FAMILY CHARACTERISTICS AND PLACEMENT OF LEARNERS WITH MENTAL RETARDATION, A CASE STUDY OF MOYALE SCHOOL FOR THE MENTALLY RETARDED.

A Research Report

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By:

ZEINAB M. ALI
BED/33179/111/DF

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Declaration

I, Zeinab M. Ali, a student at Kampala International University, REG: NO. BED/33179/111/DF do hereby declare that this report is my original work and has never been submitted to any University or any other Institution of higher learning for any award.

Sign: Zeinab M. Ali (ZA)

Name: Zeinab M. Ali (student).

Date: 20/12/12

Approval

I hereby certify that this work was done under my supervision and I have approved it for submission to the University.

Signed:.....

Name Ms.Wangechi Beatrice (supervisor)

Date:20/12/12.....

Dedication

This work is dedicated to my husband Mr. Ismail Mohamed for financial and emotional support during my course of study.

"A hundred times every day, I remind myself that my inner and outer life are based on the labors of others, living and dead and that I must exert myself in order to give in the same measure as I have received" Albert Einstein.

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ABSTRACT

This study sought to investigate the effect of family characteristics on placement of learners with mental retardation. A case study of Moyale School for the Mentally Retarded in Moyale County was taken. The study was guided by the following objectives; To identify the profile of respondents in terms of age, gender,marital status and work experience, to determine family characteristics of learners with mental retardation, to determine levels of mental retardation in institutions and to determine if there is a significant relationship betwen family characteristics and placement of learners in institutions. The study found out that most learmers in institutions come from poor families, it also found out that there is a significant relationship between family characteristics and placement of learners with mentally retarded children. It was recommended that in order to deal with learners with ental retrardation, poverty alleviation programmes should be initiated at grassroots so that family characteristics are altered.

CHAPTER I

INTRODUCTION

Background of the Study

Within the past twenty years, several challenges have confronted the field of mental retardation the world at large. The issue of care and treatment provided in institutions has been at the forefront. Continued service provision within institutions and the need for the expansion of residential services to people with mental retardation from large public settings to smaller settings in the community also have created challenges (Felce, Thomas, DeKock, Saxby, & Repp, 1985; Rotholz & Massey, 1996). The changing philosophies of professionals and state agencies over the years have influenced many of the challenges on how best to serve individuals with disabilities (Bogdan, Biklen, Blatt, & Taylor, 1981; Rosen, 1994; Schalock, 1990; Wolfensberger, 1972). From the beginning of institutionalization in the United States in 1848, until about three decades ago, individuals committed to institutions had increased steadily. In 1904, 14,000 residents were being served in state-operated institutions in the U.S., and, by 1970, the total number of residents served in institutions for the mentally retarded topped 200,000 (Scheerenberger, 1976). However, for the past several decades, the national trend has shown that states steadily have decreased the number of individuals served in state – operated institutions (Anderson, Lakin, Mangan, & Prouty, 1998).

Larson and Lakin (1991) identified several concerns voiced by parents about institutionalization. Generally, they found parental concerns included a perception of the superiority of an institutional environment and fear of potential problems in community settings. Other major concerns addressed by family members of persons with mental disabilities included finding and maintaining a safe, caring, respectful, and permanent place to live. Many families experience strong feelings of uncertainty, fear, betrayal and guilt with movement (Conroy, 1985; Mitchell, 1988). While many of these parents have expressed a willingness to accept group homes, as a means of meeting the residential

care needs for some people, they appear to have a distinct preference for the institution for their family members instead of a group home. Therefore, attention to parental attitudes and perspectives should be an important feature in planning and providing services (Larson & Lakin, 1991).

In Africa populations increased between 1985 and 1995 in residential facilities and decreased by 45,852 and between 1995 and 2005 resident populations decreased by 23,328. Between 1980 and 2005, the average daily population of large state facilities for persons with developmental disabilities decreased by 69.2% (Coucouvanis, Lakin, Prouty, & Webster, 2006). This drop in the number of residents served in institutions was not just the result of happenstance, but the result of two factors: (1) the concerted effort by many parents and professional groups such as the Association for Mentally Retarded Citizens (the ARC) (Larson & Lakin, 1989) who had advocated for change in the lives of individuals with mental retardation and came out in support for deinstitutionalization of institutions; and (2) legislation and class action suits such as *Pennhurst v. Hardermann* (1977), which ruled that rights for people with mental disabilities residing in institutions were being violated because isolation and confinement were counterproductive to habilitation (Scheerenberger, 1983).

In Kenya, according to Hayden (1998), allegations of subhuman conditions and treatment in many institutions were voiced, along with violations of rights to due process, education, and equal protection for persons served. These concerns were exacerbated further by media exposes in the early 1970s that revealed to the public the deplorable conditions and treatment to which residents with mental disabilities were subjected.

Though research findings of residential settings have not been definitive, what findings do suggest is that strong views regarding whether to institutionalize, continue institutionalization, or to deinstitutionalize often have been contradictory. Consequently, more research is necessary to examine the position of parents affected by this choice.

Statement of the Problem

Residential settings for people with mental disabilities are areas where little choice has been available. Three options exist for most people with mental retardation: mainstreaming, institutions, and homes care. (Blatt & Kaplan, 1967). As for large institutional facilities, shared views in the field have depicted these settings as dehumanizing and lacking in the basic and necessary opportunities for personal growth and development (Wolfensberger, 1991). According to Skeels (1966), institutional care retards personal care and development. Additionally, other early investigators consistently have documented declines in residents' IQ after institutionalization. Experimental studies have indicated that due to institutionalization, children with mental retardation are disadvantaged by decrements in performance on a number of tasks thought to reflect important cognitive processes, including the quality of language behavior, the level of abstraction on vocabulary tests, and the ability to form a learning set (Balla, Butterfield, & Zigler, 1974).

Despite these reports, **family members have continued to request and/or seek placement for their family members with mental disabilities** into mental retardation institutions. Researchers have identified variables that contribute to parents' decisions to seek these placements. Particularly, the degree of disability and level of functioning of the family member with the disability have been found to be highly related to the decision to place (Allen, 1972; Downey, 1965; Saenger, 1960). In several studies, factors such as family size, socioeconomic level, marital and family relations, parents' age and health status, and the presence of other family problems were identified as playing a role in the decision to seek residential care (Fotheringham, Skelton, & Hoddinott, 1972; Graliker & Koch, 1965; Wolf & Whitehead, 1975).

Additionally, problems of families caring for a developmentally disabled person included **interference with family life, difficulty in managing the individual's behavior, community rejection, and physical and time demands.** Also, the availability of social supports and community service systems has exerted an important influence on a family's decision to seek out of home placement (Hill, 1958;

McCubbin, 1979). Lazarus (1966) noted however, that family caregiver reactions depend heavily on their subjective evaluation of the situation. Therefore, before a caregiver considers the institutional environment as their only viable choice, more reliable knowledge would be helpful to clinicians and parents faced with the difficult decision of whether or not to institutionalize or continue institutionalization of a child with mental retardation (Balla, Butterfield, & Zigler, 1974).

Purpose of the Study

The general purpose of the study is to identify variables influencing family members' decisions regarding continued placement of family members with mental disabilities in mental retardation institutions. Additionally, this study will examine the impact of personal support variables such as physical/health, emotional, financial, facility and social supports on family members' decisions regarding continued placement of family members with mental disabilities in an institution.

Research objectives:

This study will be guided by the following objectives:

1. To establish the profile of the respondents in terms of:

    Age
    Gender
    Marital status
    Working experience

2. To determine family characteristics of children in mental retardation institutions.

3. To determine levels of mental retardation in institutions

4. To determine if there is a significant relationship between family characteristic and placement in mental retardation institutions.

Research Questions

1. What are the demographic characteristics of the respondents in terms of: age, gender, marital status, working experience?

2. What are the levels of family characteristics of children in mental retardation institutions?

3. What is the level of mental retardation in institutions?

4. Is there a significant relationship between family characteristic and placement in mental retardation institutions?

Null Hypothesis

This study will be guided by a null hypothesis of:

There is no significant relationship between family characteristic and placement in mental retardation institutions.

Scope

Geographical scope

This study will be conducted in Moyale District, a case study of Moyale Institution for the Mentally Retarded

Content scope

This study intends to examine the relationship between family characteristic and placement in mental retardation institutions.

Theoretical scope

This study is based on System theory in community development that argues that argues that for any project geared towards developing a community, it must directly involve the community in order to succeed.

Significance of the Study

The following disciplines will benefit from this study:

Policy makers will benefit from the research findings by understanding how family characteristic affect placement in mental retardation institutions.

Community and other stakeholders will understand the underlying factors towards placement of children with mental retardation in institutions.

Administrators and managers of the institutions will use the findings to provide appropriate environment that will lead to improvement of the children with mental retardation.

Future researchers will utilize the findings of this study to embark on related studies.

Definition of Terms

For the purpose of clarifying the problem statement in this study, the following terms of the study were defined:

Family Characteristics – this was used to refer to size of family, social economic status and caregivers who include the mother, father, mother and father responding together, sister or brother, aunt, uncle, or cousin who advocates for the individual.

Financial – income, cost, expenditures, or expenses associated with the support, care and treatment of a family member with mental retardation. This can include added

expenses often tied to unemployment, lost chances for a job or advancement, which translates to reduced family income.

Institution/Facility – residential environments for persons who have mental retardation or a condition related to mental retardation. They provide residential and habilitative services, skills training and adjunctive therapies with 24-hour supervision and coordination of the individual program.

Mental Retardation -a significantly sub average general intellectual functioning that is accompanied by significant limitations in adaptive functions in at least two of the following skill areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health and safety. The onset must occur before age 18 years. (DSM-IV; American Association on Mental Retardation, 2002).

CHAPTER II

REVIEW OF LITERATURE

Historically, family members' of people with mental disabilities have faced many challenges over the centuries in an attempt to obtain appropriate services for their family members with mental disabilities. In an effort to understand better the issues facing family members in selecting a living environment for family members with mental disabilities, the review of literature will address the following topics: (1) historical overview of the origin of institutions (2) treatment in facilities, (3) call for institutional reform, (4) legislation and court decisions impacting institutional services for individuals with mental retardation, (5) historical overview of the origin of institutions in Texas (6) legislation and court decisions impacting institutional services for individuals with mental retardation in Texas and (7) normalization, family member perspectives and factors for placement.

The historical views on the origin of mental retardation will follow a chronological order to include: the international evolution of institutions, evolution of institutions in America, early 19th century philosophical stance on rehabilitation, shift in philosophical stance, beginning of parents movement, beginning of advocacy movement, expansion continues in 1950s and 1960s, Kennedy's impact, decade of legal issues, deinstitutionalization and normalization introduced, and depopulation of institutions.

Historical Overview of the Origin of Institutions and Care and Treatment of Those with Mental Retardation

Historically, service provision to those with mental disabilities has encountered numerous transitions with regard to care and treatment. This section provides an overview of historical events that have impacted services for people with mental disabilities.

International Evolution of Institutions

Biblical Beginning

From the beginning, mental retardation has been acknowledged and can be traced as far back in history as Luxor, Egypt, around 1500 B.C. Although somewhat vague due to difficulties in translation, early documents refer to disabilities of the mind and body due to brain damage (Sheerenberger, 1983). In fact, early references to defective individuals are mentioned in the Bible as well as in the Koran. Early religious leaders such as Jesus and Mohammed advocated for more humane treatment of individuals who were developmentally disabled. Jesus' mission frequently involved healing the blind, deaf, crippled, demonic, epileptic, dumb, and paralytic (Scheerenberger, 1983). His teachings and healings would have a tremendous influence on the future course of many attitudes and social development (Scheerenberger, 1983). Following his example, the Apostle Paul wrote, "Now we exhort you brethren, warn them that are unruly, comfort the feebleminded, be patient toward all men (1 Thessalonians 5:14). The Bible also links certain afflictions to sinfulness: "The Lord shall smite thee with madness and blindness and astonishment of heart" (Deuteronomy 28:28). 14

Additionally, the Koran, which was revealed to Mohammed by Gabriel, contained 114 chapters proclaiming tolerant treatment of those who were different: "Give not unto those who are weak of understanding the substance which God hath appointed you to preserve for them; but maintain them there out, and clothe them, and speak kindly unto them" (The Women 4.5). Though it may be easy to discern that individuals with mental retardation and other persons of disadvantage were readily caught up in the variables of thought, we will see the highly variable treatment of persons with mental retardation persist for centuries (Scheerenberger, 1983).

Middle Ages

At various periods of the Middle Ages and Renaissance, individuals with developmental disabilities were procured for amusement or other purposes (Scheerenberger, 1983).

They were regarded as "fools and jesters," and no steps were taken to enlighten them; some even proclaimed that this group was "filled with Satan" (Rosen, Clark, & Kivitz, 1976). During this era, people with mental disabilities in need of residential protection many times were cared for in one of a wide variety of institutions including monasteries, hospitals, charitable facilities, prisons, almshouses, pest houses, workhouses, warehouses, and other buildings most of which had lost their original usefulness (Scheerenberger, 1983).

17th and 18th Century

During the 17th and 18th centuries, as medicine made several significant strides forward, it began to play a role in mental retardation. One of the earliest acknowledgements occurred in 1690 when John Locke published his famous work entitled, "An Essay Concerning Human Understanding." Locke believed that an individual was born without innate ideas and that the mind was a tabula rasa, or a blank slate. This profoundly influenced the care and training provided to individuals with mental retardation. He was also the first to make a distinction between mental retardation and mental illness; "Herein seems to lie the difference between idiots and madmen, that madmen put wrong ideas together and reason from them, but idiots make very few or no propositions and reason scarce at all" (Doll, 1962).

19th Century

It was not until the mid 19th Century that specialized institutions existed in the sense that we know them today (Crissey & Rosen, 1986). Seguin was the first to found an educational program and school, which later became a residential institution. In 1838, at Salpetriere, France, Seguin established his educational program in a hospital for insane persons and tested his ideas for "idiots" at the Bicetre, another mental hospital (Landesman & Vietze, 1987; Scheerenberger, 1983). At Bicetre, Seguin worked with inmates with mental retardation for one year (Scheerenberger, 1983) before moving to the United States in 1848 and becoming a driving force in the education of individuals with mental retardation (Krishef, 1983). Johann Jakob Guggenbuhl was one

of Seguin's well-known contemporaries. Hereferred to all retarded persons as cretins. Guggenbuhl became fascinated with this type of individual and devoted his life to the "cure" of cretinism" (Krishef, 1983). In 1839, he established a homelike institution in the Swiss Alps, called Abendberg (Krishef, 1983).

Abendberg was probably the first residential center for individuals with mental retardation. Their Guggenbuhl provided his patients with medical treatment and educational services (Krishef, 1983). The center further provided good diets, exercise, and sense training. Guggenbuhl's Abendberg was regarded as the model for institutional care and greatly influenced many in the field around the world (Kanner, 1964). In 1842, William Twinings of Great Britain visited Abendberg and upon his return to Great Britain in 1843, created a stir with the glowing report of his findings at Abendberg. Inspired by Twining's report, the Misses White, Queen of Great Britain, started a small school with four children at Bath on the Avon, which later developed into the Rock Hall House School in 1846. In an effort to do more to care for children considered feebleminded, Great Britain created the Highgate Institution in 1848(Kanner, 1964). Scottish royals, Sir John and Lady Jane Ogilvy, who had had their own child with mental retardation at Abendberg, were so pleased that they established a similar experimental institution on their estate in Baldovan in Scotland in 1854. By 1867, Columbia Lodge, Scotland's first institution was established. Further, when the Census Commissioners in Ireland reported that the country had 7,033 defectives in 1861, they suggested that steps be taken similar to those in England. As a result, the Steward Institution was opened at Palerston, Scotland, in 1869 (Kanner, 1964).

An enthusiastic account of a visit to Abendberg by Herckenrath of the Netherlands in 1842 prompted the Queen of the Netherlands to make a personal journey to Guggenbuhl's show place. With the aid of the court preacher, the queen was instrumental in opening a day school for "educable "children with mental retardation on May 15, 1855. By 1857, a residential place was established in the Netherlands (Kanner,

1964). Many more countries would follow by establishing institutions of their own. J.R. Hubertz of Denmark visited the Abendberg in 1852 and was so impressed that Denmark opened a small private institution on a farm, Gamble Bakkehus, near Copenhagen on November 1, 1855 (Kanner, 1964). A visit by Count Bombelles of Austria prompted the establishment of an institution for 300 children in Prague in 1871. Additional institutions for individuals considered to be of feeble mind would be established in Hungary, the Arbeit in 1877, in Latvia in 1854, and in Jacobstad, Finland, in 1876 (Kanner, 1964) all as a result of visits to Abendberg. Encouraged by the work of Seguin in Paris, France, and using the model Guggenbuhl started for cretins in Switzerland, Dr. Samuel Gridley Howe became the first person to initiate institutional care for individuals with developmental disabilities in the United States (Krishef, 1983; Crissey & Rosen, 1986). This would lay the foundation of treatment methods for people with mental retardation in the United States during the 19th and 20th Centuries (Krishef, 1983).

Evolution of Institutions in the U.S.

These institutions were developed as a spin-off from those in 19th century Europe. This section will provide discussion about the evolutions of institutions and services offered in the United States.

First Institutions in the U.S.

The United States moved along in much the same manner as France did when Dr. Harvey B. Wilbur, after having visited Sequin's school in Paris, opened the first small private school for persons with developmental disabilities in Boston, Massachusetts, in 1848 (Baumeister & Butterfield, 1970). In the same year, the Massachusetts Legislature authorized an experimental school that was to be used for ten children with mental retardation. In a wing of the Perkins Institute and School for the Blind, Howe established the first public residential facility for individuals with mental retardation (Landesman & Vietze, 1987; Crissey & Rosen, 1986; Baumeister & Butterfield, 1970). Howe's program later moved to its own building in South Boston, Massachusetts, in 1855 (Landesman & Vietze, 1987) and was named the Massachusetts School for Idiots

and Feebleminded Youth (Crissey & Rosen, 1986). This American institution concentrated its efforts on trying to assist individuals with mental disabilities to function at their best possible level. It was developed to provide temporary residential placement for individuals who, after a relatively brief period of education and training, would return to community life. In New York, Dr. Frederick Backus introduced a bill at the 1846 session of the legislature for the opening of a residential school; it was passed in one house but failed to carry in the other chamber. In the winter of 1850-1851, Howe appeared before the state authorities at Albany, with some of his patients showing what he had done in Massachusetts, and pleading for the establishment of a similar school in New York. Governor Hunt of New

York wrote to Howe in July 1851:

Your visit to our capital last winter was of great service.

We feel that we are much indebted to you for the success of the measure so far, and hope we may have the benefit of your experience and counsel in carrying our plan into practical operation (Kanner, 1964).

That same year, a school was opened in Albany, later moving to Syracuse, New York, in 1855 and was named State Asylum for Idiots. The school later was officially known as the Syracuse State Institution for the Feebleminded (Kanner, 1964). Pennsylvania followed next, and, on the tenth of February 1850, preliminary steps were taken to found the country's third institution of its kind. On the seventh day of April 1853, the legislature incorporated the Pennsylvania Training School for Feebleminded Children (Kanner, 1964). On April 17, 1857, an Institution for Feebleminded Youth at Columbus, Ohio, was called into existence by legislative enactment followed in 1858 by the first school for children with mental retardation in Connecticut, named the Connecticut School of Imbeciles (Kanner, 1964).

Early Education in U.S. Institutions

These early school facilities were established to serve four groups of residents on a colony plan: (1) a teachable portion for a school-attending age; (2) the practically unteachable; (3) a portion to serve adult males who had passed school-age and were

not self-supporting; and (4) a portion to serve adult females who should be kept under the careful custody of the State unless they can be released under exceptionally favorable and well-guarded surroundings (Scheerenberger, 1983).

The colony plan included a training school as well as industrial, custodial, and farm departments. These schools were designed with a central building, industrial departments, and separate buildings with specially arranged dormitories and day rooms to care for residents with paralysis and profound idiocy. Other buildings were for custodial and epileptic departments, with accessories for both care and training. Provisions were made for colonizing young men, as they grew into manhood, in properly arranged houses, as farmers, gardeners, and dairy help. This approach provided the cheapest and wisest method for utilizing the labor of residents whose work would command absolutely nothing if brought into competition with even the most unskilled labor of persons of normal mind (Scheerenberger, 1983).

Expansion of Institutions in the U.S

Early success at several schools dawned the opening of additional state-operated mental retardation facilities across the U.S. (Braddock, 1991). Kentucky opened an institution in 1860, Illinois in 1865, Iowa in 1877, Indiana and Minnesota in 1879, followed by Kansas in 1881, California in 1885, Nebraska in 1887, New Jersey and Maryland in 1888, Michigan in 1895, and Montana in 1896. Between 1848 and 1898, 24 public institutions were established and maintained by 19 states, and one by the City of New York. The total census of individuals in public institutions during this period was about 8,000 residents nationally (Kanner, 1964; Crissey & Rosen, 1986).

The South's Position on Institutional Care

The South, however, was slow in its care of people considered feebleminded. This concern over a lack of institutional facilities for people considered being of feeble mind prompted pleas for change. Many southern citizens realized the South had done little

for individuals considered of feeble mind, especially compared with the North. In June 1911, a newly organized Board of Trustees of the North Carolina School for the Feebleminded met in Raleigh and accepted a bid for the city of Kinston to have an institution; later the Caswell Training School would be located there (Noll, 1995). Following the lead of North Carolina, within the next seven years other southern states opened institutions for individuals considered of feeble mind. After the Georgia Commission on Feeblemindedness reported its findings in 1918, the Georgia Legislature passed a bill that created the south's second institution (Noll, 1995). The Georgia

Training School for Mental Defectives in Gracewood opened its doors to its first patients on July 1, 1921 (Noll, 1995). Between 1919 and 1923, Florida, Alabama, Mississippi, South Carolina, Tennessee, Louisiana, and Virginia all would open institutions for individuals with mental retardation (Noll, 1995). Alabama opened the Partlow State School for Mental Defectives in Tuscaloosa in 1919; Florida opened the Florida Farm Colony for the Epileptic and Feebleminded in Gainesville in 1921; Louisiana opened the State Colony and Training School in Alexandria in 1922; Mississippi opened Ellisville State School in Ellisville in 1923;

South Carolina opened the State Training School in Clinton in 1920; Tennessee opened the State Home and Training School for Feebleminded Persons in Donelson in 1923; and Virginia opened the Lynchburg State Colony in 1914 and Petersburg State Colony in Petersburg in 1939 (Noll, 1995). By 1921, the nation's state-operated institutions had become filled, with many states experiencing overcrowding. In many instances, institutions with a capacity to serve 350 residents were occupied by as many as 470 persons (Noll, 1995). Yet further, the number of institutions in the United States would nearly triple to 77 by 1930 (Lakin, 1979; Braddock & Heller, 1985) serving more than 100,000 persons with mental retardation nationwide (Crissey & Rosen, 1986). Despite these gains, however, White southerners ignored the needs and concerns of their Black brethren. As the color line solidified, money for the care of Black individuals considered

to be of feeble mind was not available. Black citizens considered of feeble mind involved in antisocial or criminal behavior often were adjudicated through the criminal justice system. Others, usually those causing no community problems, were placed in insane asylums or simply cared for at home by parents or relatives. Blacks in the South rarely received the possibility of achieving better opportunities (Noll, 1995). Black patients served in institutions for the feebleminded generally followed similar patterns established throughout the South. Few southern institutions allowed integrated wards, and Black patients remained isolated in separate wings and facilities.

Although ten southern states opened eleven public institutions for the feebleminded during the first four decades of the 20th Century, only two of these facilities, the Kentucky State Institute for the Feebleminded in Frankfort and the Louisiana State Colony and Training School in Alexandria, housed feebleminded residents of both races, though in segregated quarters. In addition, Virginia operated two institutions, each housing individuals of separate races. Along with its White-only Lynchburg State Colony, Virginia housed its Black citizens considered to be of feeble mind in a Black only facility of Central State Hospital in Petersburg. This facility achieved institutional autonomy as the Petersburg State Colony in 1939, "for the purpose of caring for and training Blacks considered to have mental defects" (Noll, 1995).

Family Members' Perceptions of Institutional Placement

Family members have however, shared mixed views about placement options.

While many embraced the concepts of normalization and deinstitutionalization and elected to move their family members with mental retardation into community settings, others have not been so excited about the concepts. The movement toward deinstitutionalization, coupled with the concept of normalization, not only created controversy but also had been a firestorm in the field of mental retardation for many years. Though many advocated closing all institutions, the primary purpose was "to habilitate as many as possible for community placement (Scheerenberger, 1983).

Despite the acceptance of the deinstitutionalization philosophy by professionals, parents, and program planners, not everyone was or is caught up in thefervor of the movement (Novak, 1976).

Early Views of Family Members

The earliest look at parents' perceptions toward placement occurred in 1953, when Pacific Colony State Hospital initiated its community care program. At that time, placement personnel confronted two problems: (1) community resistance and (2) the fact that potential foster parents wanted to serve only younger children or those with no obvious developmental anomalies or physical handicapping conditions. Foster parents also were not willing to accept such a responsibility of caring for this population for a nominal fee (Scheerenberger, 1983).

Parents objected to the community care initiative for a variety of reasons. Many reported: (1) the patient was happy in the institution, has friends on the ward, and needed medical supervision which only the institution could provide; (2) prior to commitment, many resided in private or county boarding homes and these were highly unsatisfactory;

(3) the outside world is cruel to individuals with mental disabilities, whereas institutions understand them and are kind; (4) proposed community homes are operated by families or unacceptable racial or religious grouping; (5) patients might escape from the community-based homes and be killed; (6) they waited a long time to advance up the waiting list, and now just as they have fully accepted their child being institutionalized for life, the question of placement is raised all over again (Trent, 1994).

Additional Views of Family Members

Several studies were completed nationally since the late 1970s related to perceptions of parents toward institutionalization of their relatives with mental retardation. In one of the earliest studies, Klaber (1969) surveyed parents of people in institutions in Connecticut. In his research, Klaber found that more than three fourths of parents surveyed believed that institutions in which their family member resided were extremely

high quality. He concluded that, "The parents were convinced of the excellence of the facilities in which their family members were placed. The praise lavished on the institutions was so extravagant as to suggest severe distortions of reality in this area." Brockmeier (1975) reported similarly high levels of satisfaction, coupled with skepticism about community-based care, among families of people with mental disabilities in Nebraska institutions. Willer, Intagliata, and Atkinson (1979) reported overwhelming satisfaction among families of institutionalized people in New York State.

Further, Meyer (1980) surveyed parents of 273 residents in Wester Center, an institution in Western Pennsylvania, on their attitudes toward continued institutional placement versus potential placement in a community residence. Meyer found that more than 70 percent of parents were satisfied with the care and services provided by the facility. When questioned about small group homes, the parents were opposed to the idea of community placement and thought that remaining in the institution would be best for their relatives. In another study, Conroy (1984) surveyed families of 1611 people living in institutions in Pennsylvania who had been "nominated" for movement to the community. No fewer than 91 percent of these families reported being "satisfied" or "very satisfied" with institutional services, and 81 percent were "opposed" or "very opposed" to the idea of community placement. Conroy (1987) further found that 72 percent of the families of residents at the Georgia Retardation Center reported being "very satisfied" with services provided to their relatives and overwhelmingly opposed the idea of movement to community services.

Further, Payne (1976) surveyed parents of residents in Texas institutions and found that, while they were not opposed in principle to the option of small community– based group homes, they still preferred the institution. Additionally, Payne's research was first to identify a "deinstitutionalization backlash" among parents/caregivers of residents in state-operated institutions for the mentally disabled. Payne characterized the backlash group as a loosely knit counter-movement of various local and statewide associations of

parents organized in support of institutions as opposed to community residential facilities. His study consistently reported high satisfaction with institutions among families who have placed relatives there (Janicki, Krauss & Seltzer, 1988).

While many parents saw community living arrangements as a viable way to meet theresidential care needs for some individuals with developmental disabilities, it is well established that parents of most individuals residing in large institutions had a distinct preference for that type of residential facility (Atthowe & Vitello 1982; Frohboese & Sales, 1980; Payne, 1976). However, according to Roos (1976), "the residential institution for people with developmental disabilities is in danger of emulating the dinosaur if it does not undergo adaptive modification in response to the rapid changes occurring in the field of mental retardation."

Factor's Influencing Placement

Parents deciding to request placement of their family members with mental disabilities (Blacher, 1990) were influenced by numerous factors. Most often it was related to family stress, characteristics of the person with the handicap, and the availability of caregiver support (Sherman & Cocozza, 1984). In many instances, family members reported requesting placement because of greater problems in dealing with the general care and supervision of the mentally disabled person (Black, Cohn, Smull & Crites, 1985; Black, Molaison, & Smull, 1990; Wolf & Whitehead, 1975). Persons placed out of the home tended to have more severe disabilities, greater medical or physical care needs, fewer functional skills (Borthwick-Duffy, Eyman, & White, 1987; Eyman, O'Conner, Tarjan, & Justice, 1972; Sherman, 1988), and high levels of maladaptive behavior (Black et al., 1985; Hobbs, 1964; Shellhaass & Nihira, 1969; Sherman, 1988).

Early advice from professionals and friends has been contradictory. Gorham (1975) pointed out that professionals told parents often, to institutionalize their child with mental disabilities. These professionals usually assumed that the majority of

parents of individuals with developmental disabilities supported the concepts of normalization and least restrictive environment for their offspring. This inference is based, as least in part, on the behavior of those outspoken parents active in advocate groups and who initiated litigation ensuring that these principles were incorporated into their children's treatment program (Meyer, 1980). It is possible, however, that this vocal minority is not representative of the silent majority? A study by Ferrara (1979) found that there was discrepancy between what parents think and what professionals think that parents thought. Subsequently, what was popular opinion several years ago may not be popular opinion today (Frohboese & Sales, 1980). Stedman (1977) suggested that deinstitutionalization of a relative with a developmental disability represents stress because it forces the family to question whether institutionalization is, or ever was, appropriate. The crisis of the deinstitutionalization decision parallels the crisis of the situations faced earlier by the family-diagnosis, burden of care, and institutionalization (Willer, Intagliata, & Atkinson, 1979).

A study by Frohboese and Sales (1980) reported that families in Nebraska believed the state institution offered greater freedom of movement, independence, and safety. The greatest concern expressed by these families about deinstitutionalization was their perception of the lack of permanence of community settings. Other concerns addressed by parents included availability and quality of supervision, care, and other resources; many families believe that their relative needs 24-hour medical care and felt this would not be provided in the community (Atthowe & Vitello, 1982; Frohboese & Sales, 1980; Meyer, 1980). Payne (1976) found that parents were in favor of maintaining the institution and were skeptical of the advantages of small group homes.

Parents agreed fairly strongly that large institutions offered the advantages of a concentration of mental retardation expertise, opportunities for people to be with persons like themselves, and an opportunity for them to be protected from the stressors of community life. Lastly, parents believed that large institutions were the

tried and true way of caring for individuals with mental disabilities and that those institutions would be there long after they died (Payne, 1976).

CHAPTER THREE

METHODOLOGY

Research Design

This study used a *descriptive correlation survey* since it sought to establish a *relationship* between family characteristics' and placement of children with mental retardation in institutions. This is a non-experimental research seeking to describe the characteristics of an individual or a group of individuals. *Ex-post- facto* was also used in collecting data in regard institutional placement.

Research Population

The target population included a total of 34 employees and 05 administrators from Moyale Institution for the mentally retarded

Sample Size

The sample size will include all employees in the institution.

Table of respondents

Respondents	No
Employees	32
Administrators	05
Total	37

Sampling Procedure

All employees in the institution will be included in the study including the administrators.

Research Instrument

The research tools that were utilized in this study included the following: (1) *face sheet* to gather data on the respondents' demographic characteristics (gender, age,marital status, working experience (2) *researcher made questionnaires* to determine the family characteristics. The questionnaire contains (16 items). Placement data was from a secondary source. The response mode and scoring are as follow*: (4) strongly agree, (3) agree, (2) disagree and (1) strongly disagree.*

Validity and Reliability of the Instrument

Use of standardized questionnaires will ensure the validity and reliability of the instruments. However, the supervisor will have to first approve the use of these instruments before conducting the research.

Data Gathering Procedures

1. An introduction letter was obtained from the college of Education, open and Distance Learning for the researcher to solicit approval to conduct the study from respective employees and administrators. The respondents were explained to about the study and were requested to sign the Informed Consent Form (Appendix 3).
2. Reproduce more than enough questionnaires for distribution.
3. Select research assistants who would assist in the data collection; brief and orient them in order to be consistent in administering the questionnaires.

During the administration of the questionnaires

1. The respondents were requested to answer completely and not to leave any part of the questionnaires unanswered.

2. The researcher and assistants emphasized retrieval of the questionnaires within five days from the date of distribution.

3. On retrieval, all returned questionnaires were checked if all are answered.

Data Analysis

The frequency and percentage distribution were used to determine the demographic characteristics of the respondents.

The mean and standard deviations were applied for the levels of social influences. An item analysis will illustrate the strengths and weaknesses based on the indicators in terms of mean and rank. From these strengths and weaknesses, the recommendations will be derived.

For the level of social influences and psychological consequences, the following mean range will be used to arrive at the mean of individual indicators and interpretations.

Mean Range	**Response Mode**	**Interpretation**
3.26-4.00	Strongly Agree	Very satisfactory
2.51-3.25	Agree	Satisfactory
1.76-2.50	Disagree	Fair
1.00-1.75	Strongly Disagree	Poor

Ethical Considerations

To ensure confidentiality of the information provided by the respondents and to ascertain the practice of ethics in this study, the following activities will be implemented by the researcher:

1. The respondents and school were coded instead of reflecting the names.

2. Solicit permission through a written request to the concerned officials of the universities included in the study.

3. Request the respondents to sign in the *Informed Consent Form* (Appendix 3)

4. Acknowledge the authors quoted in this study and the author of the standardized instrument through citations and referencing.

5. Present the findings in a generalized manner.

Limitations of the Study

In view of the following threats to validity, the researcher claimed an allowable 5% margin of error at 0.05 level of significance. Measures are also indicated in order to minimize if not to eradicate the threats to the validity of the findings of this study.

1. *Extraneous variables* which were beyond the researcher's control such as respondents' honesty, personal biases and uncontrolled setting of the study.

2. *Testing:* The use of research assistants can bring about inconsistency in the administration of the questionnaires in terms of time of administration, understanding of the items in the questionnaires and explanations given to the respondents. To minimize this threat, the research assistants were oriented and briefed on the procedures to be done in data collection.

4. *Attrition/Mortality*: Not all questionnaires maybe returned neither completely answered nor even retrieved back due to circumstances on the part of the respondents such as travels, sickness, hospitalization and refusal/withdrawal to participate. In anticipation to this, the researcher will reserve more respondents by exceeding the minimum sample size. The respondents were reminded not to leave any item in the questionnaires unanswered and will be closely followed up as to the date of retrieval.

CHAPTER IV

DATA PRESENTATIONS, INTERPRETATION AND ANALYSIS

Table 2

Age, Gender, Marital status and working experience

CATEGORY	FREQUENCY	PERCENTAGE
Age		
21-30	10	27.02
31-40	24	64.86
41 and above	3	8.10
Total	**37**	**100**
Gender		
Male	11	29.72
Female	26	70.27
Total	**37**	**100**
Marital status		
Single	20	54.05
Married	17	45.94
Total	**37**	
Working experience		
1-2years	8	21.62
3-5 years	23	62.16
6 and above	6	16.21
Total	**37**	**100**

64.86% of the respondents are between 31-40years, 27.02% between 21-30 years, and 8.1% above 41 years. 70% of the respondents are female while 30% are male.54% are single and 46% married.

Table 3

INSTITUTION PLACEMENT

CATEGORY	MALE	FEMALE	TOTAL	PERCENTAGE
Moderate	19	12	31	24.40
Severe	28	22	50	39.37
Profound	30	16	46	36.22
TOTAL	77	50	127	

There are 31 children with mental moderate mental retardation, 19male and 12 female which is 24.4% of the population of the children in the institution.50 children have severe mental retardation, 28male and 22 female which is 39.37% of the total population. 46 have profound mental retardation and 30 are male and 16 female, 36.22% of the total population. 39.37% are female and 60.63% are male. This means that more male children than female are institutionalized.

Table 4

Relationship between family characteristics and institutional placement of children with mental retardation

Variables correlated	Computed r-value	P-value	Interpretation of Correlation	Decision on Ho
Family characteristic and institutionalization	-0.173	0.033	Significant relationship	Reject

In table 6, the relationship between the two variables (family characteristics and institutionalization) is statistically significant or big enough since the accompanying p-value is small enough because it is less than 0.05 and so, we reject the null hypothesis that was there is no significant relationship between family characteristics and institutionalization and accept the alternative hypothesis that was there is a significant relationship between family characteristics and institutionalization. Therefore, we conclude that there is a significant relationship between family characteristics and institutionalization.

CHAPTER FIVE

INTRODUCTION

This chapter presents the summary of the findings, conclusions, recommendations following the study objectives and pertinent hypotheses and areas of future research.

FINDINGS

This study was set out to establish the relationship family characteristics and placement of mentally retarded children in institutions in Moyale County which was guided by the following objectives: to determine the demographic characteristics of respondents in terms of gender, age, marital status and working experience; to determine the family characteristics; to determine the level of placement in institutions and to determine whether there was a significant relationship between the family characteristic and placement in mental retardation institutions.

Data was analyzed using SPSS descriptive statistics for means and averages for (i) level of family characteristics (mean=2.62) rated satisfactory (ii) level placement in mental retardation institutions (Mean=62.04) high, (iii) whether there is a significant relationship between family characteristics and placement in institutions (r value =-0.173).

Regression analysis results indicated that the independent variable (family characteristics) significantly influences changes in the dependent variable (placement) (F=4.612) which led to the conclusion that family characteristics significantly explains the high placement in mental retardation institutions.

Results in table 4 indicate there is a significant relationship between family characteristics and placement of children in mental retardation institutions.

The regression value (r^2=0.24) indicating that family characteristics has a 24% effect on placement of children with mental retardation in institutions.

CONCLUSIONS

There was a relatively high effect of family characteristics in terms of family size, economic status of parents and level of parent's education. Most families with mentally retarded children have low income, larger families and low levels of education.

The level of performance was significantly average with the average performance in five cross-cutting course units, four passed and one was failed (research) that requires a lot of reading.

Falmily characteristics therefore affect placement of children with mental retardation. This could be attributed to the fact that most families have little resources to cater for such children. 39.37% %of the children in the institution have severe mental retardation, 36.22% profound and24.05% have moderate mental retardation.

RECOMMENDATIONS

This section deals with recommendations arising from the pertinent findings and conclusions of this study, following the study objectives and hypotheses;

Institutions should only accept children with severe and profound mental retardation and let those with moderate mental retardation live with their families.

The government should provide gainful employment for parents with children with mental retardation of give them funds to cater for their children. There should be funds allocated to cater for children with mental retardation in the government budget.

Institutions for the mentally retarded should be government aided and employ more male workers. This research found out that the higher percentage of workers in mental retardation institutions was female.

Guardians who cater for children with mental retardation should be facilitated to do so through the constituency development funds in order to reduce the number of children placed in mental retardation institutions.

Institutions for children with mental retardation should arrange for frequent interaction with the family and guardians of the children placed in the institutions for persons with mental retardation.

Suggested areas for further research

There is need to do research on depression in families with mental retardation and coping mechanisms.

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APPENDIX A

RESEARCH INSTRUMENT 2

FACE SHEET

Please tick where appropriate

Gender _____Male _____Female

Age _____21-30_____31-40_____40 and above

Marital Status _____Single _____Married

Working Experience

_____1 -2 years

_____3-4 years

_____5 years and above

QUESTIONNAIRE FOR FAMILY CHARACTERISTICS

Direction: On the space provided before each option, indicate your best choice by using the rating system below:

Response Mode	Rating	Description
Strongly Agree	(4)	You agree with no doubt at all
Agree	(3)	You agree with some doubt
Disagree	(2)	You disagree with some doubt
Strongly disagree	(1)	You disagree with no doubt at all

1. _____ Both parents are living.
2. _____the father is the only parent living with the child.
3. _____ the mother is the only parent living with the child.

4. _____ the family is nuclear.

5. _____ the family is extended.

6. _____ there is only one child in the family.

7. _____the family has many children.

8. _____ the child lives with relatives.

9. _____ the child lives with the parents.

10. _____ one parent is gainfully employed.

11. _____both parents are gainfully employed.

12. _____ none of the parent is gainfully employed.

13. _____the child prefers school to home.

14. _____ the child prefers home to school.

15. _____ parents frequently visit the child.

16. _____parents rarely visit the child.

INSTRUMENT FOR INSTITUTION PLACEMENT

CATEGORY	MALE	FEMALE	TOTAL
Moderate	19	12	**31**
Severe	28	22	**50**
Profound	30	16	**46**
TOTAL	**77**	**50**	**127**

TIME	ACTIVITY
February2012	Developing the title
2012March	Chapter one
2012April	Chapter two
2012May	Chapter three
2012June	Questionnaires
2012July	Submission of proposal
2012Septembers/August	Actual field study
2012October	Final Research Report

BUDGET

ACTIVITY	COST
Typing	50,000
Questionnaires and photocopying	25,000
Transport	100,000
Binding	30,000
Miscellaneous	45,000
TOTAL	**250,000**