MULTIDISCIPLINARY REHABILITATION OF THE MENTAL RETARD

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The legislation, social reforms and extensive research programmes in the Twentieth Century have benefitted the mentally retarded population. Prior to this, the mentally retarded were institutionalised and received only custodial care. As research progressed, the living conditions for the mentally retarded improved and the concept of the multifaceted approach to the problem of the mental retard was born. This in turn, led to the evolution of teams of experts working individually and in collaboration with each other.

The Medical Team comprising of the family physician, obstetrician, pediatrician, psychiatrist, clinical and educational psychologist and the nursing staff handle the early detection, clinical management, health care, prevention and relevant research.

The social worker's work within the community structure, as well as clinical and educational settings, and manages the social welfare aspect of the retard and his whole family.

The Educational and Rehabilitation Team, comprising of teachers, occupational therapists and workshop trainers, train these children from the earliest years for the development of motor, social intellectual and vocational skills to enable them to be as independent as possible.

THE PSYCHIATRIST'S ROLE:

The role of the psychiatrist as the leader of all the teams handling the multiple problems of the retard is more well established. Not only does he utilize his expertise to diagnose early, support the family during initial and persistent sorrow and grief, but he also utilizes his skill during the developmental period of the retard to guide the persons concerned as to the best manner of handling the child and provide the maximum environmental stimuli to aid the process of development. For the developing child we must observe early signs of psychological maladaptations and caution the family members accordingly.

At the Kamayani Centre, Pune, the author has found that not only the parents, but the grand parents and siblings too, suffer from emotional problems. Immature or highly ambitious parents, unprepared for the responsibility of rearing the mental retard, require constant support and guidance from the psychiatrist (Master, 1978). The psychiatrist also has to utilize his skill in devising therapeutic programmes for the individual and evolve group counselling, behaviour modification and drug therapy for the numerous psychological problems which may crop up in the retard from infancy to adulthood viz. neuroses, antisocial behaviour, hyperkinetic syndrome, speech disorders, enuresis, encopresis and infantile psychoses (Shirley, 1938; Rutter et al, 1964; Rutter, 1971, 1972; Thomas et al, 1968). The problem of the retard are a constant source of tension for the family members and which would require expert handling by the psychiatrist.

Lastly, the psychiatrist as a genetic counsellor can prevent a lot of suffering by helping the genetically vulnerable families in making decisions about marriage and parenthood of the retarded. A borderline retard need not be denied family life, provided the spouse is capable
of accepting the responsibility because not all mental retards are inherited (Rosenthal, 1970; Stevenson et al, 1970; Murphy and Clase, 1975).

REHABILITATION AND COMMUNITY CARE

As the scene shifted from the “near vegetative existence in grim custodial care type of institutions”, to “training and crafts centres”, to “special schools and workshops”, to “the modern near normalization, and motivation to learn adaptive skills, through integrated training in normal schools”, the training schools and staff requirements also changed, and community involvement in training projects became mandatory.

It is imperative to set up community training and counselling centres where the medical and social workers teams can counsel and train the parents to supply a stimulating environment, in which, through constant appreciation (Ziggler and Balla, 1977), encouragement and chance to initiate (Perry, 1974), the retarded child in to meaningful activity can be undertaken.

Jeffree and Gashdan (1971) and Master (1982) report on actual “Workshop” and “Seminars” where the parents are taught structured methods of training. If the parents can spend 15-30 minutes twice daily with their pre-school mental retards to motivate and train in an stimulating environment, the benefits by the time they are ready to enter school, are considerable. Similarly at the same centres the parents can be trained in simple behaviour modification methods for teaching a variety of self care skills, communicative skills and handling hyperkinetic children (Baumeister, 1968; Gardner, 1971; Hogy, 1972; Yule and Car, 1980).

It is also essential to set up either separate ungraded schools meant for specialised education of the retard or integrated schools, where the retarded chil-

At the Kamayani School for the Mentally Handicapped, Pune, the children are grouped accordingly to their mental age into groups of ten. Each group is in charge of two teachers, one training the whole group, while the other spends 15-20 minutes with each individual child in the group to organize the training for their structured needs. When teachers, parents and social workers use a uniform method of training with appreciation rather than condemnation gratifying results are obtained by the author.

Once the mentally retarded child outgrew the school or the institution where he was trained, he was lost, and no one seemed to care about what the future held for him. A strong plea is made for keeping up the family and community’s interests in the rehabilitation of the adult mental retard and cater for his emotional, sexual, social adaptability and occupational needs. Cooke (1981) points out that the community services should also train the retard to make their own decisions independently, meaning thereby, that the family members and the community would have to accept the retard and then change him, rather than the other way around.

The adult mental retard should also be introduced to the art of living together with others. The author has observed that the mental retard, however mild, continues to be socially rejected by the peers and till better scientific evidence is forthcoming, this aspect should be handled with caution, as it may lead to emotional and psychological problems. Tho-
ugh the retards may be chronologically adult, intellectually, socially and vocationally they remain at a childlike level and require constant supportive training to adapt in their community (Marshall, 1967; Whelan, 1973; Gunzberg, 1973; Clark and Clark, 1974).

At the KAMAYANI CENTRE, after the children finish with the upgraded school and crafts section, the adolescents pass through a period of apprenticeship in the attached sheltered workshop, where under the constant, repetitious training by skilled special teachers, they learn good habits and the importance of dignity of labour, perseverance, and completing a job once started.

After years of toil, and continuous repetitious patient training, a very tiny percentage of them can develop adaptability and work skills adequate for placement in an independent job. However, they continue to require constant encouragement and support by the ever-vigilant social worker, who acts as a liaison between the employer and the employee. The rest of the retards continue to work and various jobs in the sheltered workshop.

THERAPEUTIC CENTRES

The mentally retarded are more vulnerable to a wide spectrum of emotional and psychological disturbances as they pass through the various developmental stages, each with its critical issues, without mastering the adaptational tasks and their vulnerability to stress increases because their capacity to cope is inadequate. Barr (1904), Garfield (1963), Webster (1963, 1971) Menolascino (1965, 1975), Bernstein (1970), Ches et al. (1971), Philips and Williams (1975) Donaldson and Menolascino (1977) and Eaton and Menolascino (1981) report a wide spectrum of psychopathology from mild emotional disturbances and anxieties to frank psychoses stemming out of these situations.

Most of these conditions require to be diagnosed early, a very difficult task because the mentally retarded can neither express his symptoms, nor can he be easily detected due to the very nature of the disorder. It is, therefore, very essential to have well staffed therapeutic centres attached to the institutions for the retarded. Once diagnosed the retard can be treated by a variety of therapies like play therapy (Maisner, 1950), behaviour modification and other psychotherapies and social participation (Whitman et al., 1970; Stokes et al., 1974). Once again, because of the nature of intellectual paucity, the goal of these therapies which is to alleviate behavioural abnormalities and motivate adaptional achievements through retention of self esteem by gaining insight into their own limitations, become difficult to achieve. As their most common problems are aggressivity, hyperactivity, excitabibility and lack of social control, neuroleptics over an adequate period of time, followed by maintenance doses and drug holidays should be combined with the educational and supportive approach.

CONCLUSION

During the past 2-3 decades, the concept of mental retardation has changed drastically. The emphasis is now on deinstitutionalization, near normalization within the structure of the society, and setting up of adequate centres where parents, other care-takers and planners can, with the help of modern available techniques, train the retards to take their place with human dignity within the community as useful and productive members. It is important to have observation and diagnostic centres, therapy centres, upgraded schools and crafts centres, and training centres by way of sheltered workshops for rehabilitation in one comp-
lex only; if we intend providing comprehensive care under one roof.

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