables, correlation of each stage to the other, phrases within each stage, extent of agreement and representation of its stage, formulation objectivity and fulfillment of research goal.

Internal Coherence (Correlation Coefficient): Internal coherence validity was calculated between each stage, its phrases and total degree of questionnaire form. It showed presence of correlation among all phrases with its related stage with statistical significance as correlation coefficient reached between 0.706 and 0.492 at significance levels (0.01) and (0.05). Alpha - Kronbach coefficient value researched between (0.746 -0.811). These values show that phrases are coherent with each other and within stage they represent and that any addition or omission of any of them could possibly have negative effect of stage structure (Table 1).

Second: Questionnaire Form Stability: Stability factor was derived through questionnaire application and re-application on random sample of 22 families from original community of research and outside basic research sample with same characteristics with period of one week between the two applications. One calculating differences between the two applications and (T-test), stability factor of stages ranged between 0.915 and 0.954 and total stability factor of form 0.908 which are non-significance values proving high as shown of questionnaire form as shown in Table 2.

Table 1: Internal coherence coefficient and Alpha Kronbach coefficient for questionnaire from stage phrases N =22

First stage: Exposure to crisis			Second stage: Crisis activity stage			Third stage: Acceptance and crisis solution stage		
Phrases No.	Internal coherence coefficient	Alpha Kronbach coefficient	Phrases No.	Internal coherence coefficient	Alpha Kronbach coefficient	Phrases No.	Internal coherence coefficient	Alpha Kronbach coefficient
1	**0.615		16	**0.561		35	**0.632	
2	*0.548		17	**0.618		36	*0.562	
3	**0.552		18	**0.546		37	**0.578	
4	**0.523		19	*0.492		38	**0.609	
5	**0.658		20	*0.528		39	**0.612	
6	**0.661		21	**0.621		40	**0.561	
7	**0.541		22	**0.658		41	*0.584	
8	**0.579		23	**0.591		42	**0.555	
9	**0.629		24	**0.598		43	**0.538	
10	**0.620	0.775	25	**0.561	0.746	44	**0.618	0.811
11	**0.634		26	**0.658		45	**0.569	
12	**0.574		27	**0.586		46	**0.643	
13	*0.629		28	**0.565		47	**0.577	
14	*0.706		29	**0.643		48	**0.581	
15	**0.654		30	**0.608		49	**0.646	
			31	**0.589				
			32	**0.653				
			33	**0.577				
			34	**0.586				

** Significance at level 0.01 = 0.536 * significance at level 0.05 = 0.413

Table 2: Differences between first and second application in total each stage of mentally retarded child crisis and grand total of form and stability coefficient (correlation between the two applications) N= 22

Statistical significance	First application		Second application		Deference between two averages			
Crisis stages	S	A±	S	A±	S	A±	T-test	Stability rate
First stage: Exposure to crisis	13.189	5.602	13.054	5.265	0.135	0.855	0.961	0.954
Second stage: Crisis activity stage	10.730	8.235	10.649	7.850	0.081	0.894	0.552	0.915
Third stage: Acceptance stage and crisis solution	26.811	4.766	26.973	4.622	0.162	1.118	0.882	0.937
Grand total of form	50.730	14.071	50.676	13.340	0.054	1.985	0.166	0.908

*Significance at level 0.05= 2.08

RESULTS AND DISCUSSION

To verify first goal, repetition, percentage and Chi-square were calculated to describe research sample statistically (Table 3A) shows variables related to mentally retarded child family data.

It is shown from Table 3A presence of statistical significant differences between variables where percentage of mentally retarded children sponsored by mother is high oral difference of 58.50. In most families, mother is center of interaction with mentally retarded child and more Exposure to shock. She is its main way for fulfilling its wishes and needs [14, 15]. Social status less than moderate is higher than moderate with significance difference 45.28. Most families with mentally retarded child come from poor to moderate environment [10].

There is high rate of illiterate father and mother more than other educational levels with significance difference 39.28-35.44 successively. Rate of separated parents is low with significance difference (73.92). Disintegrated families (separated father and mother) need for retarded child more rehabilitation programs and higher effort contrary to integrated families [16]. As for data related to mentally retarded child, it is shown in following Table (3B).

Table 3B shows statistical significant differences among all variables except two variables (child type - child health insurance) where third age stage (6 years to up) for retarded children with significance difference (34.67). Mother perception of young child needs is higher than for older age and this causes severe family pressure due to lack of information about child case [17]. There is rise of normal born cases over difficult and cesarean ones by significance (22.62). There is a high rate if recognition time of child retarded postnatal in a significant way with significance difference (109.14). There is also rise in sign rate related to recognition of child retarded after physician's diagnosis with significance difference of (56.80) where most families don't have information culture

Table 3A: Research sample description according to related variables to mentally retarded child family data N= 117

Variable			Repetition	%	Chi-square
Custodian responsible for taking care of mentally retarded child	Mother		96	82.05	*85.50
	Father		42	35.90	
	Others		6	5.13	
Social status	Less than moderate		26	22.22	*45.28
	Moderate		73	62.39	
	Higher than moderate		18	15.38	
Educational level for mentally retarded parents	Father	Illiterate	43	36.75	*39.28
		Primary and Prep	18	15.38	
		Moderate certificate or diploma	28	23.93	
		Higher education	28	23.93	
	Mother	Illiterate	53	45.30	*35.44
		Primary and Prep	14	11.97	
		Moderate certificate or diploma	29	35.79	
		Higher education	21	17.95	
Separated parents	Yes		12	10.26	*73.92
	No		105	89.74	

Table 3B: Research sample description according to related variables to mentally retarded child data N= (117)

Variable		Repetition	%	Chi-square
Child type	Girl	49	41.88	3.09
	Boy	68	58.12	
Age stage	First (0-3y.)	23	19.66	*34.67
	Second (3-6y.)	25	21.37	
	Third (from 6 to up)	69	58.97	
Form of child birth	Normal	63	53.85	*22.62
	Difficult	24	20.51	
	Cesarean	30	25.64	
Time of recognizing child retardation	During pregnancy	2	1.71	*109.14
	Postnatal	115	98.29	
Reorganization signs to child retardation	Signs related to external appearance	20	17.09	*65.80
	Signs related to child Normal growth	13	11.11	
	Signs as result of shown illnesses	17	14.53	
	After physician's diagnosis	67	57.26	
Mentally retarded child degree	Mild (67-52)	66	56.41	*71.07
	Moderate (51-36)	30	25.64	
	Severe (35-20)	14	11.97	
	Profound (15 and less)	7	5.98	
Lonely retardation child in family	Yes	42	35.90	*9.31
	No	75	64.10	
Child order among brothers in case of existence	First	66	56.41	*112.96
	Second	18	15.38	
	Third and more	33	28.20	
Other similar cases in family	Yes	15	12.82	*64.96
	No	102	87.18	
Exposure of mother to illness during pregnancy	Yes	34	29.06	*20.52
	No	83	70.94	
Presence of hereditary illnesses in family	Yes	13	11.11	*70.78
	No	104	88.89	
Health insurance to child	Yes	41	35.04	10.47
	No	76	64.96	
Future vision of child case	No future vision to child case	66	56.41	*71.07
	Child adapts to its case and circumstances	30	25.64	
	Child adapts with external community	14	11.97	
	Child a useful member and has role in society	7	5.98	

about mental retardation, its causes and various characteristics of retarded child and development stages especially in mild handicap cases discovered in nursery stage. They shows rise in rate of mild retarded over other ones with significance difference of (71.07) which agrees with local and international statistics that it is most widely spread category [1]. Down children can be recognized easily since birth for their distinctive features [16]. Social skills are more nature by mild retarded children whether male or female and they receive high rate of mother acceptance [17]. Contrary to severe retarded child because if its retarded circumstances and traits where family is obligated to take care of it over long periods as result of its continued dependence on family [16].

Rate of retarded child with brothers and sisters is higher by significance difference of 9.31 than lonely child. In case of brother's retarded child as third and more significance difference would be 64.96 as effect of brothers and sisters of mentally retarded child would be more effective in relations within family [18]. Effort of brothers and sisters in big family integrate for meeting child requirements more than is the case with small family [19]. Older brothers are more attentive due to feeling of responsibility. Younger ones would be closer in understanding it and relationship is characterized by participation. However, a mentally retarded child could hinder family from taking care if its normal children fir its being center of family attention [20].

Reactions of brothers and sisters don't differ from fathers and mothers regarding refusal, fear and anger [14]. Negative view of society has great effect on their acceptance of their brother and their suffering during practicing many activities of their peers. The older brothers and sisters get, the more their fear from society

view to them and their brother and they feel embarrassed socially and find difficult in psychic and study coordination more than children with normal brother [20].

Table shows a high rate of mother cases of non exposure to illness during pregnancy with significance difference (20.52) for lack of general knowledge by mothers about various pregnancy stages to avoid causes and habits that could lead to child handicap later. There is a high rate of lack of hereditary illness in family with significance difference (70.78). Most hereditary illnesses are related to blood pressure and diabetes. There is a high rate of mothers and fathers who lack future vision about state of their mentally retarded child with significance difference (71.07). What occupies mind of parents is what future hides for such child when they can no longer serve those [15]. Their fears are centered about care and responsibility after their death especially in case of sponsor lack. In statistical description of research sample variables with differences are detected which shall be taken in consideration on setting strategies for handling and thus first aim would be realized.

To realize second aim, percentage, mathematical mean and Chi -square for each crisis stage were calculated as mathematical mean and standard deviation of crisis as a whole as whole research sample agreed on crisis stage phrases which all had significance at level of 0.05 except phrases no.21 in second stage (crisis activity). Rates varied as mathematical mean for agreement on third stage (acceptance and crisis solution, accepting actual state of affairs, adaptation, integration and asking for assistance) had largest share of crisis volume as a whole equal to 84.64%. Crisis activity stage (non balance, event sequence, pressure situations, anxiety, fear, withdrawal and putting balance on others) represents lesser share in crisis volume equal to 27.53% referring to presence of a mentally retarded child within family representing for it a crisis with varied volume and severity according to its component stages [21]. Family reaction to birth of a mentally retarded child regarding acceptance of such fact is considered extremely difficult matter hence all negative feeling of parents towards this fact should be eliminated [22]. Family ability to bear child and reactions depend on child type, its order among its brothers, retarded level and method of explaining its case [20].

Crises multiply and vary according to difference of characteristics, social and cultural level of family which are shown in (vocational expectations which family of child hopes for - refusal to raise child - over protection to

Table 4: Agreement, mathematical mean and Chi-square rate for research sample response towards crisis and its stages regarding a mentally retarded child N = 117

A mentally retarded crisis	First stage: Exposure to crisis				Second stage: Crisis activity stage				Third stage: Acceptance stage and crisis solution			
	Phrases No	Acceptance percentage	Mathematical mean	Chi-square	Phrases No	Acceptance percentage	Mathematical mean	Chi-square	Phrases No	Acceptance percentage	Mathematical mean	Chi-square
	1	32.91	0.66	*22.97	16	52.56	1.05	*15.85	35	98.29	1.97	*216.36
	2	56.41	1.13	*11.54	17	45.73	0.91	*40.67	36	96.58	1.93	*194.21
	3	32.05	0.64	*52.77	18	14.96	0.30	*120.82	37	94.87	1.90	*183.23
	4	6.41	0.13	*172.77	19	17.52	0.35	*92.67	38	94.02	1.88	*90.68
	5	83.33	1.67	*133.54	20	13.68	0.27	*134.51	39	94.87	1.90	*183.23
	6	14.96	0.30	*141.74	21	47.44	0.95	1.85	40	91.03	1.82	*152.77
	7	37.61	0.75	*34.82	22	33.76	0.68	*19.13	41	88.03	1.76	*129.59
	8	36.32	0.73	*31.74	23	22.65	0.45	*74.67	42	83.76	1.68	*88.67
	9	72.22	1.44	*50.05	24	27.78	0.56	*50.05	43	81.20	1.62	*156.33
	10	24.36	0.49	*96.00	25	26.07	0.52	*52.67	44	53.85	1.08	*7.54
	11	29.91	0.60	*56.36	26	14.10	0.28	*112.62	45	83.33	1.67	*108.15
	12	16.24	0.32	*116.97	27	25.21	0.50	*55.59	46	75.21	1.50	*61.59
	13	64.96	1.30	*24.36	28	26.50	0.53	*59.13	47	83.76	1.68	*112.36
	14	13.68	0.27	*124.97	29	31.20	0.62	*43.44	48	94.44	1.89	*70.78
	15	36.75	0.74	*44.67	30	41.88	0.84	*36.97	49	56.41	1.13	*16.77
					31	36.32	0.73	*52.51				
					32	15.38	0.31	*112.15				
					33	7.26	0.15	*167.59				
					34	23.08	0.46	*67.85				
Number of phrases	15				19				15.00			
Mathematical Mean	37.21				27.53				83.74			
Standard deviation	22.67				12.76				13.69			

* Significance Chi square at level 0.05 = 5.99

Table 5A: Divergence analysis between custodian responsible for mentally retarded child care in crisis stages and crisis as a whole

Phrases	Divergence source	Freedom degree	Total squares	Average squares	F value
First stage: Exposure to crisis	Between groups	2	195.606	97.803	*3.683
	Within groups	114	3026.975	26.552	
	Total	116	3222.581		

* Significance at level 0.05 = 3.07

Table 5B: Difference significance between those responsible for care of mentally retarded child in crisis stages and crisis as a whole by rising (LSD) test

				Difference significance between averages		
Stages	Responsible for care of mentally retarded child	Mathematical mean	Standard deviation	Father and mother	Mother only	Father only
First stage:	Father and mother	13.000	4.101		0.776	2.889
Exposure to crisis	Mother only	13.776	5.393			*3.665
	Father only	10.111	5.290			

Table 5C: Divergence analysis between social status of mentally retarded child family in crisis stages and crisis as a whole

Phrases	Divergence source	Freedom degree	Total squares	Average squares	"F" value
First stage: Exposure to crisis	Between groups	2	262.596	131.298	*5.057
	Within groups	114	2959.986	25.965	
	Total	116	3222.581		
Second stage: Crisis activity stage	Between groups	2	513.156	256.578	*4.475
	Within groups	114	6535.921	57.333	
	Total	116	7049.077		
Third stage: Acceptance and crisis solution stage	Between groups	2	172.656	86.328	*3.809
	Within groups	114	2583.823	22.665	
	Total	116	2756.479		
Total crisis stages	Between groups	2	1763.156	881.578	*6.492
	Within groups	114	15479.613	135.786	
	Total	116	17242.769		

* Significance at level 0.05 = 3.07

Table 5D: Significance difference between social status of mentally retarded child family in crisis stages and crisis as a whole by using (LSD) test

				Difference significance between averages		
Stages	Responsible for care of mentally retarded child	Mathematical mean	Standard deviation	Less than moderate	Moderate	Above moderate
First stage:	Less than moderate	13.500	5.101		0.267	*3.944
Exposure to crisis	Moderate	13.767	5.358			*4.212
	Above moderate	9.556	3.776			
Second stage:	Less than moderate	9.577	5.721		2.286	*3.521
Crisis activity stage	Moderate	11.863	8.504			*5.807
	Above moderate	6.056	5.482			
Third stage:	Less than moderate	27.808	5.441		2.726	*3.419
Acceptance and	Moderate	25.082	4.109			0.693
crisis solution stage	Above moderate	24.389	6.079			
Total crisis stages	Less than moderate	50.885	11.677		0.172	*10.885
	Moderate	50.712	12.032			*10.712
	Above moderate	40.000	9.846			

Table 5E: Divergence analysis between educational level of mentally retarded child parents in crisis stages and crisis as a whole

Phrases	Divergence source	Freedom degree	Total squares	Average squares	"F" value
First stage: Exposure to crisis	Between groups	3	406.066	135.355	*5.431
	Within groups	114	2816.515	24.925	
	Total	116	3222.581		
Second stage: Crisis activity stage	Between groups	3	658.630	219.543	*3.882
	Within groups	113	6390.447	56.553	
	Total	116	7049.077		
Third stage: Acceptance and crisis solution stage	Between groups	3	303.906	101.302	*4.667
	Within groups	113	2452.572	21.704	
	Total	116	2756.479		
Total crisis stages	Between groups	3	2761.464	920.488	*7.183
	Within groups	113	14481.305	128.153	
	Total	116	17242.769		

* Significance at level 0.05 = 2.70

Table 5F: Difference significance between educational level of mentally retarded child parents in crisis stages and crisis as a whole by using (LSD) test

Stages	Certificate	Mathematica mean	Standard deviation	Difference significance between averages: Higher education	Moderate certificate or diploma	Primary and Prep	Illiterate
First stage:	Higher education	9.933	4.920		*3.700	*4.501	*4.449
Exposure to crisis	Moderate certificate or diploma	13.633	5.229			0.801	0.749
	Primary and Prep	14.435	5.097				0.025
	Illiterate	14.382	4.767				
Second stage:	Higher education	7.300	7.245		2.667	3.178	*6.376
Crisis activity stage	Moderate certificate or diploma	9.967	7.355			0.512	3.710
	Primary and Prep	10.478	7.083				3.198
	Illiterate	13.676	8.157				
Third stage: Acceptance	Higher education	23.767	5.380		*2.967	*4.190	0.792
and crisis solution stage	Moderate certificate or diploma	26.733	2.612			1.223	2.175
	Primary and Prep	27.957	5.130				*3.398
	Illiterate	24.559	5.034				
Total crisis stages	Higher education	41.000	11.350		*9.333	*11.870	*11.618
	Moderate certificate or diploma	50.333	11.672			2.536	2.284
	Primary and Prep	52.870	10.670				0.252
	Illiterate	52.618	11.402				

it - refusal of child and attempt to lodge it in an establishment permanently - non-ability to deal with child) [22]. Introduction of a mentally retarded child causes behavioral problems and social and economic difficulties which grieve parents and make them suffer from anxiety between cure and despair. A mentally retarded child forms source of threat on family unity, relation and role that could lead to an atmosphere of family non organization and enjoyment of private life [18, 23, 24].

It leads to more psychical and social pressure which shoe when family attempts to accept retarded and adapt and live with it [3]. By defining crisis volume and each stage volume, second aim is realized as shown in Table 4.

To realize third aim, divergence analysis was used to define divergence extent among research sample answers regarding crisis stages and crisis as a whole. where integral divergence is noticed among study variables from calculated "F" value with fixed significance at level (0.05) than others. To define difference within each variable with significant differences, LSD test was used (least significance difference) as shown in Tables 5A-G.

It is shown from Table 5A existence of differences between responsible persons for mentally retarded child care in first stage where "F" value reached 3.683.

Table 5B shows difference significance between those responsible for mentally retarded child care was for benefit of mother with difference (3.665). Presence of a mentally retarded child in house greatly affects family life pattern especially for mother who plays intuitively a larger role in raising her child and caring for it. Some mothers shows excessive attachment to child even during lack of any knowledge about method of treating it [14]. Some mothers handle out of pity and others are religious and are content. But whenever mother conduct is positive towards mentally retarded child, the better its conduct improved and vice versa [25].

Table 5C shows differences between marital status of mentally retarded child family in various stages of crisis and in crisis a whole where calculated "F" value reached between 2.809 and 6.492.

Table 5D shows that difference significance between child social statuses was for benefit (less than moderate and moderate) in first. Second stages and crisis as a whole where calculated "F" value reached between 3.521 and 10.885 for benefit of less than moderate in third stage and calculated "F" value reached 3.419. Studies show that retarded increases risk of exposure to poverty as result of increasing cost of retarded child medical treatment on one hand and its deprivation from potential services on the other [26]. Some families suffer from economic problems, few material resources as result of retarded circumstances on work of parents thus increasing their feeling of helplessness and desperation [6].

Table 5E shows differences between marital status of mentally retarded child family in various stages of crisis and in crisis a whole where calculated "F" value reached between 3.882 and 7.183.

Table 5F shows that difference significance between educational level of parents came to benefit of (illiterate, primary, prep, diploma and moderate certificate) in first and third stages and in crisis as whole where "F" value reached between 3.700 and 11.870 for benefit of illiterate in second stage where calculated "F" value reached 6.367. Families with high educational level as higher education

and specializations would have rejection trend towards retarded child whose simple type is shown in excessive protection and hasty deposit in an institution for permanent residence with denial of its existence, whereas with families of low or simple education, parent's problems are concentrated in non ability to handle child during daily life [18]. Thus, third aim is realized. It is shown that presence of a mentally retarded child within family represents crisis whose nature ranges in difficulty according to stages which family passes through [3, 5, 6, 9, 10, 17-19, 27-31].

CONCLUSION

Among aim results which are verified, we could reach proposal of Three strategies that help such families in treating its mentally retarded child that:

First Strategy: Guiding framework strategy to overcome mentally retarded child birth shock

Aim: Spreading positive culture towards mentally retarded child birth shock.
Overcome mentally retarded child birth shock.

Second Strategy: Family interaction strategy with daily behavior of mentally retarded child during crisis activity stage

Aim: Rehabilitating family to live with child. Assistance from some available service for mentally retarded child.

Third Strategy: Strategy of Adaptation to surrounding circumstances to mentally retarded child to reach crisis solution and acceptance.

Aim: Making the responsible for child care acquire handling skills through knowledge of needs and developing various skills for mentally retarded child.

Vision from Strategies: With ever increasing number of mentally retarded children, there must be a vision about concepts, trends and necessary services; there must be a framework through which families are assisted in method of dealing with such children leading to child ability development according to potentialities.

Strategy Implementation Plan:

- Content analysis of statistics, studies, Arabic and foreign references which are related to research topic.
- Defining mentally retarded class as research object.
- Making disciplined interviews with the specialist academic of experience in the field of the study.
- Guidance by questionnaire form results which are designed through:
- Statistical description of research sample.
- Defining crisis volume as a whole and volume of each of its stages.
- Defining most effective variables in crisis.
- Defining related and assistant parties to child family in providing comprehensive and integrated support.

Each strategy shall be dealt with as it represents one step towards facing a crisis stage and to which child custodian with help of related parties shall be responsible for its implementation.

The implementation time of each strategy shall be defined according to child family ability to overcome each stage to reach the following one to make child an interactive member within society (Appendix 1).

Appendix 1: The Strategies
First strategy: Guiding framework strategy to overcome mentally retarded child birth shock
Aim: - Spreading positive culture towards mentally retarded child birth shock.
- Overcome mentally retarded child birth shock.

Serial	Required activity	Aim	Related parties	Success pointers	Detailed procedures of activity content	Remarks
1.	Discovery that child is mentally retarded	Knowing actual state of child	-Treating physician -Child and adolescent psychologist	Defining child case	Discovering any abnormal changes through: -Close inspection of child features -Child non follow up of its mother -Non control of head during three month age (head rising). -Non ability to sit after age of (8 months). -Delay for walking more than (12 months). -Child non-response when mother soothes it.	Family may discover that it has a mentally retarded child promptly on its birth in sever moderate case and probably in moderate one whereas simple one is mostly discovered in nursery stage and in case of child infected with down syndrome (ex-mogul).

Continued

Serial	Required activity	Aim	Related parties	Success pointers	Detailed procedures of activity content	Remarks
2.	Explaining child case	Recognizing information, facts and concepts about child case	-Treating physician. -Psychologist. -Early intervention expert. -Therapy and eruptional and physiotherapy	Family gets in contact with related parties as partners for help.	Addressing religious trend and calling positive feelings of father and mother towards child	Shock feeling by portents should be respected and their need for expressing their feelings more than confirmation that everything shall be OK.
		A-Defining moderate term	-Treating physician. -Psychologist.	Knowing that my child is mentally retarded	Visible strategy in person's ability shown in below average mental performance integrally according by defect in tow or more aspects of coordination skills (communication, self-care -household life, social skills, using society services, self direction, safety and health, academic and vocational achievement).	Society awareness should be increased about everything related to mental retarded through various mass media.
		B- Causes leading to retardation	-Treating physician. -Psychologist.	Reaching a cause of child handicap	First: hereditary causes: Before birth: infection such as (German measles, liver inflammation, TB) pregnant mother taking medicaments with harmful side effects on embryo, pregnant woman taking drugs, smoking or drinking or exposure to radiation such as X-rays or mal-nutrition. Some lack of some gland discharges such as thyroid gland and different blood types (RH) by parents. Second: Causes during postnatal: Placenta disturbances and umbilical card, oxygen lack, difficult delivery or use of helping medical tools. Third: After birth causes: Infection (Meningitis, causal head injury, taking harmful drugs or lead poisoning, harmful gases, leaving child with light clothes or in cold water during sever cold weather.	
		C-Movement characteristics psychic and social ones	-Psychologist -Therapist and vocational expert	Child joining care programs	First: Simple or educable mental moderate: Those who have limited moderate in sensory movement places and can establish social relationships and communication skills in pre-school years and usual realize social or vocational skills enabling them to self-care and some reach fifth class primary. Second: Moderate mental or trainable: They benefit from vocational training programs under normal control and supervision. They can take care of themselves but they don't advance more than second class primary. They can move independently in familiar places and adapt well with life in society but under control of others. Third: Sever mental or capable of learning by dependence on others: They acquire simple capacity or no capacity at all n communication and	Psychologist defines characteristics by a number of tests.

Continued

					self-expression and maybe trained on primary skills and self-care and benefit from early intervention and could perform simple tasks under careful supervision. Fourth: Profound mental moderate or under guardianship: Most have never moderate responsible for mental backwardness and suffer from inability to perform sensory movement skills. Best growth for them is in highly prepared environment with continuous individual care from care giver if special training is provided.	
		F-Physical characteristics	-Therapist and vocational expert		-Delayed movement growth malnutrition and lack of movement training. -Lack of attention to surrounding	
		G-Mental and intellectual characteristics	-Treating physician -Psychologist		impulses or distin guishment of similarities, perception and use of experience, weak ability to use signs in educational situations, difficulty in remembering and need for repetition.	
		H-Social and emotional characteristics	-Treating physician -Psychologist		-One category shows isolation and withdrawal from group and obstinacy in some adolescents and some behavioral problems.	Down children (Mongolian) friendly and helpful socially.
		K-Academic characteristics	-Psychologist		Mentally retarded are characterized by weak ability for study achievement specially in subjects which depend on linguistic ability. They need longer time for learning the more severs is moderate the more difficult for child to pay attention to impulses.	Learning environment should be modified to be proper and free from distracting impulses to child.
3.	Defining child case through: A- Defining child intelligence degree	Defining child hindrance degree	-Psychologist	Knowing actual state of hindrance degree	After treating physician visit, heading primly to psychologist to define child intelligence degree.	-There are many intelligence tests such as Wexller intelligence test and Feinland for social maturity. -It is difficult to define intelligence degree of sucking babies.
	B- Measuring coordination conduct skills		-Psychologist	Knowing class of hindrance degree for child	Heading to psychologist to measure coordination conduct skills.	(A.B.S)
4.	Modifying trends for parent positivity towards child	Modifying negative trends of parent towards child. They are:	-Early intervention specialist. -Psychologist -Communication expert	Good treatment of child	Looking at some present trends	It is meant by trend modification conduct followed by custodian responsible for child represented in psychic harm and methods to overcome it.
	A-Detestation				Allowing help to child and calling it by names above its ability.	
	B- Terror				Non threat of physical harm or abandoning it if it didn't follow a certain conduct or threaten to leave it in a dark place alone.	

Continued

C- Isolation	Not leaving it alone for long time and allowing it opportunity to interact inside family and outside it.	
D-Neglecting child emotional reactions	Urge for emotional interaction and respect for child feelings by parents and brothers and sisters.	
E-Rejecting child emotionally	Non punishment is a severe way letting or isolating for long time or separation from his brothers.	Child must feel that it is liked and desired.
F-Neglect or deprivation of child	Nit learning it alone in house or not clean nor be stern to control it specially in case of continued obstinacy from it.	Child must have sufficient care.
G-Parental rejection	Feeling exchange between child and parents and showing love and tenderness to it and that it is positive, loved and desired.	Child must feel safe under his parents.
H. Cruelty	Non resort to physical and oral violence on punishing it.	Moral punishment is referred.

Second strategy: family interaction strategy with daily behavior of mentally retarded child during crisis activity stage

Aim: - Rehabilitating family to live with child.
- Assistance from some available service for mentally retarded child.

Serial	Required activity	Aim	Related parties	Success pointers	Detailed procedures of activity content	Remarks
1.	Early intervention	-Participating to a large extent in methods of communication with child. -Regulating dealings with childhood years especially first five years of child age.	-Early intervention specialist. -Psychologist -Therapist -Communication specialist	- Custodian activity in applying guidelines and instructions or related parties - Start of understanding some requirement and meeting some of them	-Trend towards taking advice from related parties. -Whenever early intervention starts early the more children will be able to acquire some required skills quickly.	First five years are important in mental growth of children with special needs or normal children. It is shown that 50% of child intelligence is formed in this age period.
	Early intervention methods A-House care method	Child care when it lives in natural surrounding specially with brothers.	-Early intervention specialist - Psychologist	-Visiting specialist favors application of his instructions which reflect on child case development	-Preparing proper program for care at home through visiting specialist who guides custodian and program and encourages to him to implement it. -Allowing child opportunity to select toys from a large collection of toys pending they shall be enjoyable.	Visiting specialist could be any related party from service providers to child.
	B- Day care method at center	Child receives more care at hands of specialists trained in special education.	-Early intervention specialist - Psychologist -Therapist. - Communication specialist	Developing special child skills in various age stages.	-Child goes to day care center and returns to family after center time expiry. -Specialists set and implement program for time to stay at center and when it returns home specialists guides custodian and encourage him to take care of child but canter responsibility remains essential.	

Continued

	C-Combined care method	To benefit from combining care at home and at center	-Early intervention specialist - Psychologist -Therapist. - Communication specialist	Child stays in center for some hours per lay in certain days of the weak to receive proper care by specialists. It shall receive required care at home on hand of custodian after he receives required guidelines for child care.		
2.	D- Social support	Helping in developing child case through child positive view	-Family. -Neighbors. -Friends. -Families that have similar cases	Belief of the responsible in child care and initiative to inform all that child is mentally retarded	-Through a network of string relations to exchange experiences and information with families having similar cases. - Increasing family and friend ties and granting them chance to recognize child case and its positive characteristics	Presence of social support networked lessens pressure on child and increasing family adaptation to it self and to society.
3.	Taking courses about hindrance in specialized places for special needs	Increasing culture and awareness of those responsible for child care	-Places of providing services and social societies	-Improve capacity for child care. -Benefiting from applying some information and acquired skills in a factual way with child.	-Heading to places of services and social societies available in many places of governorates which enlighten family on how to deal with retarded children	Families with less than moderate social level need guiding support in a simple form proper to educational level.

Third strategy: Strategy of Adaptation to surrounding circumstances to mentally retarded child to reach crisis solution and acceptance

Aim: -Making the responsible for child care acquire handling skills through knowledge of needs and developing various skills for mentally retarded child

Serial	Required activity	Aim	Related parties	Success pointers	Detailed procedures of activity content	Remarks
1.	Satisfying various child requirements through:	Fulfilling various child requirements.	- Family -Neighbors and friends. -Early intervention specialist -rehabilitation center supervisors.	Feeling of custodian that child gets social acceptance anywhere whether inside or outside home	Fulfilling various child requirements.	It is important for child to a special educational program for its case observing its case and preparation.
	A- Need for social acceptance.	Social acceptance.	- Family -Neighbors and friends.	Acceptance to surrounding persons.	Encouraging those who deal with child.	Not comparing child case with others.
	B- Need to avoid failure	Providing success experience to child.	-Early intervention specialist. - Supervisors at rehabilitation center.	Child can perform some defined tasks.	Non frustration and degradation of child. -Providing helping elements for its success in performing required tasks.	Not giving higher skills than its abilities and potentialities.
	C- Need for appreciation and recognition of others.	Child participation with groups in various situations.	- Family -Neighbors and friends.	Acceptance of related persons to chills participation in some special daily activities.	-Making child feel it is useful member. -not frustrating child. Not mocking of child even as joke. -continues encouragement and providing opportunity to perform tasks in various situations.	Charging with simple tasks in form of group work.

Continued

	D- Need for independence from others.	Learning and improving self-reliance.	-Early intervention specialist. - Supervisors at rehabilitation center.	Child relies on itself for performing some simple activities.	Educations in a way to enable it to use its intelligence and benefit from available capacity.	
	E- Need to get information with scientific use. F- Need for self estimation.	Child relied on itself in doing its daily needs. Raising level of self estimation.	-Family -Neighbors and friends.	Child applies what it learns to do its daily needs. Child non hesitant to perform any task allocated to it.	Heading to rehabilitation places to get chance to receive practical situations enables it to rely on itself in doing future needs. There should be more than one way to teach and educate child such as educating it through a person he likes because that would be faster and providing incentives such as sweets and toys and setting ordered and simple steps to learn required sequence.	It is important that child applies what he learns in similar situation.
2.	Self care independence skills (daily life skills)	Enticing child mental development.	-Social worker. -special education instructor. - Participation of responsible custodian.	Child understands required activity with more ease.	Setting detailed program for teaching daily life skills in view of its mental level through training child on how to: - Eat - Dress. - Use toilet. - Bathe.	Frequently, mentally retarded children benefit from group play with specialists capable of teaching them through play.
3.	Advanced skills	Providing opportunity to make child independent as possible according to its capabilities.	Providing opportunity to make child independent as possible according to its capabilities.	Child performs activities independently from custodian.	Setting detailed program teaching advanced skills in view of its mental level through training on: A- Performing useful house work. B- Participation in social activities. C- Public transport. D- Marketing. E- Good handling in emergency. F- Doing some vocational activity.	Effective methods for training child should be known to make it feel self-esteem and can have a role within society.

RECOMMENDATION

Research Results Showed Following Recommendations:

- Setting strategies for dealing with crisis of mentally retarded child within family when importance of knowing some methods and plans is shown to be implemented during a certain period to adapt with child case and develop its capacity and potentials.
- Necessity of making social class aware id mental retardation, its cases and methods of prevention through various mass media.
- Necessity before civil community establishment to direct themselves towards mentally retarded children so as to provide care they need and allow them chance for rehabilitation with symbolic wages, especially with families having low economic standard.

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