THE UNDERSTANDING AND PERCEPTIONS OF PARENTING SKILLS OF PERSONS WITH MENTAL HANDICAPS

by

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ABSTRACT

The purpose of this study was to investigate the understanding and the perceptions of parenting skills of persons with mental handicaps and their perceptions of the quality and the availability of support services. Parenting skills were considered in terms of nutritional and meal planning skills, discipline and behaviour management, home safety and emergency and interaction and social stimulation. Supports were considered of in terms of formal and family services.

An open-ended questionnaire was used to interview 25 mentally handicapped mothers. Findings indicated that mothers perceived the process of disciplining and providing a stimulating environment as the most difficult aspect of parenting. In terms of the support services, mothers were generally satisfied with the availability and sources of formal support. However,in terms of the quality of formal support, mothers indicated that such support should be modified to meet their needs. Mothers' perceptions of family support were differentially affected by their marital status. The presence of a spouse in the home and the opportunity to interact with extended family members were two factors which affected the quality of family support. In two-parent families, spousal support enabled the mothers to deal more effectively with their children. Findings also indicated that support from extended families was not available to most mothers.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

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CHAPTER I. INTRODUCTION

Many people in contemporary societies still continue to believe that persons with mental handicaps lack the abilities and the skills required for adequate parenting (Haavik, 1986; Feldman, 1986; Schmidt, 1989). And consequently, several questions have been raised in relation to their ability to rear children. Do they have adequate parenting skills? What types of support services are available to assist them with parenting? Courts across Canada and the United States have implemented policies and regulations to minimize and sometimes eliminate the possibility of people with mental handicaps to bear and raise children (Schmidt, 1989; Haavik, 1986). These include the laws restricting or prohibiting marriage and the actions taken by the courts to prevent them from raising their children (Rioux, 1987; Schmidt, 1989). Such actions have very often been based on the assumption that persons with mental handicaps lack the skills necessary for adequate parenting.

The purpose of this study is to investigate the understanding and the perceptions of parenting skills of persons with mental handicaps. In addition, it will also examine their perceptions of the availability and the quality of formal and family support services.

This chapter will briefly outline the rationales that have commonly been used for restricting marriage of persons with mental handicaps. In addition, it will also discuss

the legal framework of the rights of persons with mental handicaps to marry and raise children and finally, it will present three recent court cases in which children of parents with handicaps were apprehended on the basis of inadequate parenting.

Several rationales exist which restrict or prohibit the mentally handicapped to marry: societal attitudes, incapacity to contract and sterilization (Shaman, 1978; Haavik, 1986; Schmidt, 1989).

RATIONALE FOR RESTRICTIONS

Societal Attitudes

Society's attitudes towards persons with mental handicaps have played a major role in the development of laws and regulations which restrict or prohibit persons with mntal handicaps from marrying (Haavik & Menninger, 1981; Shaman, 1978). For years, societies across all cultures have frowned upon the right and the need of mentally handicapped adults to marry and raise families. Such an attitude may well be the product of the old beliefs that mentally handicapped people were subhuman and idiotic and as a result, did not have the need for love and affection, both of which are integral part of marriage (Haavik, 1986; Shanan, 1978). According to Shaman (1978), persons with mental handicaps were also stigmatised with derogatory labels by the so-called "educated" members of society. He stated that in the case of Buck v. Bell(1923):

> ...even someone as enlightened (for his day) Justice Holmes once descrtibed mentally retarded persons as degenerates, criminals,and unfit.
>
> (Shaman,1978,p.69).

Furthermore, Justice Holmes' final court decision of implementing eugenic sterilization as the state goal was also accompanied by demeaning comments (Haavik & Menninger, 1981).

> ...Justice Holmes' concern with society being "swamped with incompetents", his preference of prevention for "degenerate offspring, rather than having to execute them or let them starve, and his intolerance of more than "three generations of imbeciles" leave no doubt that he accepted both the goal of improvement of the race through elimination of undesirable traits and the mthod of sterilizing people who had these traits....
>
> (Haavik & Menninger,1981,p.126).

Another common attitude toward persons with mental handicaps considered them as being "eternal children" (Haavik & Menninger, 1981). This view was based on the premise that they were individuals without the need of intimate relationships. (Haavik &Menninger, 1981). However, very often, they were regarded as being unable to control their sexual needs and as a result, engaged in indecent sexual acts (Johnson, 1979).

Incapacity to Contract

The second reason for restricting persons with mental handicaps from marrying is their perceived incapacity to

contract (Haavik & Meninger, 1981; Shanan, 1978; Dickin & Ryan, 1983) and their perceived inability to anticipate consequences of marriage (Haavik, 1981; Shanan, 1978; Floor,Baxter,Rosen,& Zisfein, 1975). It was commonly assumed that they were not capable of understanding the concept of matrimony nor of entering the marriage contract (Floor et al.,1975). As a result, they failed to understand the duties and resposibilities that were involved in the process. Failure to recognise such demands would lead to problems in marital adjustment (Haavik & Menninger, 1981; Shanan, 1978). Such an assumption was consistent with the rationalization that due to their inability to enter into contract, society must protect the mentally retarded from entering into a marriage contract (Haavik & Menninger, 1981; Floor et al., 1975).

The lack of consistency regarding what constitutes a satisfactory marital adjustment among non-handicapped people makes the study of marital success among the mentally handicapped even more difficult (Andron & Sturm, 1971; Mattinson, 1971;Haavik, 1986). Mattinson's (1971) study of marital adjustment of mentally handicapped individuals indicated that the majority had adjusted well and in addition, received a lot of moral and emotional support from their spouses (Mattinson, 1971; Haavik, 1981). Andron & Sturm (1971) found that their results were consistent with those of Mattinson's in that the majority of the couples maintained a healthy, marital relationship. However, a study

in Northern Ireland found that approximately 40% of the men and 50% of the women had problems in marital adjustment (Scally, 1973).

Studies to determine the factors which would predict marital success have failed to identify any significant variables (Haavik & Menninger, 1981; Mattinson, 1971; Scally, 1973). For example, Mattinson's (1971) study showed no correlation between marital adjustment and IQ, or institutionalization (Mattinson, 1971; Floor et al, 1975). Furthermore no correlation between marital adjustment and the degree of handicap was found in a study by Craft and Craft (1978).

One of the common controversies plaguing the issue of the marriage contract and the responsibilities entailed within is the separation of the rights and responsibilities of marriage from the rights and responsibilities of parenthood (Haavik, 1986; Hertz, 1979). As a result, courts have asserted that mentally handicapped adults should only be allowed to marry if they have undergone sterilization (Shaman, 1978; Institute of Law Research & Reform: Alberta, 1988)).

Sterilization As a Condition to Marriage

The decision of whether to procreate made by competent consenting individuals is recognised by the U.S Supreme Court as being within the domain of constitutionally protected rights. In the case of Eisandth v. Baird (1972),

the U.S. Supreme Court stated that the right to bear children was constitutionally protected (Dickin & Ryan,1983).

Imposing involuntary sterilization prior to marriage or an age requirement (Haavik, 1981; Hertz, 1979) beyond the childbearing years indicates that the prevention of procreating of mentally retarded children was another concern justifying marriage prohibition (Schmidt, 1989; Haavik & Menninger, 1986).This was evident in statutes of Nebraska which prohibited persons with mental handicaps from marrying unless they had been sterilized (Shaman, 1978). An extensive review of legal statutes indicated that many states still have policies and laws which prohibit or restrict marriage of persons with mental handicaps unless sterilization has taken place. These included California, Delaware,Georgia, Idaho, Iowa, Kentucky, Michigan, Minnesota, Missouri, Nebraska, Nevada, New Jersey, South Carolina, New York,, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennyslvania, South Dakota, Tennesse, Vermont, Virginia, Wisconsin, Wyoming and New Mexico (Haavik,1986).

CANADIAN JUDICIAL HISTORY

In 1933, both Alberta and British Columbia enacted legislation which authorised non-therapeutic sterilisation on eugenic grounds (Rioux, 1987; Institute of Law, Research and Reform: Alberta, 1988). The enactment of legislation was

undoubtedly influenced by the judgement following the case of Buck v. Bell which gave power to courts authorize involuntary non-therapeutic sterilization in the United States (Rioux,1987; Institute of Law Research and Reform: Alberta, 1988).

Originally, both the Albertan and the British Columbian Sexual Sterilization Acts called for the formation of "Eugenics Boards" to determine when sterilization should be imposed.

> ...that the person might safely be discharged if the danger of procreation with its attendent risk of multiplicity of the evil by transmission of the disability to progeny were eliminated.
>
> (Institute of Law, Research and Reform:Alberta, 1988, p.171).

The Act was reviewed in 1937 and amendments were added:

> i) mentally defective persons were specifically mentioned for the first time.
>
> ii) criteria for sterilization were not solely genetic.
>
> iii)consent of the person to be sterilised or of the spouse, parent or guardian was needed in the case of psychologically defective persons. The need for consent in the case of mentally handicapped defective persons was removed.
>
> (Institute of Law Research and Reform:Alberta,1988, p.175).

During the time that this Act was in effect, approximately 4730 cases were proposed for sterilization, and more than half of these cases were approved.

Perhaps the most significant case in the Canadian judicial history involving sterilization was the case of Eve (Rioux, 1987). The Supreme Court of Canada, on October 26, 1986, ruled that neither the court nor the parents could authorize the sterilization upon Eve (Rioux, 1987).

The Case of Eve

Eve was a twenty five year old, physically attractive, mildly to moderately mentally retarded woman with limited learning capacity. Eve was dating a young man in her school. Eve's mother petitioned the court to authorise Eve's sterilization. During the course of the trial, the judge stated that:

> ..she is described as being a pleasant and an affectionate person, who, physically, is an adult person, quite capable of being attracted to, as well as attractive to the opposite sex. While she might be able to carry out the mechanical duties of a mother, under supervision,she is incapable of being a mother in any sense..she would have no concept of the idea or marriage; or indeed, the consequential relationship between intercourse, pregnancy and birth.
>
> (Institute of Law Research and Reform: Alberta, 1989,p.65).

Advocacy groups such as the Canadian Association for Community Living and the Consumer Advisory Commission argued that any decision which would authorise the operation without the consent of the party involved, would clearly violate the basic rights of that person (Rioux,1987). They

presented the Supreme Court of Canada with the following arguments:

> i)There is no authority under provincial legislation for a non-therapeutic sterilization.
>
> ii)The inherent jurisdiction of the courts should only be used to order a therapeutic procedure.
>
> iii)The courts should be involved where it is clear that the individual cannot consent personally, the adjudication being restricted to whether the sterilization is therapeutic.
>
> iv)The court should be satisfied that there is clear and convincing evidence that sterilization is appropriate.
>
> v)If sterilization can be ordered under parens patrie and without violating the Charter, then certain conditions must be met.
>
> vi)Non-therapeutic sterilization is a violation of section 7 of the Charter: liberty and security
>
> (Rioux, 1987, p.28).

The final decision in the case of Eve was that except for therapeutic purposes, neither the parents nor the court had the right to impose sterilization upon persons solely for the reason of mental handicap. The unanimous judgement of the Supreme Court was based on two premises. First, the Court contended that non-therapeutic sterilizations were beyond the reach of the courts' parens patrie jurisdiction. As stated in the judgement:

> ...the grave intrusion on a person's rights and the certain physical damage that ensues from non-therapeutic sterilization withou consent, when compared to the highly questionable advantages that can result from it, have persuaded me that it can never safely be determined that such a

> procedure is for the benefit of that person. Accordingly, the procedure should never be authorised for non-therapeutic purposes under the parens patriae jurisdiction.
>
> (Institute of Law Research & Reform:Alberta, 1988, p.64).

Secondly, the court held that if non-therapeutic sterilisations are to be authorised, then the Canadian jurisdiction must take the appropriate action to enact legislation.

> If sterilization of the mentally incompetent is to be adopted as desirable for general social purposes,the legislature is the appropriate body to do so. It is in a positionto inform itself and it is attuned to the feelings of the public in making policy in this sensitive area.
>
> (Rioux,1987, p.43).

And finally, the Supreme Court asserted that the reason of "best interests" as the basis of previous judgements was not only insufficient but it was also depriving.

> .. the best interests test is simply not sufficiently precise or a workable tool to permit the parens patriae power to be used in situations like the present...It is difficult to imagine a case in which non-therapeutic sterilization could possibly be of benefit to the person on behalf of whom the court proposes to act.
>
> (Rioux,1987, p.46).

Current Laws

Regardless of the nature of the future legislation, critics of sterilisation maintain that the rights of persons with mental handicaps are not only being compromised but are

also being totally denied when they undergo non-therapeutic sterilization (Haavik, 1986; Rioux, 1987). Proponents of this argument assert that such a procedure infringes upon the rights to procreate, to security of the person,and to equality before the law.

Although the right to procreate is not explicitly recognised in Canadian jurisprudence, its adoption of international agreements which imply procreative rights makes the courts somewhat responsible for such rights of persons with mental handicaps. Examples of such documents are the Universal Declaration of Human Rights (1948) and the 1968 Proclamation of Teheran (Law Reform and Commission, 1979).

As stated in Article 16(i) of the Universal Declaration of Human Rights:

> Men and women of full age, without any limitation due to race, nationality or religion, have the rights to marry and to found a family. They are entitled to equal rights as to marriage, during marriage, and at its dissolution.
>
> (United Nations, 1988, p.1).

The Proclamation of Teheran (1968) states that:

> The protection of the family and of the child remains the concern of the international community. Parents have a basic rights to determine freely and responsibly the number and the spacing of children.
>
> (United Nations, 1988, p.43).

From these documents, one can logically assume that all persons, including persons with mental handicaps, have both

the right to be free from involuntary sterilization and the freedom of choice to have sterilization.

According to Tarnopolsky (1975), the Canadian Bill of Rights(1970) was yet another tool which ensured equality before the law. Tarnopolsky (1975) argued that the presumption of sterilisation as a protective measure could never be easily justified, as it would deprive the mentally handicapped of the right to participate in sexual acts. The Bill of Rights further guaranteed security of all individuals and the rights not to be deprived thereof except by due process of law.

The Preamble to the Charter of Rights and Freedom explicitly acknowledges that all persons are equal before the law regardless of race, ethnic origin or sex. However, the relationship of the Charter to sterilization remains, as yet, ambiguous (Institute of Law, Research & Reform, 1989). There are three major sections of the Charter which need to be addressed. Two of the sections, Sections 7 and 12, came into force on April 17, 1982. Section 7 protects the right to life, liberty and security of the person (Vogel, 1987). This section states:

> Everyone has the right to life, liberty, and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.
>
> (Vogel, 1987, p.32).

Section 12 of the Charter prohibits any type of exposure to cruelty and punishment. It states:

> Everyone has the right not to be subjected to any cruel and any unusual treatment or punishment.
>
> (Vogel, 1987, p.33).

Finally, the third section, Section 15, came into force on just before the Eve case was presented in court. This section is concerned with the protection and the provision of equality rights. It states:

> 1) Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and in particular, without discrimination based on race, national or ethnic origin, color,religion, sex age or mental or physical disability.
>
> 2) Subsection (1) does not preclude any law, program or activity that has as its object the amelioration of conditions of disadvantaged individuals or groups including those that are disadvantaged because of race, national or ethnic origin, color, religion, sex age or mental disability.
>
> (Institute of Law,Research & Reform: Alberta, 1988, p.62).

Although Section 15(2) enunciates the basic rights regardless of physical or mental disability, its application to non-therapeutic sterilization still remains to be an area that has not been addressed by the judicial systems However, in declaring its judgement in the case of Eve, the Supreme Court has undoubtedly opened up a new chapter which is faced with formulating legislative policies which are in

turn consistent with the tenets of the Charter (Institute of Law, Research & Reform:Alberta, 1989).

In Canada, as yet, there is no specific sterilization statute (Rioux, 1987; Institute of Law, Research & Reform:Alberta, 1989). The Act was repealed in 1972 which left both B.C. and Alberta without specific statutes on sterilization. According to recent report by the Institute of Law Research and Reform in Alberta (1989), current policy is found under the Hospitals Act of Alberta which treats hysterectomy and sterilization separately. The Act provides that:

> i) A consultation by another physician preferably one who is a specialist in the appropriate specialty shall be held for all...c) hysterctomies in patients under 40 years of age, unless adequate provision to prevent criminal abortions is made in the medical staff by laws....and e) operations for sterilizations in both males and females.
>
> (Institute of Law Research and Reform:Alberta, 1989, p.56).

However, the judgement of the Supreme Court in the case of Eve has some useful features that may affect future sterilization statutes (Institute of Law, Research and Reform:Alberta, 1989). First, it emphasized the irreversible characteristic of sterilization.

> In limiting its jurisdiction in the Eve judgement, the Supreme Court of Canada has vividly underscored the seriousness of sterilization as an intervention...The irreversible and serious intrusion on the basic rights of the individual is simply too great to allow a court to act on the basis of possible advantages which from the

> standpoint of the individual, are highly debatable.
>
> (Institute of Law Research and Reform:,Alberta, 1989,p.71).

Second, it suggests that superior courts do not have authority to authorise non-therapeutic sterilizations.

PARENTS WITH MENTAL HANDICAPS

Recent Court Cases Involving Apprehension

As a result of the judgement in the case of Eve, several questions have been raised in relation to mentally handicapped people's abilities to raise children. Can they be adequate parents? Do they have any parenting skills? What types of support services are available to assist them with parenting? Mira & Rody, 1980; Feldman, 1986). Criteria that have commonly been used in court proceedings as basis of inadequate parenting consist of behaviours which, if deficient, result in the finding of neglectful status of the child. Such a status is established when evidence of i)physical abuse, ii)inadequate housekeeping, iii)failure to meet the child's nutritional and medical needs and iv)failure to provide adequate and appropriate stimulation (Hertz, 1979) is present. However, sometimes without sufficient evidence of abuse, children are apprehended and parental rights are terminated before parents with mental handicaps are actually able to prove themselves as capable of caring for their children. Examples of three such court cases are given below.

Benjamin Jansen, born in 1986, was apprehended in July 1988 from the care of his mother, Diana Jansen. The initial apprehension was instigated on the grounds of Diana's mental handicap. In August 1988, the Superintendent of Family and Child Services of British Columbia, petitioned to the court that Diana be awarded custody of Benjamin. Soon after, Diana was given custody for six months with support from various child care services. However, the custody was given on the condition that Diana cooperate and sign various contracts. After several contracts, Diana refused to sign again as she felt that the contracts were demeaning. Following this refusal, Benjamin was apprehended again. During the course of the trial, Judge Barnett stated:

> ...I am more than satisfied that the only real reason for the third apprehension was the fact that Diana would nor sign the contract. And I am quite unable to understand why the social workers thought it necessary to take the drastic step of apprehension again. He could and should have proceded under the Family and Child Services Act.
>
> (Court of Appeal Proceedings,August 1988,p.5)

Section 13(6) of the Act explicitly states that:

> The superintendent or a parent of the child may subject to the giving of notices in the same way as under Section 12(2), apply to court for recission or variation of,an order made under subsection (1) or (5) of this section, on the grounds that the circumstances have significantly changed.
>
> (Family and Child Services Act,1980,p.21).

During the course of the hearing, Judge Barnett also held that although the apprehension itself was not illegal, it

was not the right approach. In addition, he argued that the proposed evidence that Ben was abused and that his mother was unable to care for him could not be confirmed or established by the evidence presented to the court.

In his final judgement, the judge articulated that:

> 1. Diana is mildly mentally handicapped. She is slow and sometimes acts impulsively and foolishly. She is not stupid. She is not incapable of learning or unwilling to learn.
>
> 2. Diana and Benjamin have an affectionate and usually apropriate relationship. Benjamin relies upon his mother. There is absolutely nothing to make one even suspect that Diana has ever abused Benjamin.
>
> 3.Diana is not a good housekeeper. Her appartment is usually in a great mess.
>
> 4.Diana feeds Benjamin appropriately, dresses him properly, keeps him clean and generally cares for him in an acceptable manner. He does not have any unsual history of sickness or injuries and there is really nothing to cause a reasonable person to be greatly concerned for Benjamin´s safety and well being. There are some definite areas where Diana´s skills and judgement really should improve.
>
> 5. Benjamin is apparently delayed, but only mildly so.
>
> (Court of Appeal:Quesnel,1988.p,5).

Based on these statements, Diana was finally awarded custody. Thus it seems evident that the three apprehensions may have been instigated without sufficient evidence of parental incompetency.

Another case in British Co;umbia that received attention within the judicial domain was the case of Joanne

Pattersen (Court of Appeal:Vancouver,B.C., May 1988). The apellant, who was the mother, had a mental handicap the exact nature of which was not determined. Three weeks prior to the birth of the child, a decision was made by the Superintendent of Family and Child Services to apprehend the child at birth. One week following the birth, on May 29, 1986, the child was apprehended by the Superintendent and placed into foster care. Following numerous hearings, the mother was given some access to see the child. However, in November 1986, custody of the child was awarded to foster careon the basis that the mother could not look after the child herself and as a result, it was not in the child's best interest to be raised by a number of surrogate mothers. Following the re-apprehension, the order was appealed on May 27, 1987, when the lawyer for the mother raised a number of issues related to the Charter. She claimed that the court had discriminated against her on the basis of her mental handicap, contrary to Section 15(1) of the the Charter and Section 13(1) of the British Columbian Human Rights Code. In addition, counsel for the apellant claimed that the actions of the agency denied to the mother the right to equality under the law and to equal protection and equal benefit of the law without discrimination- all contrary to Section 15(1) of the Charter. Subsequent hearings of the case led to the release of the child from foster care into the custody of the mother. The judgement was based on the fact that the strength of the evidence presented in court

was too weak to establish any form of conclusions about the mother's inadequacy to raise her son in a satisfactory manner.

The third case occured in the Manitoba courts, on August 19, 1989. This case involved Mrs. B who gave birth to a healthy baby boy on July 20,1989. Immediately following his birth, the infant was apprehended by a representative of a Winnipeg child welfare agency on the basis that the couple was unable to provid effective parenting "due to their inherent limitations and to their mental disability (Peltz, 1989, p.4). Mrs.B, who was developmentally disabled, functioned in the borderline range of inteligence with verbal skills in the borderline range and performance in the low average range. Mr. B, the father of the child, was also developmentally disabled. His overall intellectual level was in the upper range of borderline intelligence (Peltz, 1989).

Following the apprehension of the child, a petition was filed claiming that these parents were being discriminated against under Section 15(1) of the Charter as well as under Section 13(1) of the Human Rights Code. In addition they claimed that the actions of the agency had denied to them equality under the law and the equal protection of the law, thus being inconsistent with Section 13(1) and Section 9(1) of the Code. After numerous hearings, the baby was returned to his parents under a plan of 24 hour supervision and access to a live-in homemaker.

PURPOSE OF THE STUDY

Today, an increasing number of mentally handicapped adults are choosing to have children. The issue is further complicated when their rights to raise children are terminated by the judicial sytems on the basis of their handicap. Very often, such rights are terminated without providing them the opportunities to prove themselves capable of caring for their children and benefiting from community resource programs.

There are two legal presumptions that form the basis of child apprehensions. First, mentally handicapped people are believed to be "unfit" parents who lack the skills necessary to raise children who, as a result, may suffer from cognitive, emotional and physical imapairments (Haavik & Menninger, 1986; Schmidt, 1989). Secondly, while parents with mental handicaps may be receiving support from community based resources, such support may not be adequate to meet the needs of their children (Feldman, 1986).

To challenge these presumptions, there's a need to:

a)Identify problems common to mentally handicapped parents as perceived by the parents themselves,and

b)Determine who is supporting parents in their caregiving roles and what is their perceived quality of these support systems.

The purpose of the study is to investigate both the understanding and the perceptions of parenting skills as perceived by mentally handicappped parents as well as their

perceptions of the availability and the quality of formal support systems.

Definition of Terms

In this study, parenting skills will be organized under four categories: nutritional and meal planning skills, discipline and behaviour management, home safety and emergency skills and, finally, interaction and social stimulation. These categories were derived from research studies by Rutter (1983) and Hertz (1979).

Parental competency/Adequate parenting-refers to a parent's ability to respond and cater to their child's emotional, cognitive and physical needs.

<u>Parenting Skills</u> (Rutter, 1983; Hertz, 1979)

Nutritional and Meal Planning Skills

* recognizes and understands the four food groups and is able to relate them to their child's diet.

* has the ability to plan and make balanced meals for the family.

*has the ability to distinguish between nutritious any non- nutritious foods.

Discipline and Behaviour Managemnt Skills

* has the awareness of the importance of disciplining children.

* has the ability to develop and apply appropriate strategies.

Home Safety and Emergency Skills

* awareness of posionous and dangerous items inthe house.

* ability to prevent and respond to emergency situations.

* ability to take precautions to prevent accidents in the home.

Interaction and Social Stimulation

* ability to communicate love and affection to their children.

* the degree to which children are encouraged to socialize with their peers.

Chapter two will review research which focuses on what constitutes adequate parenting, factors which affect parental competencies and the availability and the quality of the community support services to mentally handicapped parents.

CHAPTER II. REVIEW OF LITERATURE

The case law and legislation authorising apprehension and terminations are based on the assumptions that mentally handicapped parents are incapable of providing adequate care for their children and as a result, they likely to suffer from cognitive, psychological and emotional delays (Schmidt, 1989; Katzman, 1981; Budd & Greenspan, 1984).

This chapter will review the research relating to these assumptions. Specifically, it will focus on two questions:

a) Which factors affect the parental competency of mentally retarded parents and how do these in turn affect the parenting skills of persons with mental handicaps?

b) What types of support services are available to mentally handicapped parents and what are their perceptions of the quality and the availability of these services?

Within the legal jurisdictions, parental competency or adequacy is very often determined by the presence of behaviours which, if deficient, result in the finding of neglectful status of the child. Such a status is very often established where parental behaviours such as i) physical abuse, ii) inadequate housekeeping, iii) failure to meet the child's physical needs iv) emotional neglect v) inadequate parenting (i.e. failure to attend to the child's nutritional needs, home safety and emergency needs) and vi) failure to provide medical care (Hertz,1979; Mira & Roddy 1980) present when raising families.

The review is divided into two sections. The first will discuss studies which examine factors that directly affect the parenting skills of the mentally retarded. The second part will discuss the role of support services in encouraging the parenting skills of persons with mental handicaps and how they perceive these services.

THE CONCEPT OF PARENTING

The concept of parenting is rooted in the fulfillment of a child's emotional, cognitive and phyiscal needs as well as the provision of supportive activities thus giving sustenance and aid to children both on a day to day basis and in time of crisis. According to De'Ath (1983), parenting involves skills and practices which enable people in their role as parents as they negotiate the stages and transitions of family life (De'Ath, 1983). To take this concept even further, Rutter (1983) postulated that parenting is rather a function of having such social skills and basic skills as:

a) The ability to respond and cater to the child's basic needs,

b) The ability to love and undertake relationships,

c) The ability to care, support and nurture other people, and

d) The ability to communicate,through active listening, giving appropriate verbal and non-verbal messages.

(Rutter, 1983, p.80).

The acqusition of such skills is generally dependent on how an individual is exposed to natural and incidental learning experiences (Schmidt, 1989; Rutter, 1983). In addition, parenting is also a function of other variables such as the parents' psychological and emotional state, the time available for parenting, the extent to which child rearing is shared between the parents and most important of all, the availability of adequate social support services (Rutter, 1983; Budd & Greenspan, 1984).

However, mentally handicapped parents may very often have difficulty in acquiring and applying such skills. Frequently, as institutionalized persons, appropriate parenting role models were not available to them and, as a result, they were not exposed to natural and learning experiences.

Who is a Competent Parent?

The challenges and responsibilities of parenting are probably the most difficult aspects of adulthood. In any one society, no one is ever quite ready to take on the lifetime responsibilities that accompany the role of parenting, and certainly,persons with mental handicaps are by no means an exception (Gallagher, Beckman & Cross, 1983).

Although educators and other paraprofessionals interested in children have observed that one must be licensed to be a plumber or a teacher, licensing for

parenthood obviously is quite absurd. Who is able to judge the criteria that define an adequate parent? Polster & Dangel (1984) found that practices which determined the level of parental adequacy varied considerably over time, and across cultures. Adequate parenting has been broadly defined by some researchers as the provision of "life necessities, safe environment, health care and education"(Rutter, 1983; Polster & Dangel, 1984; Abidin, 1982). Although definitions such as these may be of some use, the broad context in which they are applied in may lead one to infer a wide range of interpretations. In defining parental competencies, Mira & Rody (1980) stated that parental practices are those which, if deficient, result in a finding of neglectful status of the child. This involved the following categories of neglect:a)physical abuse, b)inadequate supervision or housekeeping,c)inadeqate parenting, d)sexual abuse and e) failure to provide medical care. Deficits in adequate care were based on such findings as minimal parental attention, lack of stimulation and haphazard scheduling of child care (Wald, 1975). According to Hertz (1979), the legal system in the U.S. has consistently focused on three skills in neglect cases as essential for adequate parenting. Such skills involve love and affection, housekeeping skills and fulfilling the child's physical needs. However, in cases where mentally handicapped parents are involved, many states have included

a fourth factor, that is having the ability to stimulate the child intellectually.

FACTORS AFFECTING PARENTAL COMPETENCE

Concern with the ability of persons with mental handicaps to provide adequate care has been the central issue addressed by legal jurisdictions. The majority of research studies have compared mentally handicapped parents with parents of normal intellect (Budd & Greenspan,1986; Feldman,1986). Undoubtedly, results from such studies have indicated that, as a group, mentally handicapped parents have more difficulties coping with raising families than non-handicapped parents (Budd & Greenspan,1986; Schmidt,1988). However, other studies indicate that mentally handicapped parents cope as well as those parents who come from similar socio-economic backgrounds (Fotheringham,1980; Mira & Roddy,1980).

If the mentally retarded parents find it difficult to cope with parenting, the question that is commomly posed is whether their difficulties are related to their intellectual abilities or to other factors such as the level of intelligence, the degree to which they are socially and emotionally adjusted and the degree to which they have access to support services(Mira & Roddy,1980; Feldman,1986).

Intelligence

To date, probably the most extensive study examining intelligence as a possible factor affecting parenting, was one in which 90 families (average IQ=58.6) were divided into three groups based upon the adequacy of child care along three levels : Satisfactory, Questionable and Unsatisfactory (Mickelson,1949). Results of the study indicated that 42% of the families were rated as having given their children satisfactory care, 32% as questionable care and 23% as unsatisfactory care. Mickelson found that low IQ was not necessarily predictive of inadequate parenting. Mickelson considered factors such as number of pregnancies, number of children living in the home, age distribution of the children, the mothers' IQ difference in the ages between the husband and the wife, marital adjustment and the level of income. Results indicated that adequate parenting was related more to marital adjustment, level of income, and the number of children in the home rather than to the IQ (Mickelson, 1947; Feldman, 1986; Reed & Reed, 1965).

Another study reporting similar findings investigated the degree of marital adjustment of eighty couples. Floor, Rosen,and Ziesfen (1975) found that persons with mental handicaps faced problems which were similar to those of non-handicapped parents. These included money management, and child discipline problems. In addition, their findings

indicated that out of 32 children, 52% of the children were receiving adequate medical attention, affection and appropriate stimulation from both parents (Floor et al.,1975).

Other authors have suggested that factors such as parents' age, level of education, support from extended families and the degree of handicap, also affect the coping skills of mentally handicapped parents (Craft & Craft, 1979; Mira & Roddy, 1980; Tymchuk, Andron & Unger 1987). In addition, Schmidt (1989) has also added factors such as the history of institutionalisation of parents and the degree to which they were handicapped.

Social/Emotional Adjustment

Several studies have indicated that the degree to which a mentally retarded parent is socially and emotionally adjusted plays a key role in determining the problems that are encountered by mentally handicapped parents (Mickelson, 1947; Grant, 1980; Floor et al.,1975; Budd & Greenspan, 1986).

In her study, Mickelson (1947) found that 81% of the parents who were providing questionable or unsatisfactory care showed evidence of problems related to their social and emotional well being. Such problems included excessive drinking, marital disharmony, and personality disturbances.

Budd & Greenspan's (1985) evaluation of training programs indicated that out of the total 52 families,

approximately 25% of the parents were experiencing some sort of marital emotional problems that were affecting their abilities in providing acceptable standards of child care. Geijer and Karlsson (1987) showed that out of the 15 mentally handicapped mothers, 50% of them had had unstable up-bringings, where incidences of mental illnesses, alcoholism and abuse were predominant.

The findings from the above studies indicate that cognitive and intellectual limitations are not the sole factors responsible for parenting inadequacies in mentally handicapped parents. But rather, it is the prevalence of social and emotional problems that, to some extent, play a bigger role in determining the ability of mentally handicapped parents to provide adequate care for their children (Gillberg & Geijer -Karissons, 1987; Mickelson, 1947; Budd & Greenspan, 1986).

THE AVAILABILITY OF SUPPORT SERVICES

The ability of mentally handicapped parents, like non-mentally handicapped parents, to adequately care for their children is affected by the existence and the availability of support networks within the community.

The research indicates that mentally handicapped parents benefit considerably from various types of modified support services (Budd & Greenspan,1986; Schmidt,1989). This study will distinguish between formal and family support

networks that are available to the mentally handicapped parents.

FORMAL SUPPORT SYSTEM

The Need for Professsional Help

Brown (1978) addressed the question,"What group seeks professional help?" The data suggested that helpseekers experienced more troublesome events than individuals who didn't seek help. The magnitude of stressful episodes in the lives of this group was greater than in the other gruops studied. The author suggested that professionals were contacted in situations where stressful events and higher levels of role strain were exhibited. For this group, the reliance on formal support systems seemed to reflect the inadequacies of informal supports, and a reluctance to keep asking informal associates for assistance. Very often, contact with an organization marked a turning point in the understanding and coping with the responsibilities that are entailed in parenthood.

Formal Support and Parenting Skills

Many mentally handicapped parents function in a manner similar to other parents who have similar demographic characteristics (Mickelson, 1947; Budd & Greenspan, 1985). Similarly, it has also been found that a significant percentage of mentally handicapped parents are capable of benefitting from interventional programs designed to improve

their parenting skills (Mickelson,1949; Budd & Greenspan,1985). In addition, Budd & Greenspan (1985) stated that interventional methods that are designed for non-mentally handicapped parents can be used successfully with mentally handicapped parents,although they may need to be modified. In an extensive review of training programs, Budd and Greenspan (1984) indicated that parent training pograms for clients who are mentally handicapped were more "elaborate, more directive and longer than typical programs for non-handicapped parents" (p.7). Such programs involved training parents in caretaking skills such as diapering, feeding, bathing safety, nutrition, providing stimulating home environments and positive mother-child interactions (Feldman,1986).

Feldman (1986) studied the degree to which mentally handicapped mothers provided a stimulating interaction for their children. There were four boys and three girls, (average age 13.7 months) and except for one child, none of them showed signs of developmental delay. The behaviours of interest in this study were "praising", "talking", "prompting play behaviour" and encouraging "child vocalisations". These mothers were observed in their own homes. After obtaining a baseline, the training sessions were implemented.These sessions focused on interactive target behaviours, specifically followed by discussions of mother-child interactions and modelling segments. The trainers were encouraged to provide positive feedback and

reinforcement. When however, mothers performed inappropriately, the therapists modelled the appropriate target behaviour and the mothers were requested to try again. The mothers were given a "home play chart" on which they were to record appropriate interactive behaviours. Results indicated that mothers did benefit from training sessions and increased their behaviours to the levels observed in non-handicapped parents (Feldman,1986). A follow up at ten months indicated a mean increase of interactive behaviours from eight per cent to 33 per cent in maintenance.

In an earlier study, Eyberg (1981) used similar procedures to increase the frequency of mother-child interactions. Ten parents received similar training in a group home. The sessions consisted of two parts: child-directed activities and parent-directed activities. In the former, parents were encouraged to positively reinforce their children's behaviours while at the same time, refrain from questioning or commanding their children. In the latter, parents were trained to praise appropriate behaviours, imitate child vocalisations and provide rich play environments. Eyberg (1981) found that training programs were more successful when the number of training sessions was increased from nine to 20. In addition,Eyberg argued that these parents were able to master the skills because "..of intensive in vivo experiences provided and the relatively simple rules that were involved in the parents'

application of the treatment program" (Budd & Greenspan, 1982).

THE QUALITY OF PROFFESSIONAL SERVICES

Evaluation of Parent-Training Workshops

Program evaluators are concerned about the inclusion of client satisfaction in their assessments (Sommers & Ncyz, 1979; Rosenberg & Tate 1982). According to Hill (1969) and Rosenberg and Tate (1982), the majority of people who seek help from professional outlets are satisfied with the services that they receive. In addition, they found that for educated women needing assistance with family problems, the help received from professionals was more satisfactory than help received from friends and relatives. Numerous studies have evaluated the client satisfaction of programs for mentally handicapped children, however, only a handful of studies have evaluated the client satisfaction of programs for mentally handicapped parents.

Peterson and Littman (1983) assessed programs which were designed to teach parenting skills to "high risk" families which included mentally handicapped adults. In their study, 72 parents were asked to respond to a questionnaire indicating the degree of satisfaction on a four point scale. Nearly one half of the parents reported that the therapists, life-skill workers, teaching staff, as well as other professionals, had presented the workshops in a sympathetic manner,showing dignity and respect for

mentally handicapped parents. However, some parents indicated that although the sessions at the parent training workshops were valuable, very few of them gave them "hands-on" activities which would have allowed them to experience the real situation.

In another evaluation study, by Budd and Greenspan (1986,) clients stated that sessions were not long enough. They also complained that that most of these sessions were "nothing more than another one of those jargon classes" which were difficult for clients to understand and apply the skills taught. In both studies, the need for an extension of time and modification of terminology was indicated.

Counselling Services

In addition to benefitting from services such as the ones described above, many mentally handicapped parents take advantage from community counselling services. These services are often beneficial to mentally handicapped parents with marital problems, and/or who may be having difficulties raising families (Budd & Greenspan, 1984). Sommers & Nycz (1978) monitored client satisfaction with the counselling services provided to mentally handicapped parents and their families. A questionnaire was distributed to 100 "at risk" parents as well as the professionals associated with them. Both groups were to assess and evaluate the availability as well as the quality of the

services that they were receiving. Approximately 70% of the parents indicated overall satisfaction with the services received. Twenty-five per cent of the clients found the life-skill workers to be impersonal and cold; ten per cent of felt that there was a lack of communication. The remaining six per cent felt services were not helpful. Approximately 60% of the therapists and the counsellors indicated that often they felt pressured for time. In addition they felt that many couples just needed emotional support which required more time than was available. Similar studies were done by German & Maisto (1982) who found that time was a crucial factor in determining how satisfied these parents were with services. However, despite the time constraints, almost all parents indicated a high level of satisfaction.

FAMILY SUPPORT

Benefactor to parent support

Family members (or benefactors) providing support often feel a strong sense of responsibility for the handicapped parent (Tucker & Johnson,1988;Edgerton,1967). They accept the parents' inability to cope and their eventual goal is to teach the parent to be independent (Winik,1981).

Floor et al.(1975) studied the characteristics of parents who have made a successful adjustment to the birth of a child. Their study included 80 previously institutionalised mentally handicapped parents. The data

from this study indicated that, in general, more than 63% of the children were receiving proper medical attention and affection from both parents. However, they indicated that these results were dependent on the frequency of contact with at least one other family member (such as a grandmother,aunt or cousin).

Zetlin, Weisner and Gilmore (1985) studied the relationship between the provision of adequate child care and the frequency of contact with the maternal grandmother. Close contact of parents with maternal grandmothers indicated substantial improvements in coping skills. In addition, emotional and moral support from the grandmothers encouraged handicapped mothers to adapt to the demands of being a parent.

In an earlier study, Zetlin et al. (1983) examined the interaction of handicapped mothers with their children in the presence of a mother-in law as the benefactor. In addition to giving encouraging advice, the role of the mother-in-law was to ensure that both survival and maintenance needs of the mother were met (e.g food, medical needs, housekeeping and money management). Results indicated that (over a span of six months to one year), mothers benefit from having a family member in a support role. Interaction and ability to cope with household management and caregiving skills all showed improvement.

In their study, Tucker and Johnson (1988) distinguished between "competence inhibiting" and "competence promoting" support systems to demonstrate that the mere existence of a support network was not a sufficient predictor of parental competence. Rather, it was the nature of the support-specifically whether it encouraged independence and competence-that determined positive or negative results. They examined the effects of family support as well as the nature of such support on handicapped parents' coping skills In their study of 15 families, five were two-parent families. These families received support from their extended families (benefactors), five from benefactors as well as local community organizations, and the remaining five received no support at all. The results indicated that families receiving community support received more emotional as well as moral support and were more successful. Furthermore, they were found to be far better in adapting and responding to the needs of their children. The parents (who received no support) became frustrated, angry and impatient with their children. As a result, they were unable to respond to their children's basic hygiene and nutritional needs. These parents also found it difficult and stressful to manage their children's disciplinary problems. The results of this study indicated that support from family members and community organizations are competence promoting.

Similar results were reported in an earlier study in which Gallagher, Bechman and Cross (1983) found that the mother's family had a significant impact on maternal stress. Mothers who reported the least stress were receiving more help from their husbands, sisters and other members of the extended family.

Chapter three will describe the research design of the study, the statement of the problem and the procedures used to collect data.

CHAPTER III. METHODOLOGY

This study investigated those types of parenting skills that mentally handicapped parents perceived as being the most difficult to cope with. An interviewing procedure involving a set of open-ended questions (See Appendix A) will be used to enable the subjects to openly express their feelings about the problems they encounter as parents. Open-ended questions will allow the respondents to provide an in-depth explanations and feelings of their coping strategies.

Statement of Problem

This study addresses two issues: The types of problems that mentally handicapped parents encounter when raising children and their perceptions of the availability and the quality of the support services.

More specificaly, it seeks to answer two specific questions:

a) What types of parenting skills do mentally handicapped parents perceive as the most difficult to cope with?

b) What are the major sources of support services for mentally handicapped parents and what are their perceptions of the quality and the availability of the support services?

Identification and Demographic Information of Subjects

In this study, the sample consisted of mentally handicapped mothers who were receiving support from the local parent training workshops in the Lower Mainland and in the State of Washington. The participants were contacted

through local community associations and organizations of the mentally handicapped. The process of obtaining subjects began in April 1989. At that time, a letter explaining the research project was mailed to 20 local community associations in British Columbia and Washington. Out of the 20, five community associations responded to the proposal of the study. These associations contacted 25 mothers who agreed to participate. A follow-up of the remaining associations led to the finding that most of them did not provide services for mentally handicapped parents.

Table 1

Demographic Information of Mentally Handicapped Mothers

Mother's Age	Mean=22years	Range=19-32 years
Marital Status	Married=6	Single=19
Level of Education	Elem.=17	Secondary Grade 10: 8
Source of Income	Employed=4	Assistance from Government=21
Number of Children Per Family	Range=1 to 3	Sex: M=12 F=20
Ages	Range= 1 to 8 yrs	Average Age of the child=3.3years

Table 1 shows demographic information for the 25 mothers and 32 children. As indicated in the Table, 25 mothers, who were between 19 and 32 years of age, with a mean of 22 years, responded to the questionnaire. Of the 25 families, six families were two-parent families and 19 were single parent families. In four of the two-parent families, the father was employed full-time and in the remaining 21 families, the parents received some sort of monetary assisatance from the goverment. In terms of the amount of education that they had received, out of the 25 families, 17 mothers had completed elementary school and eight had studied at the secondary level but had only completed grade ten.

Instrument

An open-ended questionnaire (See appendix A) was developed to gain an in-depth understanding of parenting skills of persons with mental handicaps. The format of the initial questionnaire was one which forced subjects to choose particular responses. However, the local associations suggested that questions of such a format may not only stigmatise these parents , it may also yield data which may not answer the research questions. As a result, an open-ended questionnaire was used to encourage subjects to respond freely. During the course of developing the questionnaire, there was the concern that, the questionnaire

was too long and subjects would become fatigued, distracted or otherwise less cooperative. The best estimate was that the questionnaire should take no longer than forty minutes.

Pilot Study

A pilot study was conducted with four mentally handicapped mothers to determine if the interview could be completed within forty minutes and to identify possible difficulties with questions. The interviews took place at the offices of the local associations. Audiotapes of each interview were made to provide a cross check of responses recorded in written form during the interview. This was important to ensure the accuracy and completeness of the information collected.

After the interviews, participants were invited to comment. Several changes were made as a result of these comments. Firstly, participants felt that there were too many questions in each category. Secondly, it was felt that the terminology and the phrasing of the questions were too difficult. In order to check for the presence of potentially threatening items, participants were asked if they believed other people would feel uncomfortable answering any of the questions. None of the participants believed this would occur. The inclusion of threatening items in the interview schedule was therefore assumed to be at a minimum level.

The final form of the questionnaire consisted of questions organised into six major categories: i) demographic information,ii) nutritional and meal planning skills, iii) home safety and emergency skills, iv) discipline and behaviour management, v) Interaction, play and stimulation, and vi) identification and assessment of support services.

Interview Procedures

Of the 25 interviews, 12 were conducted by the investigator. The remaining 13 mothers were interviewed by life-skill workers at the local associations. Therefore,with the exception of 13 interviews, all were audiotaped to provide a cross check of responses recorded in written form.

Data Analysis

In this questionnaire, respondents were given the opportunity to make subjective responses in describing and discussing their experiences in raising children. Where possible, at the end of each interview, verbatim responses for each question were transcribed. These transcriptions were analysed for patterns of responses.

Chapter four will provide a descriptive analysis of the results, together with graphs and tables which will be used to report the findings of the study.

CHAPTER IV. RESULTS

This chapter presents the results of the study. The data is organized under the following categories: i) Interventions from the Ministry, ii) types of handicaps in the children iii) nutritional and menu-planning skills, iv) discipline and behaviour management, v) home safety and emergency and vi) interaction, play and stimulation. Data regarding support systems is classified into two groups: formal and family support systems.

Interventions from the Ministry

Out of the 25 mothers, eight indicated that the Ministry had temporarily removed their children from their care and were subsequently placed in foster care. Table 2 shows the number of children who were placed in foster care.

Table 2

Number of Children Removed Per Family

Number of Children	Sex		Age at the time of removal
	M	F	
2	1	1	1 8 mos.
3	 1	1	1 3 1 2
1	1		6 mos.
2	1	1	4 1
1		1	2
2	1 1		1 10 mos.
2	1	1	11 mos 16 mos
1		1	6 mos

As it can be seen from Table 2, the number as well as the ages of the children that were placed in foster care varied. The average length of the stay in foster care ranged anywhere from one month to two years. Although specific reasons for the removal of the children were given, they were not always understood by the mothers. As a result, mothers perceived that their children were removed because of their own inadequacies and incompetencies. Examples of such perceptions were:

"I don't know....they said that I was not well enough"
"He said that I won't be able to manage on my own"
"They think I'm dumb"
"I bet they did it because they felt that I won't love my baby"

Since all the subjects in the study were mentally handicapped, data were also collected to see if the children manifested any forms of handicaps. The results which indicate the number of children with different types of handicaps are represented in Table 3.

Table 3

Frequency of Handicaps in Children by Gender

Disability/Handicap	Male	Female	Total
Learning Disability	2	1	3
Autistic Tendencies	1	2	3
Developmentally Delayed	9	6	15
Speech Delay	2	2	4
Behaviour Disorders	2	0	2
Mentally Handicapped	0	1	1
No Disabilities	2	2	4
Total	18	14	32

It can be seen from Table 3 that out of the total number of children, only 4 (12%) were indicated to have no specific handicaps. This may be due to the fact that these children were too young for developmental delays or handicaps to be identified. However, the remaining 28 were found to have mild to moderate degrees of handicaps. For example, 15 out of 32 (47%) manifested some degree of delay in their developmental milestones. Such children were delayed in walking, toilet training,and language formation. Manifestations of other forms of handicaps varied.

Figure 1 shows the breakdown of specific types of handicaps in girls and boys. Two out of twenty girls had autism while two out of 12 boys were behaviourally disordered; six out of 20 girls and nine out of 12 boys manifested some sort of developmental delays..

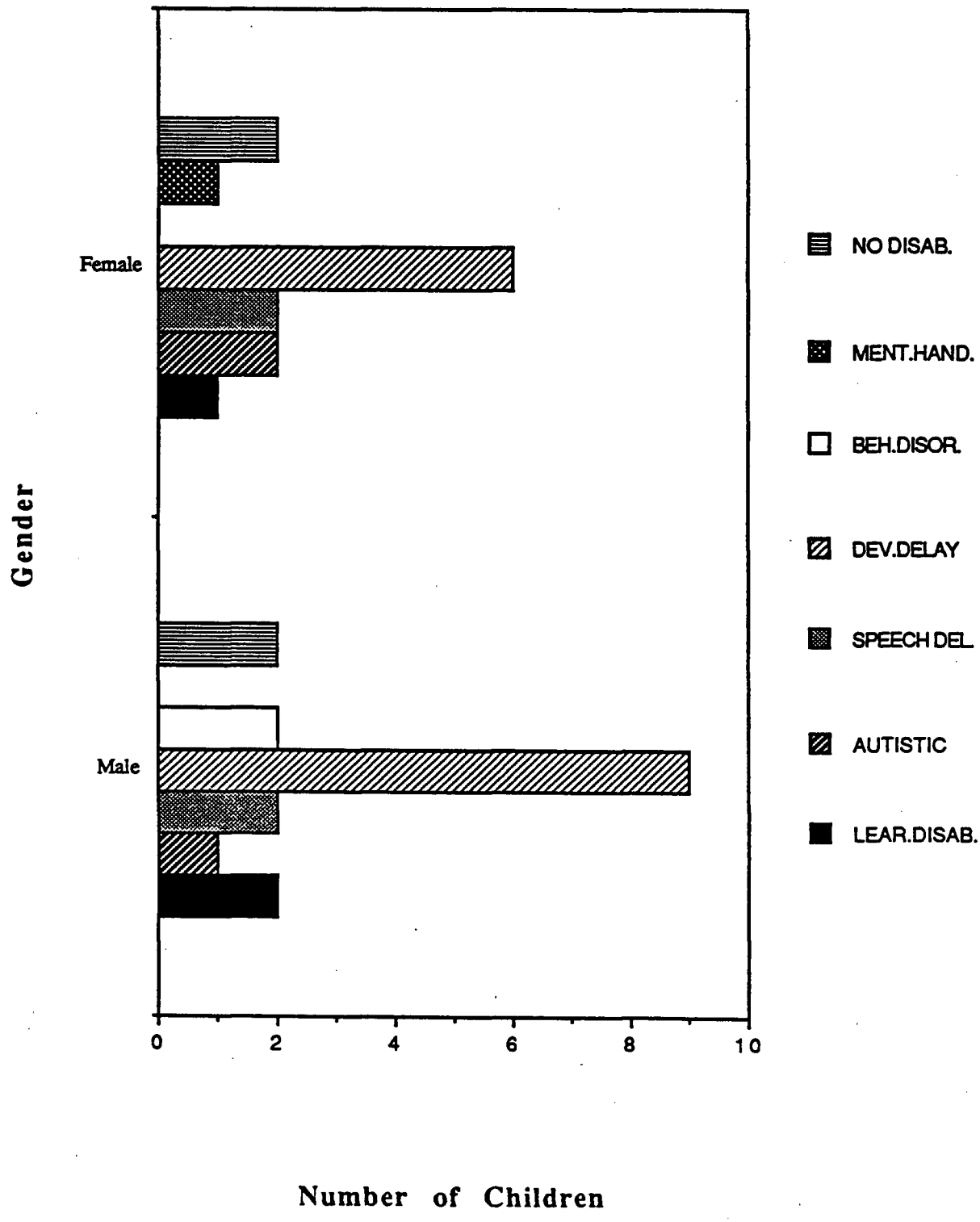


Figure 1: Frequency of Handicaps by Gender.

In addition to the varying number of children with specific handicaps, the ages of children varied with the type of handicap. Figure 2 graphically represents the average ages of children with specific handicap.

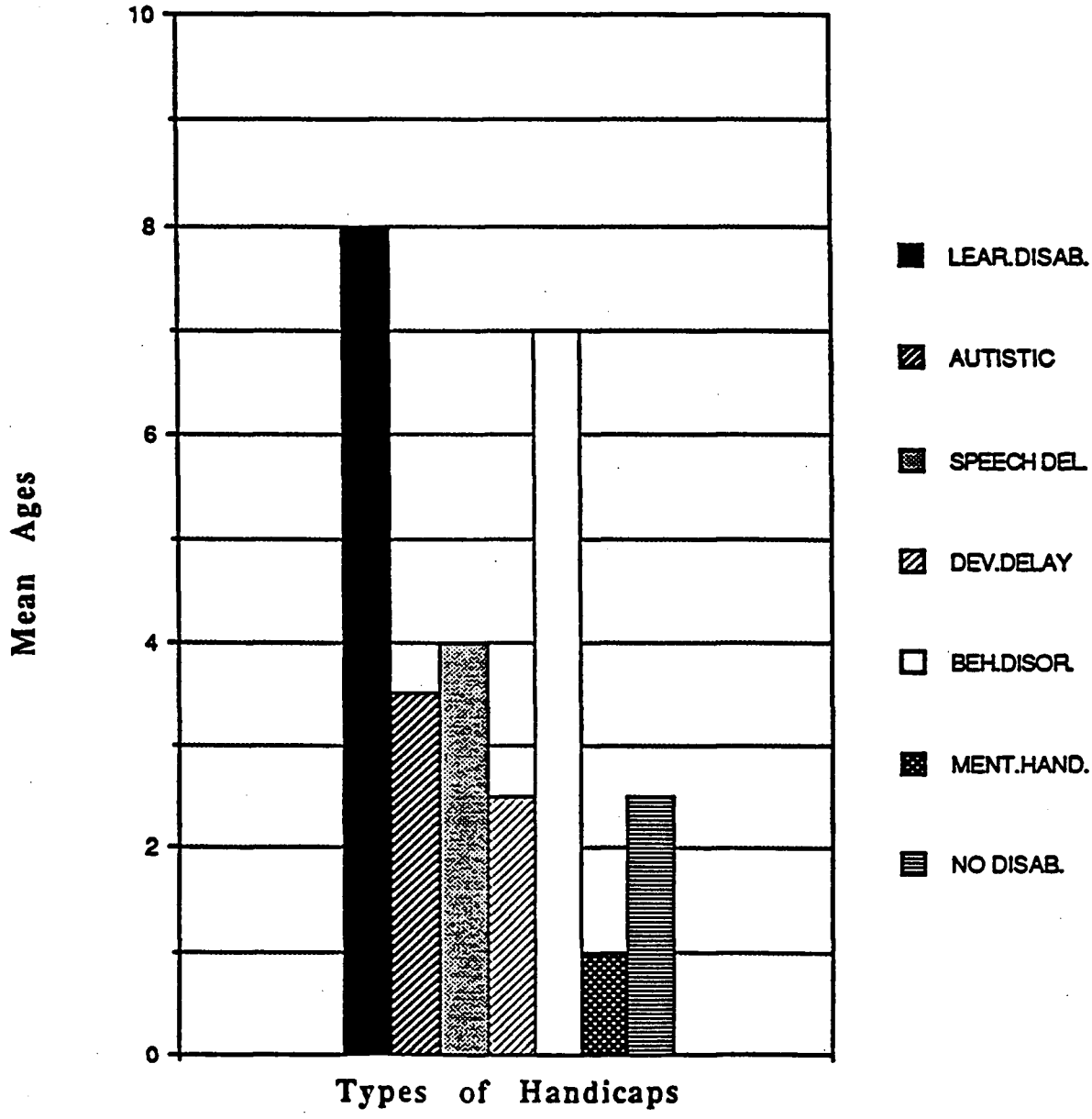


Figure 2: Mean Ages of Children With Handicaps.

Nutritional and Meal Planning Skills

In order to determine the mothers' level of awareness of the importance of nutrition, questions were asked to determine the degree to which mothers were able to understand the importance of an appropriate diet for their children. Where possible, results will be reported under specific questions. The first question was related to the mothers'ability to identify foods that belonged in specific food groups..

The names of the four food groups were given to the mothers.

Interviewer: If I gave you the four food groups, I would like you to give me an example of 3 items (food) that belongs in that group.

Table 4 shows the frequency of the number of correct responses per food group .

Table 4

Frequency of Mothers Giving Correct Responses

Number of Items	Food Group			
	F/V	M/D	M	B/C
Three Items	23	18	2	5
Two Items	2	4	21	18
One Item	0	3	2	2
Incorrect Responses	0	0	1	0

As it can be seen from Table 4 the rate of incorrect responses was very low. For all food groups, mothers were able to give at least two items. The response rate for "one item" was also very low in that seven out of twenty-five mothers could identify one item per food group.

To further gain an understanding of the mothers' awareness of healthy foods, mothers were asked the following questions:

Interviewer: What do you think are good examples of nutritious (healthy)foods?

What do you think are good examples of foods that are not healthy

Table 5 represents the distribution of foods that were perceived as being nutritious and non-nutritious by the mothers.

Table 5

Types of Foods Perceived as Nutritious and Not Nutritious

Item	Frequency of Responses	
	Nutritious	Not Nutritious
Ice-Cream	8	-
Milk	20	-
Potato Chips	-	18
Candy	-	23
Cookies	-	1
Fruit	19	-

In addition to see if they were able to distinguish foods which were healthy from those which were not, mothers were also asked why they considered these foods as being nutritious or non-nutritious. Some of the reasons were:

> "Too many cookies can be bad for lunch-he´ll get lots of cavities"
>
> "Ice-Cream is good because it´s made of milk"
>
> "He won´t grow enough if he doesn´t have energy"
>
> "They would get too fat with all those fries"
>
> "Milk is good ´cause it can make your bones strong and...also it can make your teeth white"

With respect to balanced meals, mothers were asked to give examples of two meals that they served and which they considered to be nutritious. Table 6 shows the percentages of mothers who served meals which they perceived as being nutritious.

Table 6

Typical Meals Served and Perceived as being Nutritious

Meal	Percentages of Mothers
Hot Dogs and Chips	85%
Hamburgers and Chips	75%
Chinese Food	10%
Lasagne	5%
Sandwiches	60%
Soups	75%

After stating the type of meals that they typically served, mothers were given a list of meals and were asked to

indicate if they considered these meals as being nutritious for their children. Results showing the data are tabulated in Table 7.

Table 7

Meals Perceived as Nutritious or Not-Nutritious

Type of Meal	Nutritious Meal	Not Nutritious
McDonalds	18	7
Eggs and Toast	20	5
Mashed Potatoes and Beans	15	10
Stir-fried Beef veg.and rice	25	0
Wieners/Hot Dogs	21	4
Vegetable Soup	19	6
Macaroni & Cheese	15	1
Fish & Chips	19	6

Overall results indicated that mothers were aware of the importance of providing appropriate nutrition for their children. In addition, they did not perceive any difficulties in this area of parenting.

Discipline and Behaviour Management'

In this section, questions were asked to determine if mothers perceived discipline as being an important part of raising children. In addition, they were also asked to indicate why they considered it to be important. Results indicated that all mothers were aware of the importance of disciplining their children. However,85% of the mothers were not able to give specific reasons for its importance.

"I don't know- I can't think of any".

"We're supposed to-that's what they said"

Some of the typical responses from the remaining 15% of the mothers were :

> "...it´s important because he has to learn that he can´t get away with stuff"
>
> "...or else they won´t listen to anyone when they grow up"

To see if mothers knew when children needed to be disciplined, the following question was asked:

Interviewer: In what types of cicumstances do you feel it´s necessary to discipline your child?

Mothers´ responses were reviewed and organized under four categories as reported in Table 8.

Table 8

Occasions as Perceived to be important to Discipline Children

Perceived Occasion	Frequency of Mothers
During bedtime	60%
Aggressive behaviour	80%
Eating Habits	60%
Doesn´t clean up bedroom	60%

As it can be seen from Table 8, most of the mothers dsisciplined their children when they behaved aggressively toward others; 60% of the mothers indicated that they tried to discipline their children when they didn´t clean up their rooms (putting their toys away); 60% indicated that

they disciplined them when their children would not go to bed and when they would not finish their food.

In order to determine how they disciplined their children, mothers were asked to indicate what strategies they used. Figure 3 reports their responses under 4 categories.

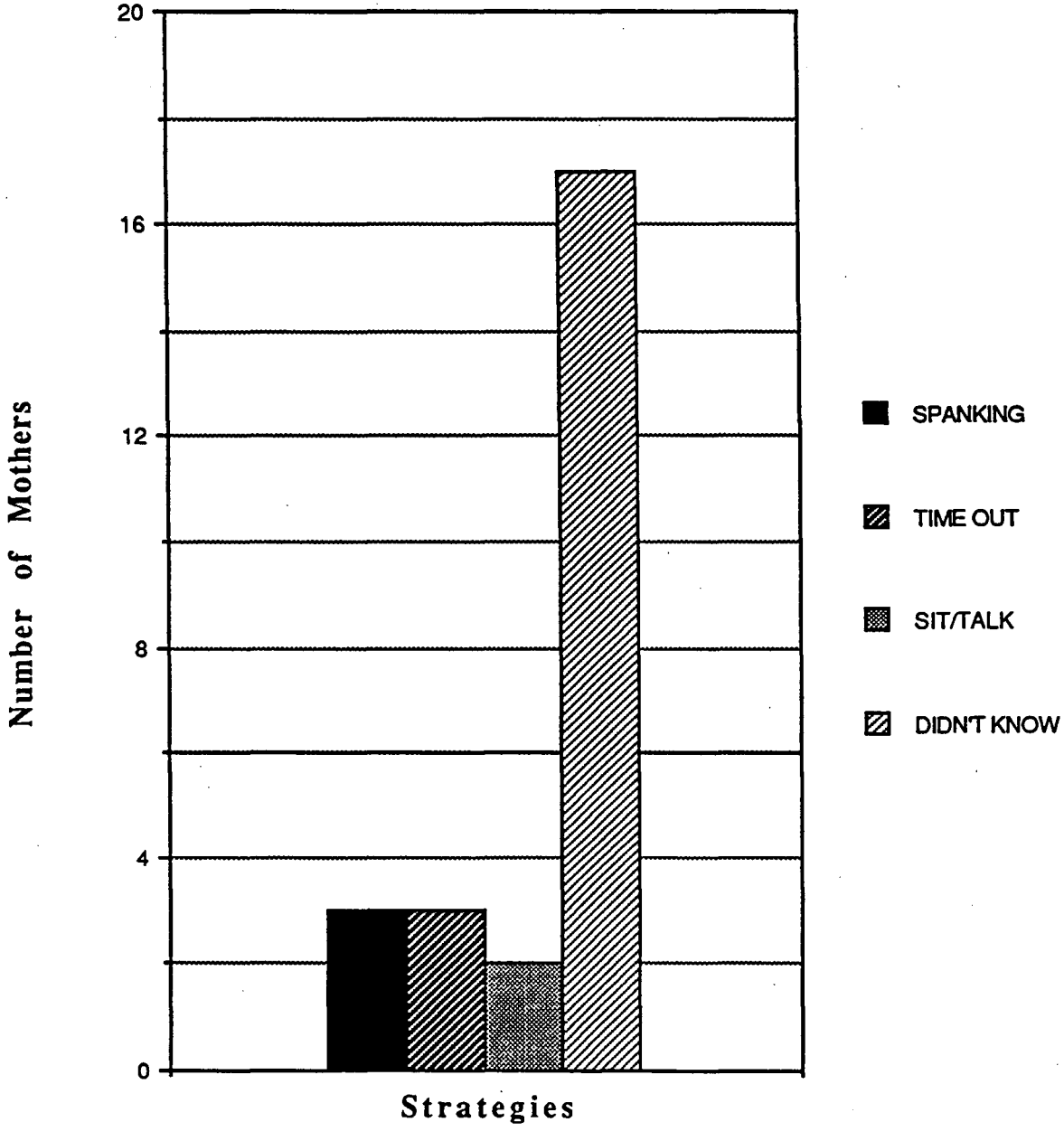


Figure 3: Strategies Used to Discipline Children.

As indicated by Figure 3, 17 of the mothers felt that they experienced great difficulty in deciding how to discipline their children. They added that their inability to decide often led to feelings of frustration, anger and helplessness. Approximately three of the mothers spanked their children; two sat down and talked to their children,and two of the mothers got frustrated and sent their children to their rooms.

Overall results indicated that although all mothers were aware of the importance of disciplining their children, many of them perceived the process of discipling their children to be difficult

Home Safety and Emergency

This section of the questionnaire focused on the abilities of the parents to respond to scenarios relating to emergency situations. It also included questions which related to the strategies which would be undertaken in specific emergency situations.

In the first part, mothers were asked the kinds of precautions that they would take in preventing their children from certain accidents in the home. For example, the following question was asked:

Interviewer: In your home,what steps would you take from preventing (stopping) your child from:

a) falling from the window?

The mothers responded to this question in many different ways. Some of the typical responses included:

I would put a lock on the window

I'd get rid of the window

Put a screen on the window so he can't look out.

I wouldn't leave the window open-keep it closed

Should remove chairs or tables from the window and have nothin' beside the window-so she can't climb up.

The second part of the question required them to decide how they would prevent their child from "slipping on the floor". The results indicated that parents knew the dangers as well as the types of precautions to take. Typical responses were:

...don't walk on wet floors

I clean my floors when my girl is sleeping

Pick up the things from the floor

Be sure the floor is dry

In addition to these types of questions, mothers were also asked about other types of potential dangers in the home. Specifically, mothers were asked to identify possible types of items that would be considered as being unsafe in various parts of the house: a)Kitchen and b) Child's bedroom. This allowed the investigator to determine the mother's ability to decide what was safe and unsafe for their child at home.

Mothers indicated that items such as hot stoves, hot pots and messy kitchens were dangerous for the child. In

addition, parents were then asked to explain **why** these were considered to be dangerous. Modal responses were:

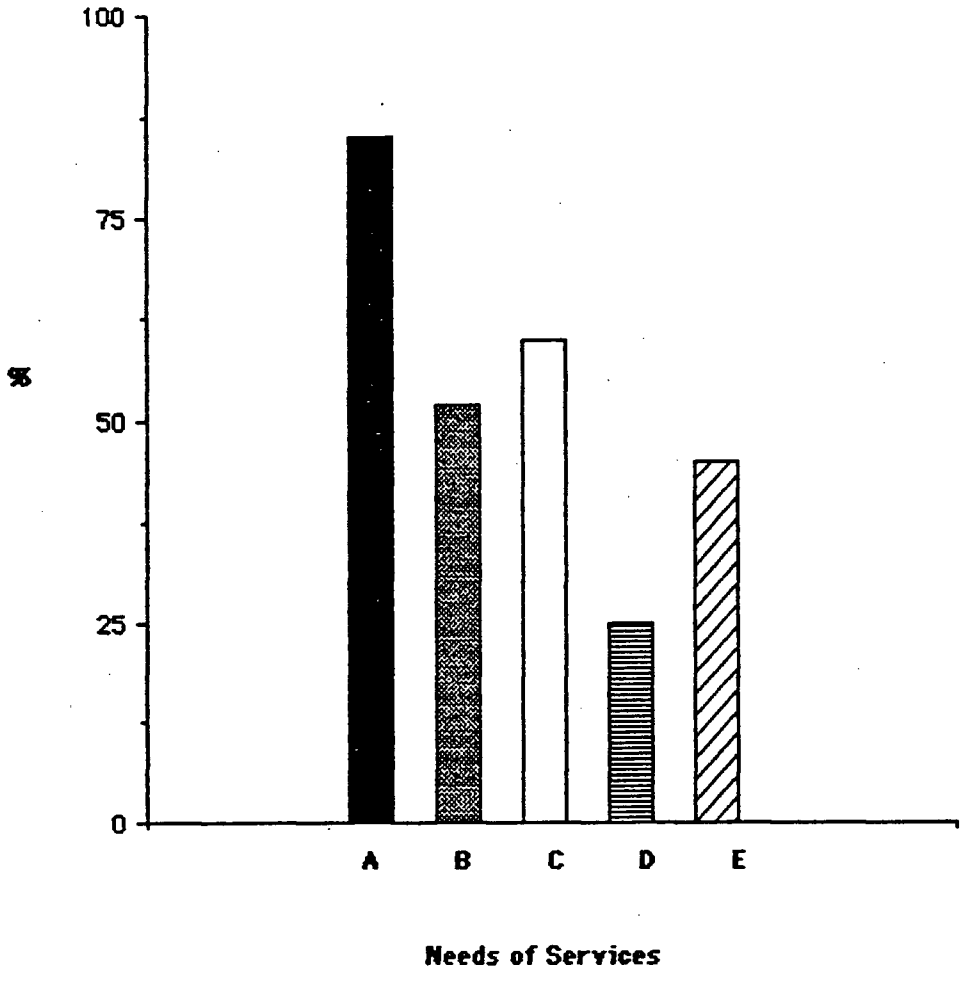
> not safe because he can get all burnt
>
> because children like to play around with the
>
> pots and pans,...and the pans may be hot or something can spill on them.
>
> if the kitchens are dirty and messy, the baby can easily trip over.

When parents were asked what types of items in the child's bedroom were unsafe, some of the typical responses were in the form of :

> I don't keep any plastic bags in the rooms or else he can easily put it on his head and won't be able to breathe.
>
> no big wires in the room-she can easily strangle herself
>
> When my daughter was wee, I always mde sure that there wouldn't be small objects on the floor otherwise she'd eat it up and probably choke to death
>
> No pills in the her room-she may think it's candy
>
> make sure that the crib is not by the window

Other types of questions regarding home safety were those that would indicate if the mother was aware of poisonous items, ways of storing such items and ways of dealing with situations which involved accidents and emergencies. The results from these were tallied and

converted to percentages. Figure 4 graphically summarises these results.



Legend

A Discipline and Behaviour Management

B Socially Stimulating Environment

C Time Management

D Shopping/Menu Planning

E Budgetting

Figure 4: Distribution of Mentally Handicapped Mothers' Safety and Emergency Skills.

As it can be seen from Figure 4, 85% of the mothers were able to indicate which items were poisonous or unsafe for the child. Typical responses to this question were :

> Ajax oven cleaner
>
> bleach
>
> pills and other stuff from the doctors
>
> pet food isn't very good for the child

The remaining 15% indicated that they did not have anything that was poisonous in the house. Their responses were:

> I only have all the good stuff in the house
>
> Why would anyone want to keep anything that was poisonous in the house...I don't understand.

When the interviewer provided these mothers with probes such as:

Interviewer: Well, what types of clensing agents do you use to clean your bath tubs or kitchen?

the mothers did not perceive and /or did not know these items as being harmful for their children.

> I don't think it was harmful
>
> Are those things (bleach, ajax) harmful? I didn't know?

In terms of knowing how to store things that were unsafe for the child, 22 (90%) mothers indicted that they would either store the items "up high on the shelves" and "in the cabinets". The remaining 3 mothers said that they would not keep anything that would be harmful in the house.

Results relating to medical emergency indicated that all mothers were able to respond successfully to scenarios and questions. Scenarios of the following types were presented:

Interviewer: You're feeding your child and all of a sudden, your child begins to choke. Why do you think that he choked? How would you stop him from choking? Who would you phone?

Mothers were able to generate several reasons as to why the child could have choked. Typical reasons were:

> May be he ate somthing big
>
> He could have eaten something that was too hard-like a big chunk of carrot
>
> he ate too much
>
> maybe she swallowed something like a penny or something he picked up from the floor.

In addition to giving these reasons, all the mothers were able to indicate how they would stop the child from choking.

> ...hit him on the back
>
> Could search in the mouth for the stuff and hit softly on the back
>
> Bend them over the knee and pat them on the back

Such findings regarding home safety and medical emergency lend to the fact that with exposure to support from

parenting workshops, mentally handicapped parents are able to respond to their children's medical and safety needs.

Results relating to the mothers' awareness of the importance of providing a safe environment for their children showed that the mothers did not perceive this area as being a difficult part of parenting.

Interaction and Social Stimulation

Questions in this category centered on how mothers interacted with their children and expressed their love, the types of reinforcing strategies they used to approve and disapprove of certain behaviours, the degree to which the families and their children associated with other families, and the types of social activities or clubs that their children were involved in. From the four possible choices i) physical contact, ii)verbal expressions, iii)primary reinforcer-e.g a candy) and vi) I don't know, mothers were asked to indicate how they expressed love and affection for their children.

Out of the 25 mothers, 15 indicated that they used hugs and kisses, three used verbal expressions (such as "I love you", "I care for you,sweetie"and "talking gently to him"), four used a combination of verbal expressions and giving the child something (e.g. candy) and the remaining three used a combination of physical contact and verbal expressions.

In terms of reinforcing an appropriate behaviour, out of the four possible choices (verbal praise, give a primary

reinforcer-a candy/sticker, hugging, and don't know), 16 mothers indicated that they verbally praised and hugged their child, five said that they would hug their child and the remaining 4 indicated that they used a combination of verbally praising, giving their child a primary reinforcer and hugging their child.

The degree of socialisation with other families was another area of concern in this part of the questionnaire. When mothers were asked if they associated with other families, seven indicated that they frequently went out with friends and neighbors, 12 mothers associated with their families only but did not have that many friends and the remaining six mothers didn't socialise at all. Responses of three mothers were :

> I don't really know anyone besides the people here.
>
> I don't have the time...By the time I finish doing everything with her, it's time to go to sleep.
>
> People don't talk to me when I go out-they don't like my boy-so I don't like going out with them.

In terms of encouraging their children to mix with other children, 70% of the mothers felt that, inspite of their encouragement, they often felt their children were not wanted by families of other children.

Overall results relating to the mothers' ability to provide a socially stimulating environment, indicated that

some mothers did perceive this skill as being a difficult part of parenting.

IDENTIFICATION AND PERCEPTION OF SUPPORT SERVICES

This study also investigated the availability and the general perceptions of both formal and family support.

Formal Support

The length of time that the mothers had spent attending the parenting training programs varied. It ranged from 1 to 3 years with an average of one year. The mothers indicated that the parenting training programs were very supportive and helpful. These workshops required parents to attend these sessions where life skill workers worked in small groups to teach the parents basic skills involved in menu-planning, home safety nad discipline. This was done by both role playing and modelling. In addition to this, following the instructional sessions, once a week, the life-skill workers then helped and observed these parents at home.

When mothers were asked if they would be able to cope without support from their workshops, all of them expressed that they would feel "lost, frustrated and helpless" as they wouldn't be able to cope. An example of a response from one mother:

> I hope that never happens because they'd take him away from me. I love my son but they won't believe me that I can be a good mum. They took him away once and then I started coming here for help and they gave Joey back to me.

In addition to receiving support from parent training prorams, some mothers also received help from other members of their associations.

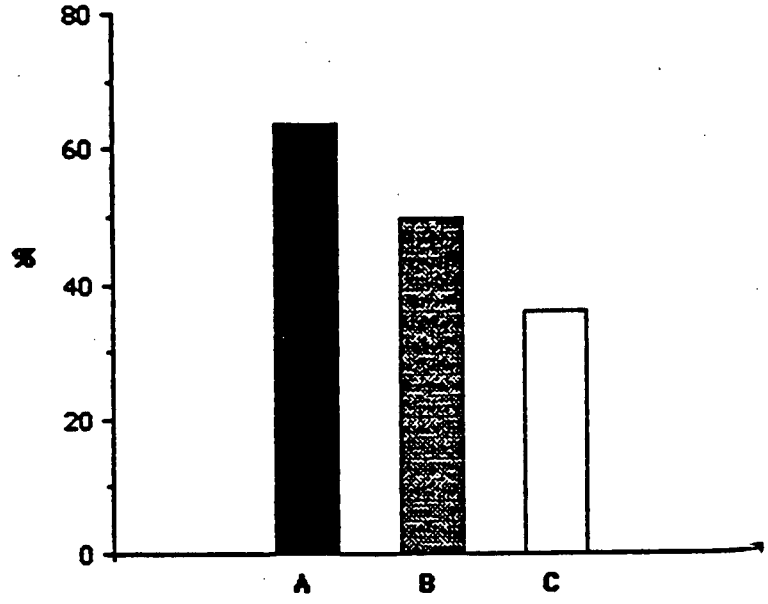
Table 9

Additional Types of Support Services Received by Mothers

Type of Support	Number of Mothers Receiving Services
Infant development Worker	8
Homemaker Services	5
Counsellors	1
Public Health Nurse	8
Social Worker	10

Table 9 illustrates the types and the combination of services that mothers were receiving from their associations. In addition to receiving help from parent training workshops, some parents were also receiving a combination of support services from social workers, public health nurses, counsellors and infant development workers. Support visits from homemakers ranged from one visit to three visits per week. Support from public health nurses was given if necessary or if requested by the mother. Infant development workers visited mothers once a week and helped them in such skills as making meals for the baby, bathing the baby and basic child hygiene.

In an attempt to see if mothers had attended any prenatal classes, it was found that a total of sixteen mothers had attended the classes as indicated in Figure 5.



Legend

A Mothers attending classes

B Mothers completing classes

C Mothers not attending classes

Figure 5: Distribution of Mentally Handicapped Mothers' Perceptions of Needs of Services.

Figure 5 shows that out of the 16, only 8 mothers attended the full session.

The remaining stopped attending the classes for several reasons. Typical responses were in the form of :

"I couldn't understand the stuff"

"It was too hard for me"

"I was all alone-it would have been nice to have some company"

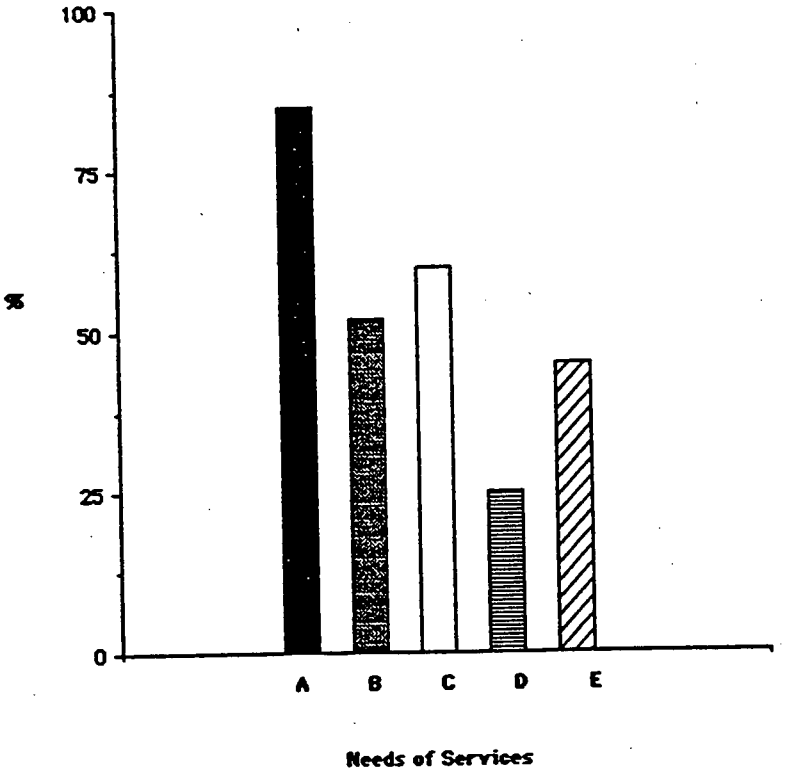
"They were going too fast"

"I didn't know what kinds of questions to ask-it was boring"

Feelings of frustrations and incompetencey were also experienced by these mothers who felt "dumb" and "stupid" because they couldn't understand the concepts. Thirty-six per cent of the mothers didn't attend any form of prenatal classes because "nobody told them about them" amd because they were "too hard-it's like going to school".

In the final part of the study, mothers were asked questions relating to the availability and the quality of the services that they were receiving. All mothers stated that although they were satisfied with the availability and the frequency of help, there were some areas in which they needed more help in to be able to cope more effectively with their children. As shown in Figure 6, 85% of them felt that they needed a lot of help in deciding how and when to discipline their children. From the 25 mothers, 13 (52%)

felt that they needed more exposure to ways of providing a socially stimulating environment for their children. Fifteen out of 25 (60%) felt that they always "wasted a lot of time" and needed life-skill workers to show them effective ways of spending time with their children. In addition, they felt that at home, they had difficulty organising and planning a schedule to spend time with their children. The results are graphically summarised in Figure 6.



Legend

A Discipline and Behaviour Management

B Socially Stimulating Environment

C Time Management

D Shopping/Menu Planning

E Budgetting

Figure 6: Distribution of Mentally Handicapped Mothers' Perceptions of Needs of Services

In addition, mothers were also asked if they were satisfied with the structure of the material that was presented in the workshops. 80% of the mothers indicated that rather than going to the workshops three times a week, it would be more useful for them if the life-skill workers increased the number of home visits, thus also increasing the number of "hands on" experiences.

Family Support

The degree to which mothers perceived support from their families was also investigated.

Table 10

Mothers Perceiving Families as Supportive

	Spouse	Extended Family
Very Supportive	8	4
Not Supportive	2	6
Not Available	15	14

As shown in Table 10, eight mothers reported that they were highly supported by their husbands and two mothers indicated that their husbands did not help them at home with the children. The remaining 15 mothers were single parents. Results regarding support from extended family members indicated that ten parents were supported by members of their extended families. Members such as grandmothers, aunts and mother-in-laws came home on a weekly basis to help them at home. Six mothers indicated that they had no such

support and the remaining nine indicated that none of their relatives lived in their neighborhoods.

Chapter five will present the discussion of the findings, the conclusions of the study, suggestions for future research and the limitations of the study.

CHAPTER V DISCUSSION AND CONCLUSIONS

This chapter will present the discussion and the conclusions of the findings, suggestions for future research and the limitations of the study. The results will be discussed under specific categories.

DISCUSSION

Handicaps in Children

This study found that more than 50% of the children manifested some sort of a handicap. All children in two-parent families had a handicap whic ranged from having learning disabilities, autistic tendencies, developmental delays or mental handicaps. Children in single parent families also had developmental delays, speech delays and some types of behavior disorders. Research studies relating to children of handicapped parents have indicated that the chances of any form of handicaps or retardation is 40% higher in children when both parents are handicapped. Its occurence is decreased when only one parent is handicapped. Scally (1973) indicated that in cases where only one parent is handicapped, the prevalance of delays or handicaps in children is even higher when the mother, rather that than the father is handicapped. Therefore the degree of interaction (as opposed to the handicap) between the mother and the child may play a biggger role in child development.

Interventions from the Ministry

Mothers who had had their children removed from their homes perceived that often, the Ministry intervened without providing them with a chance to prove themselves as adequate parents. Such actions may well be infringing upon their rights in that the right to parent inevitably requires parents to demonstrate their ability ot care and where necessary, gain access to support services that meet the needs of,the parents (Vogel, 1987).

PARENTING SKILLS

Nutritional and Menu Planning

Results indicated that all mothers were able to identify foods which belonged to specific food groups. This showed that they were aware of the food groups as well as of the specific types of foods that belonged in the groups. In addition, mothrs were aso able to distinguish between foods which they perceived as being nutritious and those which they perceived as not being nutritious for their children. Mothers were not only able to give examples of foods whcih belonged to the specific categories, but they were also able to state why they perceived these foods to be in those groups.

However, their perceptions of what constituted a nutritious balanced meal varied. Their perception of certain meals (e.g.hot dogs and fries) as being healthy for

their children may well be due to what they could actually afford rather than their inabilityto determine what constituted a balanced meal.

Discipline and Behaviour Management

All mothers perceived disciplining as the most difficult aspect of parenting. Although all mothers were aware of the importance of disciplining their children, they perceived that they didn't know how to manage inappropriate behaviour in their children, and as a result, they felt frustrated and helpless with their chidlren.

Research in this area indicates that their difficulties may more be due to their limited exposure to appropriate role models and to minimal exposure to incidental learning experiences. Such experiences are important for the acqusition as well as the application of appropriate caregiving skills in every day life (Rutter, 1983).

Home Safety and Emergency

Findings suggested that the mothers were not only able to indicate items that they perceived as being unsafe for their chidlren, but they were also able to respond successfully to scenarios related to emergency situations. This indicates that with support from the training workshops, mentally handicapped mothers are able to learn skills necessary for a safe environment.

In terms of previous research, the findings here are similar to those of Tymchuk, Andron & Anderson (1987). In their study, Tymchuk et al. found that exposure to parent training workshops led to an increase in their ability to take precautions in emergency situations and a decrease in the numbe of home accidents.

Interaction and Social Stimulation

Findings relating to the mothers' abilities to interact and provide socially stimulating environments indicated that many mothers used verbal reinforcement as opposed to primary reinforcers as a strategy to interact with their children and to encourage appropriate behaviour.

In terms of socializing with others around them, many mothers indicated that they didn't have many friends. In addition they often felt that they were not wanted. Such findings are consistent with previous research in that Lusthaus, Hanrahan and Lusthaus (1981) found that despite the fact that many mentally handicapped adults live in a community setting, they "are virtually living in a world of isolation from non-handicapped people around them" (p.25).In contrast, Winik (1987) found that the majority of mentally handicapped adults had friends who they met at workshops or social recreational programmes and that many subjects in their study participated in social activities.

SUPPORT SERVICES

Similarities in Formal and Family Support

In both formal and family support systems, there is an underlying principle of care for persons with mental handicaps. Particularly, supportive activities, behaviours and procedures give sustenance and aid on a day to day basis and in times of crisis. The support and resources offered to mentally handicapped parents may be provided through many channels and it is the impcat of this which enables the parents to feel supported. The multidimensional nature of the concept of support is apparent in both formal and family systems of support.

Differences between Formal and Family Support

Formal support is based upon the provision of care in specific areas of need. The requests and expectations made of professional organizations are inherently dissimilar from those made of relatives. The professional organization is responsible for the provision of a service to the individual. The services rendered are placed within time parameters and the relationship between the client and the organization is palced within the same time constraints.

The scope of behaviour in family support is not defined to the same extent as it is in formal support, and therefore, the relationship may take any course.

Formal Support

In this study, parents indicated that, in addition to receiving support from the parent training workshops,additional support from their local associations, when required, was available and therefore, they were satisfied with the availability of services. Mothers perceived life-skill workers as being very supportive in their roles. Life-skill workers were described as being very empathetic-showing interest and concern for the well being of the parents as well as the children.

Support from parent training workshops was not only readily available but it was also tailored to meet the needs of the mentally handicapped mothers. For example, the material that was presented in the workshops was simplified, and where necessary, the content was modified to facilitate the undestanding of the skills. However, such modification was not always implemented in other programs. For example, the low percentage of attendance in prenatal classes was mainly due to complexity of the material bing presented. The results indicated that not only is there a need to provide support but there is also a need to modify and adapt the content to meet their needs.

Mothers indicated that the general quality of support they were receiving from their parent training workshops was very good, and without the support from these workshops, they would have great difficulty in coping with their children. However, the parents stated that changes in the

structure of sessions would be more beneficial. Specifically, such changes included decreasing the number of sessions at the associations and increasing the number of home visits, so that they would get more "hands-on" experiences. Suggestions for changes in the focus of the content were also expressed. Many mothers perceived that the training workshops should focus on certain parenting skills for a longer period of time than on others. Examples of such skills include those aspects of parenting which would enable mothers to develop and apply appropriate strategies of discipline. Some mothers also indicated tt they needed more support in helping them to develop ways by which they could provide socially stimulating environments.

Family Support

This study indicated that although mothers were satisfied with the availability and the quality of support received from the local associations, such satisfaction was not extended to family support. The presence of a spouse in the home and the opportunity to interact with extended family members were two factors which affected the availability and the quality of family support.

In two-parent families, most mothers received considerable support from their husbands. They indicated that their husbands not only shared the responsibilities but they also were actively involved themselves with their chidlren. Such support also affected how well the mothers

coped with their children. Previous research examining the role of family support indicated that mothers who reported the least levels of stress, were receiving support from their husbands (Gallegher, Bechman, & Cross, 1983).

With respect to support from extended families, most parents indicated that such support was not available since their extended families lived at considerable distance from them. Those mothers who did receive support reported that members of their extended failies not only helped them with the household chores, but they also provided them with moral and emotional support.

Conclusions of the Study

In conclusion, results of this study can only be generalised to persons who have the same degree of mental handicaps as those who participated in this study. Mothers with mental handicpas in this study showed an understanding of the parenting skills discussed in the study. The skills which they perceived to be the most difficult were those of developing and applying strategies of discipline and providing socially stimulating environments.

This study also indicated that support services should be modified and simplified to meet the needs of persons with mental handicaps. More specifically, they should be more structured, directive, and where necessary, they should focus on skills such as discipline and social stimulation,

which the mothers perceived as being the most difficult to cope with.

Limitations of the Study

The study was limited by the relatively small sample size and therefore, the results can only be generalized to persons who participated in the study and to those who have the same degree of mental handicap. In addition, it was also limited by the nature of the population surveyed in that mentally handicpped mothers in this sample were all receiving parent training support from their local associations and as a result, the lack of a control group not receiving such support made it difficult to generalize the findings. In addition, since the sample was selected from various local assocations,the types of training that the mothers were receiving from their local associations and the amount of time that they had spent in the training workshops may have varied. Such variability may have affected the results. Since it was not possible to tape all the interviews, the lack of consistency and uniformity may have affected the accuracy of data collection. Furthermore, the potential for socially desirable responses may have affected the validity of data.

Suggestions For Future Research

Future research could include a group of families whose socio-economic backgrounds are similar to those of

persons with mental handicaps. Another useful aspect to be studied could also include the perceptions of life skill workers of the parenting skills of persons with mental handicaps and compare such perceptions with those of persons with mental handicaps to identify and investigate any discrepancies between the two groups. Finally, perceptions of parenting skills of mothers who are receiving support from parent training workshops can be compared to those mothers who are nor receiving such support.

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APPENDIX A

PERSONAL PROFILE SHEET

NAME

AGE SEX

DISABILITY/HANDICAP OF PARENT

EDUCATION LEVEL OF PARENT

i)Secondary School----
ii)Elementary School----
iii)College------
iv)Other-----

INCOME (Source)

i)Welfare Assistance----
ii)Employed------
iii)Other------

OTHER SUPPORT SERVICES

i)Infant Development Worker
ii)Homemaker-----
iii)Counselling----
iv)Public Health Nurse-----
v)Social Worker------
vi)Life Skill Workers-----

NUMBER OF CHILDREN----

AGE--- SEX---

SPECIFIC HANDICAP OF CHILD

DISCIPLINE

1.Do you think it is important to discipline your child?

2.(If yes) How do you discipline your child?

3.(If no) Why not?

4.In what circumstances do you feel it is important to discipline your child?

NUTRITION

1.If I gave you the four food groups, I would like you to give me an example of three foods that belong to that group.

2.What do think are good examples of nutritious foods?

3.What sort of a meal would you consider to be good for your child? (They may give an example of a chidl).

4.What kinds of foods do you think are not good for your child?

b)Why not?

HOME SAFETY AND EMERGENCY

1.How do you make your home safe for your child?

2.In your home, what steps would you take from preventing your child from:

i)falling from the window

ii)slipping on the kitchen floor

3.Which household items would you consider to be poisonous?

4.If your child has something poisonous what would be the first thing you would do? Who would you phone?

5.If your chidl does choke, how would you stop him from choking? Who would you phone right away?

7.At her/his age, what sort of toys are not safe for your child? Why?

INTERACTION AND SOCIAL STIMULATION

1.How do you show your child that you love her/him?

i)physical contact (hugs etc.)----
ii)Verbal expressions------
iii)Other--------

2.When your child does something that you approve of, how do you reinforce him?

i)verbal praise-----
ii)give the chils something----
iii)hug him----
iv)don't know-----

3.When your child does something that you don't approve of, how do you let him know?

4.How often do you cuddle your child?

5.Why do you think it's important to hug your child?

6.Do you mix with othr families who have children thesame age as yours?

b)If not, why not?

7.Do you feel it´s important to encourage your child to mix with other children?

7b) Why or Why not?

IDENTIFICATION AND ASSESSMENT OF SUPPORT SERVICES

1.Did you attend any prenatal classes?

2.If not, why not?

3.(If yes) Did you find these classes helpful? If not, why not?

4.How long have you been receiving support from your local associations?

5.How has this type of support helped you?

6.Wher would you go if it weren´t for the support that you were receiving from your local association?

7.How do you feel you would cope if it weren´t for the support that you are getting?

8.Do you feel that you are getting enough help from your asscociation?

9.In what areas do you feel that you are getting the most help in?

i)Time Management
ii)Shopping/Menu Planning
iii)Dudgetting
iv)Child Discipline
v)Providing a socially stimulating environment

10.Which other organizations are you receiving help from?

11.Do you friends or family that come and help you at home?

12.If so, how often do they help you and how do they you?