

## **CHAPTER 2**

### **LITERATURE REVIEW**

#### **2.1 INTRODUCTION.**

Psychiatric nurses today are under tremendous stress as a result of accountability, responsibility, and the ever expanding role that he/she plays. Due to the expanding role the psychiatric nurse must therefore be prepared to assess the problems, needs, facilities and resources/services required by the mentally handicapped patient in order to contribute to the wholeness of the patients.

According to Polit & Hungler (1999:91) the task of reviewing research literature “involves the identification, selection, critical analysis, and written description of existing information on the topic of interest.”

Therefore in this study, a literature study was done of the mentally retarded patient who since infancy has caused his parents much concern as his development was slow, as he started to talk and walk later than his peers, or often not at all, and needed so much more attention. The literature study or review is done on the child who just could not manage to dress or feed himself and who had to wear nappies for a very long period of time or indefinitely. The mentally retarded in the community have special physical, emotional, financial, psychological, social, educational, spiritual, and cultural needs that need to be addressed by the community and the government, so that the de-institutionalization

process can be a success.

## 2.2 CAUSES OF MENTAL RETARDATION

The causes of mental retardation are as follows:

- Heredity, such as Downs Syndrome and Fragile X Syndrome.
- Environment in exceptional cases. In these cases receiving absolutely no stimulation at home or around the child's environment.
- Evidence of some or other form of brain damage before, during or after birth, due to infectious diseases such as German Measles (Rubella), incompatibility of the parents blood groups, malnutrition, over exposure to radiation or pathological conditions of the mother.
- Injury during child birth process. The baby's brain may be injured as a result of lack of oxygen or incorrect methods of delivery.
- Brain dysfunction, due to suffocation, serious illnesses and accidents in infancy or early childhood.
- Infections may cause meningitis and encephalitis, whilst even jaundice and measles may cause brain damage.
- Abnormalities of the cells (chromosomes and genes) or disturbance of the hormones (Steenkamp & Steenkamp 1980:2-3).

Having discussed the causes of mental retardation, the prevention of mental retardation, will be discussed.

## **2.3 PREVENTION OF MENTAL RETARDATION**

Mental retardation can be prevented at three levels of health care delivery namely:

### **2.11.1 Primary Prevention**

The most obvious way in which nurses can be involved in the primary prevention of mental retardation is by ensuring good antenatal and maternity services. However, this is a serious problem in South Africa, as in 1986 the South African Nursing Association identified a lack or poor obstetrical services in the country. The peri-natal and mortality rates support this diagnosis. Therefore birth injuries may be expected to remain an important cause of mental retardation in South Africa (Uys 1999: 490).

Another important preventative measure is genetic counseling to prevent genetic abnormalities. The most common abnormalities in South Africa that cause mental retardation are Down's Syndrome and "Fragile X Syndrome." Prevention of these syndromes is not easy as Mabaso (1989) found that black parents would not consent to a therapeutic abortion even if a serious congenital abnormality were to be diagnosed pre-natally. Early genetic counseling, aimed at the prevention of high-risk pregnancies would probably not achieve much greater acceptability (Uys 1999:490).

Only long term strategies such as the improvement of socio-economic status of families and improved literacy would make genetic counseling a more successful strategy for the overwhelming majority of the population.

### 2.11.2 Secondary Prevention

Secondary prevention involves the early detection of mental retardation in order to commence stimulation and learning programmes as soon as possible after birth. This could play an important role in optimizing the capabilities of all children. Early detection means early identification of groups at risk because of developmental handicaps.

The establishment of programmes which were originally used in the United States of America for early detection of mental retardation, stimulation and learning in South Africa is hampered by the following factors.

- There are few psychiatric nurses in primary health services in the country who would launch this type of program. Also alternative staff such as primary school teachers who have the knowledge and skills, and clinical psychologist, are scarce.
- A large proportion of the population is illiterate and very poor, and the home environment in such circumstances does not facilitate the early recognition of retarded development.
- Specialized services for retarded children and even for other children are not generally available in large parts of the country (Uys 1999:491).

### 2.11.3 Tertiary Prevention

This would mean that adequate, goal-directed programs and services should be available for the optimum development of all identified mentally retarded people throughout their lives. This is an ideal that has not yet been remotely realized (Uys 1999: 491).

A complete assessment of mentally retarded persons include more than the assessment of the individual. It also includes assessment of the parents or caregivers and the environment.

When a mentally retarded child is born, a professional team should be involved with the developmental assessment of the infant and young child as seen in Figure 2.1

The professional team that are involved include:

- A developmental Paediatrician, who would be concerned with the child's development, both physically and mentally.
- Depending on the outcome, the child is referred to a Physiotherapist, Speech Therapist, Social Worker, Psychologist and Occupational Therapist.
- Outside the child's immediate environment, the mentally retarded child is referred to a Neurologist, a Psychiatrist, an Ear, Nose and Throat Surgeon, an Ophthalmologist and an Orthopaedic Surgeon. This ensures that the mentally retarded child is treated "holistically" by the professional team, who are experts in their field of work.

Figure 2.1

Table 2.1 shows the developmental features for each of the subtypes of mental retardation, known as mild, moderate, severe and profound mental retardation.

**Table 2.1: Development features for subtypes of mental retardation (adapted from Kaplan and Sadock, 1988)**

Degree of mental Retardation	Preschool age: 0 – 5 years	School age: 6 – 20 years	Adult: 21 years and over
Mild: IQ 50 – 55 to about 70	Can develop social and communication skills, minimal impairment in sensor – motor areas; often not distinguishable from normal children.	Can master academic skills, often taught in special classes in normal schools, can be guided into social adjustment.	Can usually master vocational skills well enough to be self-supporting but require guidance and support when under unusual social or economic stress, open job market; are in unskilled or semi-skilled employment.
Moderate: IQ 35 – 40 to 50 – 55	Can talk and learn to communicate; poor self- awareness, fair motor development but reach mile-stones later; profit from training in self-help procedures by means of early detection and stimulation and learning programs,	Profit from training in social and occupational therapeutic skills; can learn to travel alone in familiar places; trained in training centers.	May be self-supporting and able to do sheltered employment in special workshops; require supervision and guidance when under moderate social or economic stress.

	placements in day		
	centers from the		
	age of three years.		
Severe:	Poor motor-	Can talk or learn to	May contribute
IQ 20 – 25	development;	communicate, can	partially to self-
To 35 – 40	speech minimal;	be trained in	care under full-
	profit little from	Elementary hygiene	time supervision,
	training in self-help	skills; profit from	can develop self-
	procedures; few or	Systematic habit	protection skills to
	no communication	training in	A minimally useful
	skills, early	stimulation centers.	level in a controlled
	detection,		environment,
	stimulation and		spend their lives in
	learning		stimulation centers.
	programs		
Profound:	Minimal capacity	Limited motor	Limited motor and
IQ below 20 or 25	for sensor-motor	development; may	speech development
	functioning;	respond to minimal	may develop very
	require total	or limited training in	limited self-help
	Physical care.	self-care, admission	skills; require
		to care facilities	total care for life.
		often necessary.	

The mentally retarded are classified into different levels of mental retardation depending on their intelligence quotient. The classification of mental retardation has been outlined.

#### **2.4 CLASSIFICATION OF MENTAL RETARDATION**

Intelligence is an important aspect of educability of the mentally retarded patient / child.

One should look at the normal distribution curve to determine the intelligence quotient

distribution of the whole population (if theoretically only heredity determined

intelligence). Figure 2.2 is a normal distribution curve showing the classification of



intelligence quotient, when plotted on a graph and Figure 2.3 is a normal distribution graph showing the classification of intelligence quotient.

**Table 2.2: The classification of intelligence quotient**

145 +	HIGHLY GIFTED
130-144	SUPERIOR
115-129	ABOVE AVERAGE
85-114	AVERAGE
70-84	BELOW AVERAGE, WITH POOR SCHOLASTIC PROGRESS
50-69	MENTALLY MODERATELY HANDICAPPED AND NEEDS SPECIAL EDUCATION TO MAKE ANY PROGRESS
25-49	SEVERELY MENTALLY HANDICAPPED AND CAN ONLY ADJUST IN A DAY CENTRE
BELOW 25	PROFOUNDLY HANDICAPPED-NORMALLY DEPENDENTLY ON INSTITUTIONAL CARE

Figure 2.2

Figure 2.3

It must be borne in mind that it is impossible to determine any one's IQ with absolute accuracy. The World Health Organization only regards children with an IQ below 70 as mentally handicapped and labels the day-centre child as mildly or moderately handicapped (Steenkamp & Steenkamp 1980:6).

According to the distribution curve, Figure 2.2, approximately 84% of all children should be able to cope or even do well at school, whilst nearly 16% will exhibit learning problems, may struggle at school, fail a standard or two or will have to be placed in a special class.

Only about one out of 1000 children will not be able to make any scholastic progress at all and will need other training or special care. Because mental handicap (as opposed to mental giftedness) is not caused as much by heredity as by brain damage or genetic abnormality, there is an accumulation of the mentally retarded at the lower end of the scale (Steenkamp & Steenkamp 1980:7).

Empirical studies in developed countries reveal that four to five per 1000 children qualify for day centres. In our present-day culture this figure is particularly high as handicapped children who previously would have died are now kept alive by means of improved medical care, such as the number of Downs Syndrome children who remain alive increased fourfold in recent years.

Infants who are seriously injured during birth or through an accident or illness, frequently recover with medical assistance, but often at the expense of a brain lesion that can never

be reversed (Steenkamp & Steenkamp 1980:7).

It is of great importance to know what the Mental Health Care Bill of 2001 states regarding the mentally retarded.

## **2.5 THE MENTAL HEALTH CARE BILL**

According to the new Mental Health Care Bill of 2001, mental retardation, intellectual disability and mental handicap are discussed separately from mental illness.

The Mental Health Care Bill of 2001 (chapter 1:3) determines that “every patient should be on an individualized treatment and rehabilitation program aimed at possible community discharge,” giving attention to the importance of care in the community and normalization as well as quality care in the institution.

Chapter 2, states the levels of treatment and care and are described at primary health care level.

Section 5 (c) of The Mental Health Care Bill of 2001, mentions that institutions would provide for “in-patient care of people with severe or profound intellectual disabilities/mental handicap/mental retardation”. No provision is made for those who are moderately and mildly retarded who are abandoned, children in need of care in terms of the Child Care Act or those who have behavioral problems to the extent that facilities in the community cannot cope with them. The Mental Health Act of 1973 and the Child Care Act did not provide adequately for the mentally retarded child as the mentally handicapped were classified together with the mentally ill.

Section 5 (d) of the Mental Health Care Bill of 2001, does not spell out the financial responsibilities of the provincial authority nor is this issue covered in Chapter 6, Section 33 or Section 44 (n). It will be of no use if new legislation attempts to defend the human rights of the mentally ill and the mentally retarded people without budgeting efficiently to make proper care and treatment possible whether in the community or institutions.

Section 9 mentions “all accompanying medical and social reports” should be forwarded to a judge in chambers in terms of Section 8 and 10. Psycho - social reports are important and necessary before referring patients to a psychiatric hospital / care and rehabilitation center, so as to prevent unnecessary detention in psychiatric hospitals and care and rehabilitation centers.

Chapter 6, Section 33 of The Mental Health Care Bill of 2001, provides for licensing of residential and day care facilities but no mention is made of the age of persons attending these. Stipulations about inspections of these facilities are not made, nor anything mentioned about budgeting for the subsidization of such facilities and by whom.

Chapter 7, Section 36 of The Mental Health Care Bill of 2001, makes allowance for the appointment of a curator to serve the interest of a person suffering from mental illness. No mention is made of the mentally retarded.

Section 44 (d) determines the setting of standards and norms for the care of people in mental health facilities. This is important to protect patients as well as facilities and may ensure possible up-liftment.

Section 16 provides for mentally ill patients to be charged and criminal procedures followed should they commit a crime against another person. No mention is made of the mentally retarded person in this regard with subsequent observation and the possibility of becoming a state patient.

Section 17 provides for the Mental Health Review Boards (MHRB) and proposes one MHRB per province. The MHRB will be able to attend to the right of the mentally ill / retarded persons. However, one MHRB per province seems to be inadequate. No mention is made of the task of the MHRB towards the minority of licensed homes and should be included in the final act.

Where the sterilization of mentally retarded women and therapeutic abortions were very contention matters in the past, this is not even an issue anymore for the general population with the new "Termination of Pregnancy Act No. 92 of 1996" due to the wide publicity by the various media in relation to issues such as women abuse, teenage pregnancies, and HIV/AIDS.

Alcohol and drug abuse presently fall under Mental Health. Some patients who are mentally retarded abuse alcohol and drugs. There is however no provision made for these persons who

may also be mentally ill / retarded. It has always been a problem that Rehabilitation Centres have refused to admit persons who are / were also mentally ill while psychiatric hospitals refuse to admit and treat mentally ill persons who are also drug abusers until they had degenerated to Korsakoffs Psychoses. This should be prevented.

No mention is made of co-operation between the different government departments dealing with the mentally ill and mentally retarded. The responsibility of each department needs to be specified and provision made for collaboration.

The White Paper on an Integrated National Disability Strategy (1997:57) argues the importance of legislation and says, “..... if correctly administered, legislation can be used to promote the rights of people with disabilities whether they are physical or mental disabilities.

Mental retardation affects all mankind, and therefore, all cultures. The psychiatric nurse should be knowledgeable about mental retardation and culture.

## **2.6 MENTAL RETARDATION AND CULTURE**

The concept of culture and its relationship to the health care beliefs and practices of the patients and their families and friends provides the foundations for trans-cultural nursing.

The identification of mental retardation as an illness is regarded as an appropriate



behavior, will depend largely upon the culture and the traditional practices.

Culture was initially defined by the British anthropologist Sir Edward Tylor in 1871 as stated in Smeltzer & Bare (2000:103) as “including knowledge, belief, art, morals, laws, customs, and any other capabilities and habits acquired by humans as members of society.” Through the decades culture has been defined in hundreds of ways with themes stated by Tylor. However, in what ever way culture is defined, it primarily provides guidelines for a way of life, and is a result of the way that people have adapted to a particular environment.

People act in fixed ways that are in line with the ideas, precepts and shared knowledge of their culture, which is in line with the definition of Madeleine Leininger, founder of the speciality called transcultural nursing that indicates that culture involves “learned and transmitted knowledge about values, beliefs, rules of behavior, and lifestyle practices that guide a designated group in their thinking and actions in patterned ways” (Smeltzer & Bare 2000:103).

Giger and Davidhizar further state that culture develops over time as a result of “imprinting the mind through social and religious structures and intellectual and artistic manifestations” (Giger & Davidhizar 1995:3).

For many, culture determines the causes of illness such as mental retardation.

### 2.6.1 Causes of illness

For many families, parents, patients, etc, mental retardation/handicap only becomes meaning-full once a cause has been ascribed to it. By identifying the cause, it would then become a significant factor about the subsequent coping strategies, e.g. who is to be consulted and what form of practices or treatment that should be followed.

There are however three major views, or paradigms that attempt to explain the causes of disease and illness.

#### 2.6.1.1 *The biomedical or scientific world view*

The biomedical or scientific world view prevails in most health care settings and is one that most nurses and other health care providers embrace. The assumptions underlying this perspective is that all events have a cause and effect, that the human body functions like a machine, and that all of reality can be observed and measured, such as intelligence quotient test.

One example of the biomedical or scientific view is the bacterial or viral explanation of communicable diseases (Smeltzer & Bare 2000:106).

#### 2.6.1.2 *Naturalistic or holistic perspective*

According to this view, the forces of nature must be kept in natural balance or harmony.

One naturalistic belief, held by many Asian groups, is the yin / yang theory, in which health is believed to exist when all aspects of a person are in perfect balance or harmony.

Foods are even classified as hot and cold in this theory and are transformed into yin and yang energy when metabolized by the body. Yin foods are cold and are eaten when the person has a hot illness, such as fever, rash , sore throat, ulcer, infections . Yang foods are hot and are eaten with a cold illness, such as cancer, headache, colds, stomach cramps).

Those who embrace the hot / cold theory maintain that health consists of a positive state of total well - being, including physical, psychological, spiritual and social aspects of the person.

According to this view, breaking the laws of nature creates imbalances, chaos, and disease. Those who embrace this paradigm use metaphors such as “ the healing power of Nature ” (Smeltzer & Bare 2000:106-107).

### 2.6.1.3 *Magico-religious world-views*

The basic premise is that the world is seen as an arena in which supernatural forces dominate. The fate of the world and those in it depends on the action of supernatural forces for good or evil. Examples of magico -religious causes of illness include belief in voodoo or witchcraft among many Black cultures. Faith healing is also based on this view and is most prevalent among selected Christian religions, including Christian Science. Various other healing rituals may be found in many other religions such as Roman Catholicism, Mormonism, and others (Smeltzer & Bare 2000:107).

However it is possible to hold a combination of world views, and many patients are likely

to offer more than one explanation to the cause of their illness. Regardless of the view held, and whether the nurse agrees with the patients beliefs in this regard, it is important to be aware of how people view their illness and their health and to work within this framework to promote the patients care and well-being.

Several cultures believe in folk or indigenous healers.

### **2.6.2 Folk or indigenous healers**

Several cultures believe in folk or indigenous healers. Some may turn to a spiritualist, a herbalist or a healer who manipulates bones and muscles. Some seek assistance from a voodoo priest or priestess, spiritualist, or a root doctor. Patients of Asian descent may mention that they have visited herbalist, acupuncturists, or bone setters . Several cultures have their own healers, most of whom speak the native tongue of the patient, make house calls, and cost significantly less than healers practicing in the bio - medical or scientific health care system.

It is best not to disdain a patient's belief in a folk healer or undermine trust in the healer.

To do so may alienate and drive the patient away from receiving prescribed care. Efforts must be made to accommodate the patients beliefs while advocating the treatment proposed by modern health science.

The culture of nursing is one of collaborative practice.

### 2.11.1 Collaborative practice

At the beginning of this chapter the ever-expanding role of the nurse has been mentioned. Many references have been made of the significance of the psychiatric nurse as a member of the health care team. As the unique competences of nurses are becoming more clearly articulated, there is increasing evidence that nurses do provide certain health care services distinctive to the profession. However, nursing continues to recognize the importance of collaboration with other health care disciplines in meeting the needs of patients.

Within a decentralized organizational structure, nurses and physicians function collaboratively in making clinical decisions.

The collaborative model should be a primary goal for nursing - a venture that would promote shared participation, responsibility, and accountability in a health care environment that is striving to meet the complex health care needs of the public.

Figure 2.4 compares the “Traditional Practices Model ” (A) with a centralized structure, from the physician > professional nurse > ancillary personnel > patient, to the “Collaborative Practice Model” (B), which has a decentralized structure, where there is shared participation between the physician > professional nurse > ancillary personnel in the holistic care of the patient.

**Figure 2.4**

The mentally retarded, like every other human being have rights that should be respected.

## **2.7 THE RIGHTS OF THE MENTALLY HANDICAPPED CHILD.**

In 1959 the United Nations General Assembly formulated a Declaration of the Rights of the Child.

This includes the right:

- to affection , love and understanding
- to adequate nutrition and medical care
- to free education
- to full opportunity for play and recreation
- to a name and nationality
- to special care, if handicapped
- to be among the first to receive relief in times of relief
- to learn to be a useful member of society and to develop individual abilities
- to be brought up in a spirit of peace and universal brotherhood
- to enjoy these rights, regardless of race, colour, sex, religion, national or social origin (Steenkamp & Steenkamp 1980:148).

Since then, particular attention has been paid to the handicapped child, and on the 20<sup>th</sup> December 1971, the Declaration on the Rights of the Mentally Handicapped Persons was accepted by the United Nations General Assembly at the 2027<sup>th</sup> Plenary meeting:

The mentally handicapped person has, to the maximum degree of feasibility, the same

rights as other human beings.

- a right to proper medical care and physical therapy, and to such education, training, rehabilitation and guidance as will enable him to develop his ability to maximum potential.
- a right to economic security and to a decent standard of living.
- a right to live with his own family or with foster parents.
- a right to a qualified guardian when this is required to protect his personal well-being and interest.
- a right to protection from exploitation, abuse and degrading treatment right to proper legal safeguards against every form of abuse (Steenkamp & Steenkamp 1980:148-149).

The mentally retarded also have needs like every other human being.

## 2.8 NEEDS OF HUMAN BEINGS

The instinct and drive theories were predominantly influential in the 1950's. In reaction to these theories, Abraham Maslow (1943, 1954, 1955, 1970, 1971 ) developed a theory of **instinctoid** needs. By using this term, Maslow wished to indicate that needs are “innate but not so specifically directed as are the instincts and drives” (Jordaan & Jordaan 1990:651). This means that **instinctoid** needs lead to greater variations in patterns of behavior and can be modified by learning, by cultural demands, and by a persons particular circumstances.



### 2.8.1 Hierarchy of needs

Maslow distinguished between five groups of needs as demonstrated in Figure 2.5.

- physiological needs;
- security needs;
- the need for love and belonging;
- the need for esteem and appreciation;
- the need for self - actualization.

The five groups of needs are arranged in a hierarchy. However this does not imply that hierarchally higher needs develop out of hierarchally lower needs, but that a higher need is experienced only when the preceding lower need has at least been partially satisfied, and the person feels assured of satisfaction of such lower need in the future (Jordaan & Jordaan 1990:651).

This scheme of Maslow's hierarchy of human needs shows how a person moves from fulfillment of basic needs, with the ultimate goal being integrated human functioning and health.

Such a hierarchy of needs is a useful organizational framework that will be applied for the assessment of the needs of the mentally retarded patients.

Figure 2. 5 depicts the 5 groups of needs, which are arranged in a hierarchy.

**Figure 2.5**

### 2.8.1.1 *Physiological needs*

These are the most basic and strongest needs, such as food, water, oxygen, sex, and elimination.

If the physiological needs are not satisfied, they override all other needs (Jordaan & Jordaan 1990:652; Smeltzer & Bare 2000:4).

The mentally retarded need these basic and strongest needs including food to eat, water to drink, oxygen to breathe, like every other human being.

### 2.8.1.2 *Security needs*

These needs are usually more clearly seen in children than adults. When the physiological needs have been sufficiently satisfied, then the security needs are experienced .

Security needs includes a number of specific needs, e.g. the need for stability (predictable routine), order, protection and freedom from fear and anxiety (Jordaan & Jordaan 1990:653-654; Smeltzer & Bare 2000:4).

The mentally retarded need security which include the need for stability, such as routine and also protection from fear and anxiety. This makes the mentally retarded less anxious and therefore, lead to feelings of security.

### 2.8.1.3 *Need for love and acceptance*

When the physiological and security needs have been sufficiently satisfied, people then experience the need for love and acceptance. The need for love is generally characterized

by the striving to establish and maintain loving relationships with the other people, such as friends , relatives, a spouse and children. This need involves both the giving and receiving of love.

The need for acceptance and to belong some where, is characterized by the striving to achieve membership of and identification with a group (Jordaan & Jordaan 1990:655; Smeltzer & Bare 2000:4).

The mentally retarded also have a need for love and acceptance. The mentally retarded will therefore attach themselves to certain members of staff and will do things to please certain members of staff such as eating very well when being fed by certain staff members.

#### *2.8.1.4 Esteem and self respect needs*

When the need for love and acceptance has been sufficiently satisfied, the need for esteem is experienced. Most normal people need to feel self - respect and a sense of their own value, but they also need to feel that they are respected and appreciated by others. When the satisfaction of this need is obstructed, the person experiences a feeling of inferiority and helplessness (Jordaan & Jordaan 1990:655; Smeltzer & Bare 2000:4).

When a mentally retarded patients goal has been achieved, e.g. toilet training after months or even years of being on a program, the patient experiences self esteem and self respect.

### 2.8.1.5 *Need for self-actualization*

Jordaan and Jordaan (1990:655); Smeltzer and Bare (2000:4) states that when the other four needs (deficiency needs) have been sufficiently satisfied, the person becomes freed to attempt the active expression of his or her self-actualization.

According to Maslow, this need amounts to “a desire to become more and more what one is, to become everything one is capable of becoming”(Jordaan & Jordaan 1990:655).

This need, and the behavior it gives rise to, enable the person to “grow.” The direction in which a person will grow depends to a large extent on his particular abilities, talents and potential. It is because people differ so much from one another in this regard that there are, at this level of hierarchy, so many individual differences.

Self - actualization is therefore unique to each person; it is something each person must discover and achieve for him/herself (Jordaan & Jordaan 1990:655; Smeltzer & Bare 2000:4).

Self-actualization is also unique to the mentally retarded patients. However all mentally retarded patients may never reach self actualization e.g. thee severely and profoundly mentally retarded individuals.

A human being cannot be viewed in isolation or as separate parts, but as an integrated holistic being.

## **2.9 THE INTEGRATED APPROACH TO THE NEEDS OF THE MENTALLY RETARDED.**

A complete assessment of the mentally retarded individual will include a holistic orientation to health care that recognizes all aspects of a person as significant and considers how these interact to affect the whole person. According to Beck, Rawlins & Williams (1988:22) each individual is viewed as a person with physical, emotional, intellectual, social and spiritual dimension which is similar to Maslow's Need Theory, which includes physiological, security, love and acceptance, esteem and self respect and self actualization needs, and as one who is in constant interaction with others and with the environment. All factors contribute to health and illness.

No one human dimension, either within the person or as seen in that person's interaction with others, can be considered in isolation.

### **2.9.1 Viewing the whole person**

A basic premise inherent in all definitions of "holism" and "holistic health" is that living and non living entities are viewed in terms of "wholeness relationships, processes, interactions, freedom and creativity (Beck et al 1988:22).

It is therefore inaccurate to consider individuals, societies, or things in isolation.

Humanism has contributed to holistic health care philosophy an emphasis on the value and importance of being human. It has also influenced health care by directing attention toward the

**whole person** rather than only the specific problem and “has encouraged recognition of the basic and rights of clients to choose a personal life path” (Beck et al 1988:22).

### **2.11.1 Human uniqueness**

Within a holistic health framework, each individual is considered unique. Complex factors, including human dimensions, comprise a persons view of himself, the world, health and illness. For any person, the interaction of different dimensions and the interaction of the person with his / her environment is unique (Beck et al 1988:23-24).

Uniqueness demands that people be viewed as requiring individualized approaches to health and illness. What is healthy for one may be detrimental to the other.

Individuals have different needs, such as physical, psychological, social, emotional, financial, educational and cultural needs with respect to the achievement of balance within themselves and in their particular life situations.

When an individual’s uniqueness is not respected, then health care may be approached in a way that has been effective with other clients but is not with this one. When health care professionals consider only the disease process, the symptoms, or a label, then the individual’s uniqueness is not respected. When this is done, the nurses also limit their ability to perceive individual needs and innovative solutions (Beck et al 1988:23-24).

### 2.9.3 Context of health and illness

The philosophy of holistic health care asserts that health and illness must be considered within the context of the individual's life situation. People, including their states of health and illness, do not exist in isolation, but function within many settings, such as familial, occupational, communal, social and cultural. The values, beliefs and behaviors that develop from these settings influence health and illness. A holistic perspective acknowledges the significance of these factors, such as, families may offer a safe setting for the expression of feelings; a person's work place may serve as a source of creative challenge or of chronic unrelieved stress.

When nurses view health and illness within the context of the individual's life, they are better able to understand the person's experience of health and illness. They are better able to understand that people with similar symptoms react in different ways, that individuals with similar disease processes do not necessarily respond to identical interventions, and also that people differ in their perceptions of health and illness (Beck et al 1988:24).

In any particular situation, "normal" people have access to various resources which may be taken for granted such as schools, social clubs, churches/places of worship, shops, hospitals/clinics, and not to others, as may be the case with the mentally retarded. The availability of financial, social, educational and community resources will all be assessed to determine to what extent these are needed in the community, as these are also the needs of the mentally retarded.



### 2.11.1 Health versus illness

Health is more than the absence of disease; it is a dynamic, active process of continually striving to reach one's own balance and highest potentials. Because everything in one's life has an impact on health, each choice one makes leads toward or away from health (Beck et al 1988:26).

The World Health Organization (WHO) defines health as a "state of complete physical, mental and social well being and not merely the absence of disease and infirmity" (Smeltzer & Bare 2000:5). However such a definition does not allow for any variations in the degrees of wellness or illness. On the other hand, the concept of a health-illness continuum allows for a greater range in describing a person's health status.

The limitations of the WHO definition of health are clear in relation to chronic illness. A chronically ill person cannot meet the standards of health as established by the WHO definition. However, when viewed from the perspective of the health - illness continuum, people with chronic illness can be understood as having the potential to attain a high level of wellness, if they are successful in meeting their health potential within the limits of their chronic illness.

Therefore when talking about mental handicap, we are not talking about a disease, but a chronic non - progressive condition which is a form of developmental disability (Lea & Foster 1990:185).

### **2.9.5 Illness as opportunity**

The primary factors that determine the impact of illness are one's attitudes toward it, what one is able to learn from it, and what growth one engages in as a result of the illness. Some people view illness as a catastrophe that simply "happened" to them and over which they have no control. They see themselves as victims being persecuted by the illness. However other people are able to view illness as an opportunity to evaluate their current life situations. This information is then used to set new goals and move in new directions.

The holistic health philosophy is consistent with this approach, which asserts that there is "personal meaning, or a message, in any illness"(Beck et al 1988:24). By discovering this "message" or "personal meaning" would provide an opportunity for growth for each individual.

Illness may often be related to needs that a person has, but is not meeting. When people are not conscious of, or ignore certain needs, they may develop an illness or particular symptoms to meet their needs. This is usually an unconscious process and occurs when people do not have better coping mechanisms available, as may be the case with the mentally retarded.

### **2.11.1 Client-nurse partnership**

Within a holistic health framework, the relationship between the client and nurse is an active partnership, and responsibility in healing and growth is shared. This relationship has a healing effect, as both the client and the nurse experience growth and change.

The nurse in a holistic health care setting attempts to create conditions that are conducive to healing and optimal health. The client's current belief system is the beginning framework, and from this point, the nurse provides support and assists the client in finding healthy ways to meet individual needs.

Clients in a holistic setting are co-participants in healing and health promotion, working closely with the nurse to determine necessary and appropriate interventions. Nurses/practitioners have the opportunity to influence clients so that they are better able to strive toward optimal health (Beck et al 1988:25).

Figure 2.6 identifies the client-nurse partnership, involved in the communication process by the imparting or exchange of information, ideas or feelings that then result in growth and development for both the client and nurse.

Figure 2.6 client nurse partnership

This active communication between the nurse and client involves 4 other processes:

- **Orientation** – it is the act or process of orienting or the state of being orientated (Collins Concise Dictionary 1985: 796).
- **Identification** – it is the act of identifying or the state of being identified
- **Exploitation** – to make the best use of (Collins Concise Dictionary 1985: 390).
- **Resolution** – the act or an instance of resolving; a judicial decision on some matter, verdict, judgment (Collins Concise Dictionary 1985: 978).

The nurse and the client through communication and the 4 processes of orientation, identification, exploitation and resolution, form a partnership, which results in growth and development for both the nurse and client.

### 2.9.7 Self-care

Holistic health philosophy supports self-care as a valid and necessary component of the larger health care system. The formal health care system cannot provide all services associated with health and illness. Self-care proponents encourage individuals, families and communities to assume more responsibility for health status improvement. By pursuing self-care one would know how and when to best use professional assistance (Beck et al 1988:25-26).

Besides knowing the Traditional Model and the Collaborative Model in the care of the patients, it is important to know the retrospective view of methods in handling the mentally retarded.

## **2.12 RETROSPECTIVE VIEW OF METHODS OF HANDLING THE MENTALLY RETARDED**

Very little is known about how primitive man approached the mentally handicapped, but it can be accepted that they were regarded as “possessed by evil spirits” and were shunned, tortured, or killed.

Even the "civilized" Greeks and Romans a few hundred years before Christ, referred to them as "fools" or "monsters". The Spartans, who abhorred any form of handicap or abnormality, frequently put them to death (Steenkamp & Steenkamp 1980:8).

During the Middle Ages, mentally handicapped people were often murdered, humiliated or taunted as village idiots, whilst others were kept as court jesters.

The rise of Christianity in the Western World brought a better dispensation and their fellow men acted with more responsibility and compassion toward them. However, the peculiarity of the phenomenon still caused it to be associated with the "unknown " and the handicapped were either honoured as "chosen people" or feared as "Satan's children" and rejected or incarcerated with the insane in lunatic asylums (Steenkamp & Steenkamp 1980:8).

It was only in the 19th century that the theories of philosophers such as Rousseau and Locke led to the recognition of the rights of the child, including that of the mentally handicapped. It was especially the work of physician Itard that gave rise to the more specific approach to, and care of these children. The number of institutions increased but little attention was given to real education. As there was no possibility of recovery or a "cure", most mental handicap persons had to spend their entire lives in institutions and gradually public interest in their fate waned (Steenkamp & Steenkamp 1980:9).

Since the Second World War, the increasing emphasis on welfare services resulted in the flourishing of the social sciences and the parents of the mentally handicapped children began to fight for the educational rights of their children. In December 1971, the General Assembly of the United Nations proclaimed the "Declaration of the Rights of the Mentally Retarded Children."

In South Africa the Mentally Retarded Children's Training Act, 1974 (Act 63 of 1974), had led since 1976 to almost complete state subsidization of day centres controlled by the Department of National Education (for white children) (Steenkamp & Steenkamp 1980:10).

Following are the past and recent resources and support systems in South Africa and other countries.

## **2.11 RESOURCES AND SUPPORT SYSTEMS IN SOUTH AFRICA AND OTHER COUNTRIES**

### **2. 11. 1 Italy**

As a developed country, Italy went to the extreme and abolished all institutions. During the 1960's and early 1970's, Italy experienced limited reform in its mental health structure similar to that experienced in the United States and the United Kingdom. There was a drop in the numbers of patients in institutions and simultaneously, care in the community was increased. In 1978, Law 180 of the Italian Mental Health Act was introduced. This law prohibited patients from being admitted to existing psychiatric asylums and demanded that all chronic patients should gradually be discharged from hospital. This law also stated that after December 1988, no ex-patients could be readmitted. All existing psychiatric hospitals were to be unlocked and patient's civil liberties returned to them. Provision was made for a maximum of 15 psychiatric beds in general and district hospitals. Local community and mental health centres were to be developed and become more involved in mental health care. Compulsory admission to hospital was allowed for a maximum of 15 days with independent judicial reviews at two and seven days. Franco Basaglia who was the leader of the "Psichiatria Democratica" movement, challenged both the medical and the legal justifications for the congregative control of mentally ill and he joined in with the political parties of that time as well as the union, woman and student groupings all to integrate and accept the mentally ill in the community (Freeman, Lee & Vivian 1994:16).



Law 180 was unfortunately implemented very unevenly through the provinces in Italy. In some areas community services were developed while in other areas hospitals had been closed or bed numbers reduced without the support services prescribed by the changed law (Freeman et al 1994:17).

The idea of a country without asylums drew widespread reaction. So far, consensus on the eventual outcome has not been reached. Once again the evaluators of one middle class sub-region in Italy, South Verona, came to the conclusion that it is possible to practice without mental hospitals, but that long term hospitalization cannot be avoided until alternative settings have been developed (Freeman et al 1994:18).

No mention has been made of the mentally retarded as such in the literature available on developments in Italy. Some researchers of Italian experience differ from most of the researchers in the United Kingdom and the United States of America who assert that some long stay beds for the psychiatric patients are needed even when comprehensive community care is in place. Italian researchers, however, state that it is essential to have sufficient and well - staffed residential facilities for certain patients with severe and chronic disabilities (Freeman et al 1994:21).

### **2.11.2 The United States of America**

The care and treatment of the mentally retarded in the United States was very similar to that in England due to strong cultural affinities and influences.

Efforts were made to improve conditions in the various institutions but this was linked with an increase in the expenses of institutional care. Litigation gave attention to the rights of people detained and also to staff-to-patient ratios. Parameters to prevent overcrowding were also defined (Segal 1995:377).

Segal (1995:708) reported that in 1977 private facilities numbered 10,219 and had increased to 38,657 in 1989 and included intermediate facilities, foster homes, and group residences that provide 24-hour, 7 days a week responsibility for room, board and supervision. By 1986, 51,9 % of the beds available in both public and private facilities were located in facilities where the average number of residents was no more than 35.

### **2.11.3 Developments in South Africa**

In the 1990's, political changes were taking place with an emphasis on human rights for all, especially those vulnerable groups of South Africa who have been traditionally disadvantaged over many decades. The African National Congress has been highly critical of the previous regime and is very enthusiastic about promises to wipe out all discriminatory, legislation and practice accordingly. The New Constitution of the Republic of South Africa, Act No 108 of 1996 was adopted and amended.

In District 22, KwaZulu-Natal, there are facilities in the community to assist with the care of the mentally retarded under the auspices of the Mental Health Societies and Cerebral Palsied Associations. Most of these facilities have waiting lists of applicants needing placement but they are also financially constrained. In the past, some of these facilities were able to sponsor some residents who had no parents or whose parents were unable to pay an extra amount as determined by the hostel or day care centre. Many of them have been unable to keep up sponsoring indigent residents (McLaren & Philpott 1998:37).

Some of the facilities in the community are being subsidized by the Department of Welfare and Population Development and others by the Department of Health. Mutual understanding by all the different departments on the needs of the mentally retarded person does not always exists, and effective collaboration is not always possible.

The researcher needs to investigate the present situation of resources in the community.

## **2.12 CONCLUSION**

The purpose of this research is to assess the needs, the services and facilities of the mentally retarded living in the community of District 22 (sub-district 222), KwaZulu-Natal. This is the first step in providing more effective health care services in the community.

This chapter provided basic information concerning a needs assessment process with regard to persons with mental retardation. The theoretical framework of "wholism " formed the basis on which individual needs could be assessed, in order for the process to be successful.

"Wholism " refers to the physical, spiritual and mental wholism of the individual.

Health and illness were also viewed as two opposite concepts on the health-illness continuum. A person's culture also influences the way a person views his/her illness. However, health potentials do exist even for those who are mentally retarded. Therefore the needs of the mentally retarded must be assessed effectively in order to enhance and meet the health care needs of the mentally retarded.

Chapter 3 will provide an overview of the methodology adopted to conduct this research.