

COVER PAGE

**Phenomenological experiences of mothers of children with
mental retardation in Mopani and Vhembe districts,
Limpopo Province**

By

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DECLARATION

I declare that the mini-dissertation hereby submitted to the University of Limpopo, for the degree of Masters of Arts in Psychology has not previously been submitted by me for a degree at this or any other university; that it is my work in design and in execution, and that all material contained herein has been duly acknowledged.

Rikhotso, T.G (mrs) Date

DEDICATION

This work is dedicated to my Lord and saviour Jesus Christ who has been my strength and helper throughout my life. I would also like to dedicate this work to my late brother and grandmother for their wisdom and guidance.

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Firstly, I would like to thank the Almighty God, who gave me strength and courage to conduct this study. Next, I want to thank the following people for their contributions to this dissertation:

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Abstract

This study explored the phenomenological experiences of mothers of children with mental retardation in two special schools (i.e. Fulufhelo and Pfunanani). The former is in Vhembe while the later is situated in Mopani district in Limpopo province. A qualitative approach was followed and participants were selected using purposive sampling. The sample consisted of 24 members (12 for individual interviews and 12 for focus group) whose children were diagnosed with mental retardation at the time of the study. Data were collected through unstructured interviews and analysed using interpretative phenomenological analysis. The following psychological themes emerged from the study: mothers' subjective understanding of mental retardation; mothers' understanding of the causes of mental retardation; living with a mental retarded child; psychological reactions of mothers to a diagnosis of mental retardation and mothers' causal explanation of mental retardation. The present study discovered that all families with mentally retarded children are directly or indirectly affected by this condition.

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CHAPTER 1

INTRODUCTION

1. Introduction

Although there are many studies to suggest that mental retardation is a serious problem in the worldwide (Paul, Desai & Thorburn, 1992), there are very few studies undertaken to give a clearer indication of the prevalence of this condition in South Africa. A study by Wigton, Adnams and King (1997) suggests that the prevalence of mental retardation is relatively low (approximately 4 to 5 cases per 1000 children) compared to Jamaica which has a prevalence rate of approximately 81 children with mental retardation per 1000 children.

The World Health Organisation (WHO) has estimated that the overall global prevalence of mental retardation is between 1% and 3% of the general population (World Health Organisation, 2001). The majority of these cases of mental retardation which have been found to be more prevalent in developing countries (Butcher, Carson, & Coleman, 1999). These high incidences of mental retardation in developing countries are attributed to higher incidences of injuries, deprivation of oxygen at birth and early childhood brain infections (World Health Organisation, 2001).

In a study that investigated disability in children aged between zero and six years in China", Xie,Bo, Zhang, Lui, Zhang, Ji, Yan, Sui, Na, Gou and Wu (2008) found that, in total, 560 of the 60 124 children that were surveyed were diagnosed as intellectually disabled with the overall prevalence of 0.93%. The study further found the prevalence of intellectual disability to be the highest in children living in medium-developed areas with a prevalence of 1.20% when compared to 0.75% for those living in developed areas. In a study undertaken by the Health Australian Institute (2007) in Western Australia, it was found that an estimated 102 900 Aboriginal and

Torres Strait Islander people living in remote and non-remote areas had some form of disability or long-term health conditions. In particular, intellectual disability was estimated to affect 15 800 Australians in remote areas and at least 19 600 people nationally.

Courchesne, Carper and Akshoomoff (2003) state that a study with excellent ascertainment conducted in Aberdeen, Scotland, yielded a prevalence of 1 in 300 for severe mental retardation and 1 in 77 for mild mental retardation. Among those with severe mental retardation, there were more boys than girls (male-to-female ratio 1.2:1), and among those with IQ >70, in the mild range of deficiency, boys exceeded girls by a ratio of 2.2:1.

Although prevalence rates vary from country to country, the variance in prevalence may be attributed to ascertainment bias, the standardisation methods employed from study to study, and a generalised upward drift in IQ scores over time. Even so, the greatest variance in statistics of prevalence is most likely to fall within the category of mild Mental retardation, a group for which the ascertainment bias is large.

In South Africa, the 1996 census data indicated that there were 192 553 (0.42 %) people with mental retardation as at October 1996 (Statistics South Africa, 1996). The same census data indicated that there were 22 578 (0.46%) people with mental retardation in Limpopo Province. In a 2001 census, the total number of people with mental retardation in South Africa was estimated to be 206 451 (0.45 %) whilst the total figure for Limpopo province was found to be 26 223 (0.5%) (Statistics South Africa, 2001). These figures suggest that the number of people with mental retardation in Limpopo Province has grown by 3 645 (0.04%) between 1996 and 2001. In a study that was done by Christianson (2002) in Bushbuckridge it was found that 238 out of the 669 children screened were diagnosed with intellectual disability.

1.2. Motivation for the study

In South Africa, the 1996 census data indicated that there were 192 553 (0.42 %) people with mental retardation as at October 1996 (Statistics South Africa, 1996). The same census data indicated that there were 22 578 (0.46%) people with mental retardation in Limpopo Province. In a 2001 census, the total number of people with mental retardation in South Africa was estimated to be 206 451 (0.45 %) whilst the total figure for Limpopo province was found to be 26 223 (0.5%) (Statistics South Africa, 2001). These figures suggest that the number of people with mental retardation in Limpopo Province has grown by 3 645 (0.04%) between 1996 and 2001. In a study that was done by Christianson (2002) in Bushbuckridge it was found that 238 out of the 669 children screened were diagnosed with intellectual disability.

Previous studies have shown that mental retardation can have both negative and positive effects on family functioning. For example, a study by Chang and McCaskey (2008) found that mental retardation tended to a) strengthen family cohesion; b) increase opportunities for personal growth and achievement; and, c) increase awareness and appreciation of life. On the other hand, the same study found that mental retardation could lead to negative consequences like: a) poor communication in the family; b) the mentally handicapped child being seen as a source of sorrow; and, c) emotional bewilderment for the siblings. A study by Olsson, Marlin and Hwang (2008) has suggested that mothers of children with mental retardation show low levels of well-being when compared to the fathers. It is these kinds of consequences of mental retardation on the family that motivated the researcher to embark on the present study. Furthermore, the researcher hopes that the findings of the study will provide an opportunity to understand subjective notions of mental retardation by individuals and families in a rural South African context. Such an understanding would also deepen our understanding on how individuals and families psychologically cope and deal with mental retardation and other forms of disability.

1.3. Aim of this study.

The aim of the present study is to understand and describe the experiences of mothers of children with mental retardation in two special schools in Mopani district, Limpopo Province.

1.4. Objectives of the study.

- To understand and describe the mothers' understanding of what mental retardation is;
- To understand and describe the mothers' explanations and views regarding the causes of mental retardation;
- To understand and describe the mothers' experiences of living with children with mental retardation; and,
- To understand and describe the mothers' views regarding how best mental retardation can be managed.

1.5. Operational definition of concepts.

- **Mental retardation:** In this study, mental retardation is defined in accordance with the Diagnostic and Statistical Manual of Disorders IV Text Revised (American Psychiatric Association, 2000) as someone who shows a significantly below average level of intelligence (an IQ of 70 or below) and adaptive ability. The difficulty in adaptive behaviour will be reflected in areas such as communication, work, leisure, health, or safety. Intellectual disability: This term is used when a person has certain limitations in mental functioning and in skills such as communication, taking care of him or herself, and social skills. These limitations will cause a child to learn and develop more slowly than a typical child (Smith & Osborn, 2003).

According to the Mental Association on mental Retardation, quoted in the policy guidelines for psychosocial rehabilitation of persons affected by mental disability (2000) (in Shai-Matlou, 2012) , mental retardation refers to substantial deficits in certain aspects of personal competences. Nicholas (2003) defines mental

retardation as a label given to anyone who has been assessed to have an IQ score of 70 or less on a psychological test of intelligence. However, mental retardation does not only affects performance on tests of general mental functioning, but places limitations on one's capacity for self-care, language and speech ability, social educability and vocational proficiency.

- **Mental handicap:** According to Mash and Wolfe (2002) mental handicap refers to significantly sub-average general intellectual functioning that is accompanied by significant limitations in adaptive functioning in at least two of the following skills areas: communication, self-care, home living, social or interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health and safety. The onset must occur before the age of 18 years.
- **Intellectual disability:** According to McCarthy (1999), intellectual disability refers to a person who has difficulty in learning and managing daily living skills. This is because their cognitive (thought-related) processing is impaired. A person is said to have an intellectual disability if they have the following before they are 18 years of age: an IQ below 70 (average IQ 100) and significantly difficulty with daily living skills including looking after themselves, communicating and taking part in activities with other. In the present study, the researcher will use the concepts of mental retardation and intellectual disability interchangeably as they are interpreted to be having the same meaning.

1.6. Organisation of the dissertation

The Chapter 1 starts with a presentation of the background to the study, including the motivation for the study. This is followed by a presentation of the aims and the specific objectives of the study. The operational definitions of key concepts are also given. The Chapter 2 starts by focusing on the most common theoretical perspectives of mental retardation. I give a brief presentation of the Afrocentric perspective as the theoretical framework that has guided me in this study. The reactions of family members following the diagnosis of mental retardation, including the stages of grief and the ways of coping with the diagnosis on mental retardation is

also presented. In Chapter 3, the research methodology that was followed in carrying out this study is presented. In this regard, the chapter covers the following topics: research design; sampling; data collection; and data analysis. The ethical issues that were observed in carrying out this study are also presented. In Chapter 4, the results of the study are presented whilst in Chapter 5 the results are discussed in the context of existing literature on the subject. Finally, Chapter 6 gives a summary of the findings and draws conclusions based on my findings in this study.

CHAPTER 2

LITERATURE REVIEW

2.1. Introduction

In this chapter, I will start by presenting in the first part, some popular theoretical perspectives on mental retardation. This will include some of the biological, psychological, sociological and environmental perspectives on mental retardation. This will be followed by a presentation of the theoretical framework that has informed this study, which is the Afrocentric perspective. The second part of this review will focus on reactions and responses of family members towards mental retardation whilst the third part will explore the stages of grief in reaction to mental retardation and lastly the ways of coping and dealing.

2.2 Theoretical perspectives of mental retardation

According to Nicholas (2003), causative factors in mental retardation include genetic, biological and environmental factors. The more severe forms of retardation often result from genetic or biological disorders. In most cases, the causes are unknown. Because of the severity of mental retardation, and the heavy burden that it imposes on affected individuals, their families and the health services, prevention is extremely important (WHO, 2001). Lea and Foster (1990) note that a detailed knowledge of causative factors of mental retardation within a community forms the basis for instituting preventative measures. This statement is supported by the WHO (2001) by saying that in view of the variety of different aetiologies of mental retardation, preventive action must be targeted to specific causative factors. Preventative strategies at each of the three levels (genetic, biological and environmental) can work to curb the incidence of mental retardation (Nicholas 2003).

2.2.1 Biological perspectives

Those in the biological sciences define mental retardation as the presence of observable or inferred brain pathology. They view mental retardation as an organic impairment (observed anatomical, neurological, or biochemical abnormality).

According to Gates and Beacock (1997), those with a biological bent look inward at the biological processes of human functioning. Biological theorists believe that psychological disorders are linked to anatomical or biochemical problems in the brain. Researchers have found that abnormalities in the activity of certain neurotransmitters, chemicals released into the synapse between two neurons, are often connected with specific psychological disorders.

About 25 percent of retarded individuals have biological defects that account for their intellectual limitations; the remaining 75 percent are usually described as having familial retardation (Weiner, 1992). Biological causes of retardation include inborn abnormalities that prevent normal mental growth from taking place and physical events that interfere with mental development early in life.

Louw and Edwards (1997) found that genetic diseases such as phenylketonuria and Down's syndrome may result in mental retardation. Various health problems in pregnant women increase the risk of their giving birth to a retarded child. During the first trimester, the fetus is vulnerable to harmful effects of infectious diseases, especially rubella (or German measles) and syphilis (a sexually transmitted disease). Half of the children whose mothers contracted illness early in pregnancy are likely to have some resulting mental or physical handicap. Many of these children will be deaf, and about 25% will be mentally retarded (Weiner, 1992).

According to Weiner (1992), certain complications during the birth process increase the risk of subsequent mental and physical handicaps. Infants who are born prematurely have a significantly lower intellectual level than full-term babies on average and a higher incidence of achievement problems in school. Thus, the lesser the birth weight, the greater the risk of handicaps.

2.2.2 Psychological perspectives

2.2.2.1 Behavioural perspective: According to Louw and Edwards (1997), the behavioural approach is concerned with what people do, rather than what they feel or think. It is concerned with individual problems and the identification of clear objectives for enhancing an individual's ability to perform behaviours that he or she is currently unable to do.

2.2.2.2 The developmental perspective: The developmental perspective is in some ways an outgrowth of the social system perspective-where the emphasis is on external factors that influence an individual's cognitive development. This perspective view holds that people with mental retardation are not innately "uneducable," "un-trainable, or "non-teachable" rather holds that some people with mental retardation are capable of behavioural change through appropriate programs of education and habilitation (Gates & Beacock, 1997).

According to Moeschler and Shevell (2006) Knowledge of the normal course of human development provides a starting point for understanding development in persons with mental retardation. Clearly, however, the presence of a cognitive disability affects these normal developmental processes. When comparing the social and emotional lives of individuals with and without mental retardation, four major factors must be taken into account. The first, obviously, is level of cognitive development. Intellectually, an individual with mental retardation functions at a level similar to that of a normally developing person of a younger age, a fact that has significant implications for social and emotional functioning.

Second is chronological age. Despite their delays in cognitive development, individuals with mental retardation generally have age-appropriate physical maturity; in addition, their social role expectations are often similar to those of their chronological age-mates. Next, one must consider the effects of social environment. People with mental retardation are born into all kinds of families and life

circumstances. However, at least in industrialized modern cultures, they have in common the experience of being cognitively limited in an environment in which intelligence is highly valued. Finally, it is important to look at individual variations in temperament and personality. No two people with mental retardation are exactly alike.

2.2.2.3. The humanistic perspective: The humanistic approach believes that people are born with natural inclination to be friendly, cooperative, and constructive; and are driven to self-actualise, that is, to fulfil their potential for goodness and growth. When this drive is interfered with, abnormal behaviour, including mental retardation may result (Comer, 1998).

2.2.3 Sociological perspectives.

From this perspective “mental retardation” is an achieved social status and mental retardation is the role associated with that status (Gates & Beacock, 1997). According to Louw and Edwards (1995), the sociological approach to learning disability focuses on the role of this group of people within society. It is suggested that because of the images that society holds towards them, expectations for their role are limited. He further argues that it is in this sense that learning disability was a creation of society. It focuses on the influence of external factors.

Others focus on social networks and supports and how they may affect a person’s psychological functioning. Still others examine societal stress and consider the unique characteristics of a given society that may create special problems for its members and heighten the likelihood of abnormal functioning. Finally, some theorists focus on societal labels and reactions; they hold that society categorises certain people as “crazy” or “mentally ill”, and that the label produces expectations that influence the way the person behaves and is treated (Gates & Beacock, 1997).

According to Gates and Beacock (1997), it is important to examine the social context if we are to understand abnormal behaviours. The socio-cultural perspective looks outward at the social rules, pressures, and related factors that influence all members of a society. Some socio-cultural theorists focus on family structure and communication; they see the family as a system of interacting parts in which structure, rules, and patterns of communication may force family members to behave in abnormal ways.

According to Ainsworth and Baker (2004), psychosocial issues have also been implicated in the development of mental retardation. So-called “psychosocial retardation” has been closely linked to an impoverished environment. Indeed, most psychosocial factors act in combination and vary between different lower socioeconomic groups. Prevalence estimates are higher among impoverished individuals and non-Caucasian races; however, the relevance of race to development of mental retardation may be coincidental if non-Caucasians are over-represented in the study group of impoverished people. Isolating any specific impact of poverty is, therefore, difficult. Further, psychosocial issues in the mental development of a child are subject to disagreement. It is important to remember that the vast majority of individuals living in poverty display normal intellectual function.

2.2.4. Environmental perspective

Deprivation of stimulation is the primary environmental precursor of delayed development, which can lead to cognitive disabilities. Mild mental retardation is significantly prevalent in low social- economic groups, where cognitive stimulation is limited. Such environments are often characterised by exposure to poor medical and nutritional care, family instability and inadequate caregivers. Wicks-Nelson and Israel (1997) on the other hand state that, severe social isolation can result in serious

retardation, but even a milder lack of stimulation might lead to intellectual deficits. Educationally and economically deprived parents may lack skills and knowledge to stimulate children's language and cognitive development. Parents of any social class who stressed and lacking social support undoubtedly find it hard to provide their offspring with continuous sustenance and achievement motivation. This is supported by Edgerton (1999).

2.2.5. African conceptions on mental illness and disability

Various studies that have sought to understand mental illness, including mental retardation in the different parts of the African continent have suggested that there are some regional variations relating to what can be considered the causes of these conditions (Patel, 1998, Olugbile, Zachariah, Kuyinu, Coker, Ojo & Isichei, 2009). For example, among the Yoruba people of Nigeria, it is believed that mental ill health, including mental disabilities can be attributed to four factors: i). natural sources, such as those resulting from accidents or drug use; ii). supernatural or mystical sources, such as those resulting from the anger of the gods; iii). preternatural sources like in the case of witchcraft; and, iv) the inheritable conditions which can include mental retardation (Jegede, 2005).

Several studies have suggested that most indigenous African communities hold a view that there is continuous unity and harmony among the Supreme Being, the spirits and other living organisms, such as plants and animals, including human beings (Chidester, 1992, Crafford, 1996, Kadadiie & Osei, 1998). In this regard, many illnesses, including mental disabilities, are regarded as a sign of lack of harmony between the person and the environment (Cassel, 1991). The lack of harmony usually causes illnesses that destabilise relationships within communities. This harmony, in most African communities, is maintained by the ancestors who need to constantly communicate with the living.

In most traditional African communities in South Africa, various forms of mental illness such as *mafofonyane*, including other forms of disability such as mental retardation and Down syndrome are believed to be caused by a number of factors. These include: poisoning (Ngubane, 1977); pollution (Sodi, 1998); environmental hazards (Hammond-Tooke, 1981); ancestral displeasure (Ngubane, 1977); and, witchcraft (Hammond-Tooke, 1981). Perceptions about illness issues, such as diagnosis, cause and treatment are social constructs and thus reflect societal values and norms (Castillo, 1997; Heini, Ryder & Yang, 2002; Kleinman, 2004; Swartz, 1998). These norms and values differ across contexts because of differences in cultural assumptions about illness.

2.3. Theoretical framework: Afrocentric perspective

In most traditional African communities, including South Africa, various mental illnesses such as *mafofonyane* and other forms of disability such as mental retardation and Down syndrome are believed to be caused by a number of factors. These include: poisoning (Ngubane, 1977); pollution (Sodi, 1998); environmental hazards (Hammond-Tooke, 1981); ancestral displeasure (Ngubane, 1977); and, witchcraft (Hammond-Tooke, 1981). Perceptions about illness issues, such as diagnosis, cause and treatment are social constructs and thus reflect societal values and norms (Castillo, 1997; Heini, Ryder & Yang, 2002; Kleinman, 2004; Swartz, 1998). These norms and values differ across contexts because of differences in cultural assumptions about illness.

All societies have to respond to illness in the course of their development. Societies have long utilised their indigenous knowledge to formulate meaning around illness and also to find ways of managing illnesses. Such contextual differences in norms and values have implications for the classification, diagnosis, and management of illness. For instance, studies conducted in South Africa show how African people will simultaneously access the services of Western and traditional healers for the same symptoms based on the cultural conception that an illness is both physical and

spiritual. These services, for the most part, are used to complement each other (Berg, 2003).

In the case of witchcraft, it is believed that some people (known as witches) have the ability to manipulate some mystical forces and to use some concoctions which have the potential to inflict some forms of illness and disabilities on those that they do not like. In the search for meaning for their situation some parents may resort to traditional beliefs and see their child as the result of misfortune of their own, or as a blessing in disguise from God, sent to test their faith and fortitude (Fraser, 1998). This study will adopt an Afrocentric perspective because the researcher seeks to understand the experiences of mothers of children with mental retardation in an African context.

2.4. Reactions of family members

2.4.1 Reaction of parents

According to Marsh (1992), all family members are affected by the presence of disability; however, the mental retardation of a child undoubtedly poses special challenges for mothers. The care-giving role has been assumed to be fundamental for women, who have traditionally had primary responsibility for the needs of others, including men, children, and older persons. Consequently, they are likely to assume the primary care giving burden for children of any age with mental retardation, whatever their other responsibilities inside or outside of the home.

Research findings show that mental retardation can impact on family functioning in that families may have to make new adjustment to accommodate the child and higher special needs. The arrival of a new baby has a massive effect on any family, but there is a qualitative difference when the baby has a disability or special needs (Wicks-Nelson & Israel, 1997). Birth, for most families, is a time for rejoicing, for pride, for gathering together loved ones and sharing with them in the celebration of a renewal of life. For other families, birth may not be a joyful occasion. On the contrary,

it may be a time for tears, despair, confusion and fear for those who become parents of children with mental retardation (Alpher, Schloss & Schloss, 1994).

According to Seligman and Darling (1989), people live within a context of the family and when something happens to one member of the family, everyone is affected. Within a family there are four sub-systems, namely, marital, parental, siblings and extra families (extended family and friends). The birth of a child with mental retardation can be a traumatic and challenging event for a family (Hillier, Johnson & Harrison, 2002).

Marsh (1992), states that there is much evidence that family members experience a range of powerful emotions in response to a diagnosis of mental retardation, including denial, shock, anger, grief, guilt, embarrassment, withdrawal, depression and fear. Alpher, Schloss and Schloss, (1994), note that parents usually do not accept a diagnosis and may continue to shop for a new diagnosis or cure. They may also minimise the seriousness of the disability as they develop coping mechanisms.

In a study conducted by Kermanshahi et al. (2008) mothers of children with mental retardation were found to experience the following six major problems: a) challenging the process of acceptance; b) painful emotional reactions; c) the inter-relatedness of the mother's health and the child's well being; d) struggles to deal with oneself or the child; e) inadequate support from the family and community; and, f) anxiety related to the child's uncertain future.

2.4.2 Reaction of siblings

According to Snyman, (1993), having a brother or sister with a disability in the family provides siblings with special expectations and causes specific reactions. For example, being a sibling of a retarded child could evoke a range of emotional responses that may include pride, enjoyment, irritation or resentment. The siblings may react positively or negatively towards the retarded child. They may react positively by becoming more tolerant and patient with others and learn how to be helpful to others and may develop greater empathy and understanding for people

with disability. On the other hand, the presence of a mentally retarded child can bring negative effects on the non-retarded siblings. These negative effects may include: a) anxiety and conflicts with parents; b) lower sociability; and, c) adoption of life goals involving dedication and sacrifice (Snyman, 1993).

In a study which was conducted by Mulaudzi, (2001) the presence of mentally retarded children in the family was found to also have both negative and positive effects on the family relationships. 'Normal' siblings were found to feel resentful of the way their mentally retarded sibling was treated by their parents, particularly their mothers. They felt that the mentally retarded children were often rewarded for being 'victims'. She further found that the siblings of children with mental retardation who were interviewed stated that mentally retarded siblings were normally slow in performing different tasks but in return parents appeared to love them more than they loved their 'normal' children. Heller and Hsieh (1997) also found that 'normal' siblings often felt jealous since they felt they deserved the same treatment as their mentally retarded siblings.

2.5. Stages of grief in reaction to mental retardation

According Alpher, et al (1994) parents pass through a sequence of feelings and reactions after giving birth to a retarded child. These reactions include the following:

2.5.1. Disbelief: At first, parents will not accept the diagnosis and may continue shopping for a new diagnosis or cure. They may minimise the seriousness of the disability as they develop coping mechanisms. This is in accordance with Nsamenang (2000) who stated that after the diagnosis, they consult with other family members hoping to get a new diagnosis or cure.

2.5.2. Self blame: The parents may often develop an overwhelming feeling of guilt. Parents may experience regret about some of the things they think they should not have done. For example, some mothers may even believe that the disability is a result of something they did during pregnancy.

2.5.3. Anger and self-pity: Parents may feel helpless when they realise that they are unable to change the disability condition. This helplessness may develop into either anger or pity. Parents may displace their anger onto the professional, the spouse, or the institution. Self-pity and/or depression can be expected from parents of children with disabilities and should be permitted as parents wrestle with how to cope with their problems. This is also supported by Booth and Booth (2000).

2.5.4. Giving or sharing: A common type of parental reaction that usually takes place after the above three stages is giving or sharing, which results from acceptance of the condition. In this case, parents may volunteer to help other parents of children with disabilities. This is in accordance with Nonye and Oseloka (2009) (in Shai-Matlou, 2012) who highlights that there is an urgent need to increase community awareness about the scope and existence of mental health services and the amenability of mental illnesses to orthodox care, which should lead to positive attitudes that will enhance timely visits to a psychiatrist, as well as prompt treatment of conditions.

2.6. Ways of coping and dealing with mental retardation

People from different cultures may differ in their coping skills and help-seeking behaviour due to several reasons. Firstly, there may be variation in the way people experience the problem as a specific diagnosis or just symptoms. Secondly, different cultures can ascribe different meanings to symptoms. Thirdly, culture may influence the extent people are willing to disclose certain symptoms, especially because of perceived stigma. Finally, cultures influence the way symptoms are expressed and communicated when in contact with health care facilities and professionals. A study on the role of family member advice as a reason to seek health care in Oman

showed that the advice of family members remains a strong mechanism for care-seeking (Al-Busaidi, 2010).

Parents might achieve some degree of acceptance after the child's initial diagnosis, yet once again experience coping difficulties when the child fails to reach, or is delayed in accomplishing, other major developmental milestones such as crawling, talking, walking, begging school, attaining puberty, or reaching adulthood (Helton & Jackson, 1997).

Marsh (1992) defines coping as efforts to master demands that are appraised as exceeding or taxing an individual's resources. According to Nicholas and Polman (2006) people tend to use one of the three main coping strategies when dealing with circumstances that may be stressful to them: These strategies are: appraisal focused; problem-focused; or emotion-focused coping. Similarly, families who have children with mental retardation may adopt these strategies to cope with the disability.

2.6.1. Appraisal-focused: This occurs when a person modifies the way they think, for example, employing denial, or distancing oneself from the problem.

2.6.2. Problem-focused: This refers to efforts to improve the person-environment relationship by changing things. People who use this strategy try to deal with the cause of their problem. They do this by getting information on the problem and learning new skills to manage the problem.

2.6.3. Emotion-focused: This refers to thoughts or actions designed to relieve the emotional impact of stress. This may involve a number of activities like releasing pent-up emotion, distracting oneself, managing hostile feelings, meditating or using systematic relaxation procedures.

2.7. Conclusion

While the upbringing of all children can be taxing, there is no doubt that taking care of a mental retarded child frequently makes demands that go a long way beyond what is usually required of parents of non-disabled children. The amount of time, energy and direct caring work with the child tends to be greater and more complex than with the other children. Families of children with mental retardation experience a range of positive and negative emotions in response to mental retardation as such they tend to use different coping mechanisms.

CHAPTER 3

RESEARCH METHODOLOGY

3.1. Introduction

This chapter will focus on the methodology I employed in my study. The first section will focus on the research design that guided my investigation. Other sections will focus on sampling, data collection and data analysis. I will conclude the chapter with an overview of the ethical considerations that informed my study.

3.2. Research design

In my study, a qualitative research approach, and in particular the phenomenological method of inquiry was used. Qualitative research has been recognised as a legitimate way to obtain knowledge that might not be accessible through quantitative methods and to provide extensive data on how people interpret and act on their symptoms (Smith, Pope & Botha, 2005). According to Fouche and Delport (2005), qualitative research enables the researcher to study the human experience in a great deal of depth. Mayes, McConnell and Llewellyn, (2006) describe phenomenology as a school of thought that emphasises a focus on people's subjective experiences and interpretations of the world. In other words, the purpose of phenomenological research is to understand phenomena and the human experience from the perspective of the actors in a situation.

The phenomenological approach is also aimed at understanding and interpreting the meaning that subjects give to their everyday lives (De Vos, Strydom, Fouche & Delport, 2005). The approach, however, generates non-numerical data (Holloway, 1997). To qualitative researchers, behaviour is intentional and creative, and can only be explained and not predicted (De Vos, 2002). It is, therefore, defined as a "multi-perspective" approach (utilising different qualitative techniques and data collection methods) to social interaction in terms of the meanings that the subjects attach to it (De Vos, 2002).

3.3. Setting and sampling

The two special schools (Fulufhelo and Pfunanani) that were identified for the purpose of the present study were selected from the two districts. Fulufhelo Special School is in Vhembe District whilst Pfunanani Special School is in Mopani District. The participants in this study were selected through purposive sampling, which is a type of a non-probability sampling technique. In purposive sampling, cases are chosen because they illustrate some feature or process that is of interest for a particular study (Silverman, 2000) and researchers will be having a clear criterion in mind and rationale for their decisions (Creswell, 1998). Neumann (2000) points out that purposeful sampling are appropriate when one is looking to gain an in-depth understanding of people's experiences and for content analysis.

During my research I visited two special schools for children with mental retardation in Mopani and Vhembe districts in order to obtain the residential addresses and contact details of potential participants. I used the contact details obtained from schools to access the mothers. I called the mothers to set up appointments. Based on the above considerations, 12 mothers, between the ages of 26 and 45, were identified and selected to participate in the study. Six mothers were from Fulufhelo Special School whilst the other six mothers were obtained from Pfunanani Special School.

3.4. Demographic details of the participants

The participants were individually interviewed in two districts (i.e. Vhembe and Mopani) that are in Limpopo Province. As stipulated in the Constitution of the Republic of South Africa, Act 108 of 1996, Section 103, Limpopo is one of the nine provinces that constitute the Republic of South Africa. Vhembe District is one of the five districts of Limpopo Province. It is the northernmost district of the country and shares its border with Zimbabwe in the north. According to the 2001 census (Statistics South Africa, 2001), Vhembe is the largest district in terms of population size with about 1 127 000 Inhabitants (with VhaVenda being the predominant

population group, estimated at 800 000). The second highest population group (estimated at 300 000) is comprised of the Tsonga people whilst the Northern Sotho speaking people constitute the third largest population group at approximately 27000 people. Mopani District is the third (Statistics South Africa, 2001) largest district in Limpopo and has a population estimated at 964195 people. Most of the inhabitants of this district speak Xitsonga (468 120) whilst Northern Sotho is the second commonly spoken language (446 993 inhabitants).

As reflected in the table below (Table 1), the sample of this study comprised twelve (12) mothers (Fulufhelo Special School = 6 mothers; Pfunanani Special School = 6 mothers) who had children with mental retardation. Their ages ranged from 18-32 (33%) to 33-47(67%) years. Their mean age was 35 (SD: 5.8). Participants were included in the sample because they all had the common experiences of having children who have mental retardation. In terms of marital status, the results showed that four of the mothers (33%) were single, five (42%) were married, two (17%) were separated from their spouses, and one (8%) was widowed. The majority of the participants (70%) were unemployed. It was also found that most of the mothers (i.e. 90%) had only one child in the special school.

Name	Age	Marital status	Occupation	Name of the school	No of children in that school
Participant 1	26	Single	Not working	Fulufhelo	1
Participant 2	28	Single	Not working	Fulufhelo	1
Participant 3	29	Single	Self-employer	Pfunanani	1

Participant 4	33	Separated	Domestic worker	pfunanani	1
Participant 5	32	Married	Not working	Pfunanani	1
Participant 6	37	Married	Not working	Fulufhelo	1
Participant 7	35	Separated	Nanny	Fulufhelo	1
Participant 8	42	Married	Pensioner	Pfunanani	2
Participant 9	45	Married	Pensioner	Pfunanani	3
Participant 10	39	Married	Not working	Fulufhelo	1
Participant 11	37	Single	Not working	Pfunanani	1
Participant 12	36	Widow	Not working	Fulufhelo	1

Table 1: Demographic details of the participants

3.5. Data collection

The primary instrument of data collection in this study was semi-structured interviews. The participants were individually interviewed to explore their phenomenological experiences of living with a child who has mental retardation. A self-developed interview guide (see Appendix A1) was used as a primary instrument to collect data during individual interviews whilst focus group interviews were used as a secondary instrument. According to Babbie (2001), an interview guide ensures

that the interviewer covers the same material and keeps focused on the same predetermined topics and issues, while at the same time remaining conversational and free to probe into unanticipated circumstances and responses.

In my research I started the interviews by building rapport with the mothers. Before the interview was conducted, I asked for permission from the mothers, who were asked to sign a written consent form written in Xitsonga (see Appendix A2) stating that they agree to be interviewed. Confidentiality and anonymity were assured. Participants were informed that the interviews would be audio-taped and transcribed for analysis and that they could terminate their participation at any time. All the individual and focus group interviews were conducted in Xitsonga. Each individual interview was conducted at the participant's home.

After the individual interviews, I invited 6 mothers from Fulufhelo Special School to participate in a focus group interview (different from individual interviews) which was the secondary instrument of data collection in this study. This focus group interview was conducted in a classroom in the school. Similarly, another 6 mothers from Pfunanani Special School were invited to participate in a focus group interview that was conducted in a classroom at the school. The purpose of the focus group interviews was to triangulate the results. As Denzin (1978) puts it:

“... no single method ever adequately solves the problem of rival causal factors ... Because each method reveals different aspects of empirical reality, multiple methods must be used”.

3.6. Data analysis

According to Marshall and Rossman (1999), in qualitative research, data collection and analysis typically go hand in hand in order to build a coherent interpretation of the data. This means that the researcher starts making sense of the data whilst still in the field. All the audio-taped data protocols derived from the individual interviews were transcribed and then translated from Xitsonga to English by an English teacher.

Afterwards another translator (this time a Tsonga teacher) translated back to Xitsonga. The protocols were read again to ensure that objectivity was maintained and that there was no loss of information due to the process of translation. All this was done before the protocols were analysed.

The translated data protocols were analysed using the interpretative phenomenological analysis (IPA). According Denzin and Lincoln (2000), interpretative phenomenological analysis is an approach that seeks to explore in details how participants are making sense of their personal and social world. The following interpretive phenomenological analysis stages were followed by me, the researcher:

- **Managing data:** This is the first step in data analysis. During this stage I organised data into files folders. Besides organising files, I converted my files to appropriate text units, for example, a word, a sentence, an entire story, for analysis either by hand (De Vos, 2002).
- **Reading and writing memos:** I read the transcripts several times, trying to get a sense of the interview as a whole before breaking it into parts (De vos, 2002). I also read through the data to familiarise myself with both data and notes of the main concepts or ideas found in the transcripts
- **Describing, classifying and interpreting:** I described, classified and interpreted the data obtained. I also searched for explanation these data and the linkages among them.
- **Representing and visualising:** I presented the results from the investigation in a text form.

3.7. Ethical consideration

Before the study could be conducted, ethical clearance was obtained from the University of Limpopo's Research Ethics Committee. I fully informed the participants about the reason, aims, and purpose of the investigation before conducting the study. Participants were informed that participation is voluntary and that they can withdraw at any stage of the study. Their right to privacy was ensured. It was also explained to the participants that they would remain anonymous and that their real names would not be disclosed and that their identity would not be revealed in the research report. I, as the researcher, promised to use numbers rather than names to identify participants on all working documents such as data sheets, as well as in the final research report. It was further explained to them that the audio-tapes and all other data materials like field notes of their interviews would be completely destroyed after the research has been completed. I followed all these ethics in accordance with Strydom (2002).

CHAPTER 4

RESULTS

4.1. Introduction

I start by presenting the demographic characteristics of the participants followed by a phenomenological explication of the lived experiences of the participants. The phenomenological explication will entail presenting the results of the individual interviews and those of the focus group interviews separately. These individual and focus group results will be followed by a section where I, as researcher, will integrate the results of both the individual and focus group sections. Then, I will conclude this chapter by giving a summary of the findings.

4.2. Phenomenological explication

4.2.1. Individual interview results

4.2.1.1. Receiving a diagnosis: It is well known that mental retardation can be hard to detect before preschool, especially when there are no visible and facial features of it. Most mothers reported to have known of their children's' condition during their preschool years. For example, some mothers said:

He started schooling when he was 6, he passed Grade R well. The problem started when he was doing Grade 1; he started failing each Grade twice. He had to be condoned to move to the next Grade. This went on or several years until his teacher informed me his problem (Participant 1).

Teachers at the public school where they were attending before going to Pfunanani they told that they are not performing well, I should take them hospital (Participant 3).

Some participants have arrived at the knowledge of mental retardation primarily through comparison. They compared their children with other 'normal' children. The following extracts illustrate this:

My child is different from her siblings, she is weak in her body, she cannot walk properly, and she has a big head. She is unable to take care of herself this is evident by her inability to bath herself, feed herself and dress herself.

And he is unable to interact with other children (Participant 9).

Some mothers were found to have arrived at the knowledge of their children's condition through observation. This is what some mothers said:

I noticed some abnormalities just 3 days after birth, and then I took them to Letaba Hospital. They were examined by a white doctor who said I should take them back when they are four years old. After four year I went back to the hospital that is when they told me they are mentally retarded (Participant 2).

I had my suspicions but I knew for sure when we went to the hospital for the second time that is when the doctor told me (Participant 4).

Mothers seem to have been hurt by their children's' diagnosis as reflected in the following extracts:

It was the hardest and unpleasant news I have ever heard in my entire life. It was difficult for the whole family to accept especially for his father but as times went by we all came to terms with the situation (Participant 3).

I do not want to lie it was hard no pain can be compared to it. I wished I would disappear and be no more. I tell you is not nice to know that your child will never be like other children but as time went by I came to terms with the situation (Participant 12).

Many community members treated mothers and their children badly after the diagnosis. However, it appears these community members became receptive as time went on. The following extracts illustrate this point:

The community members used to laugh at her and call her “dunderheaded”, but now they are used to her (Participant 8).

The community members used to laugh at him and called him names, but now they are fine. Some relatives were very good while others enjoyed our misery (Participant 6).

There were also few community members and relatives who were supportive of the mothers and their children as indicated in the following extracts:

The community members were nice and still are nice to us. My relatives were very good and supportive especial my sister I could not have made it without her. She was there with me every step of the way (Participant 4).

The community members and relatives were kind and supportive (Participant 1).

4.2.1.2. Mothers’ notions of mental retardation: Participants appear to understand mental retardation in different ways. Others tended to view mental retardation as gift from God. For example:

My understanding is that no one chooses to be mental retarded but God decides who should be mental retarded. I also understand that a mental retarded child different from other children that is why they need extra love and care (Participant 10).

My understanding is that Mental Retardation is a gift from God. God is a creator of mankind and he decides who should be disabled or not (Participant 8).

Still there were other notions of mental illness communicated by the mothers as indicated in the following extracts:

My understanding is that mental retardation is incurable and that my child will be in this condition for the rest of her life. Furthermore, it is not because I am the worse sinner in the world but it is the will of God (Participant 4).

My understanding is that having a mental retarded child is not a curse rather a challenge which needs to test your faith (Participant 7).

Some participants found it hard to accept when the professionals diagnosed their children even though they had suspected that their children could be mentally retarded:

Even though I had my suspicions; it was hard to hear the doctor say it (Participant 2).

I was hurt, it was hard for me to accept but as time went by I learn to leave with the situation (a tear dropped) (Participant 1).

In the interviews analysed, mental retardation was frequently constructed in terms of 'inappropriate or different' behaviour on the children with mental retardation. The following extracts illustrate this:

He has infant-like behaviour and he likes playing with children younger than him (Participant 9).

He has an infant like behaviour which does not correspond with his age (Participant 5).

Other mothers explained their children to be quiet and that they do not like interacting with other children. The following extracts illustrate this point:

He is always quite and passive in class but outside he is a trouble maker and violet (Participant 8).

And he is unable to interact with other children (Participant 12).

Some mothers described their children to be violent and aggressive towards other people. For example:

He is always quite and passive in class but outside he is a trouble maker, aggressive and violet (Participant 6).

He is aggressive and violent towards other children and he does not listen to his teachers at school (Participant 3).

Some participants tended to conceptualise mental retardation as a phenomenon which manifests in the form of cognitive difficulties like poor school performance,

difficulties in doing calculations and forgetfulness. Here are some of the statements by participants to illustrate this:

He started schooling when he was 6, he passed Grade R well. The problem started when he was doing Grade 1; he started failing each Grade twice. He had to be condoned to move to the next Grade. This went on for several years until his teacher informed me his problem (Participant 11).

They told me that they were condoning her from Grade R and that she cannot concentrate for a long time in class and that she forgets a lot (Participant 2).

She has a problem when it comes to money, when you ask her to give someone change it is either she gives them more or less change (Participant 8).

There were some participants who tended to conceptualise mental retardation in terms of some physical problems or atypical physical features. The following extracts are illustrative of this:

She is weak in her body and she has a small head, and she is unable to take care of herself, she cannot dress herself and use the bathroom on her own (Participant 12).

The twins are unable to do basic things like bathing themselves, dressing themselves and brushing their teeth. They cannot talk proper, also have disfigured face (Participant 1).

She also has a problem in speech, if you are not used to her you will not understand what she says but when do understand her because we are used to her (Participant 9).

He cannot bath himself, he is weak in his body and saliva comes out continuously (Participant 5).

As indicated in the extracts above, it does appear that mothers tend to describe mental retardation as a condition that manifests in the form of behavioural, cognitive and physical problems. It was also noted that some participants tended to understand mental retardation as a condition that is typified by some atypical physical features that are shown by the child.

4.2.1.3. Mothers' understanding of the causes of mental retardation: Many participants had different views regarding the cause of mental retardation. Some believed that their children inherited mental retardation from their family members and relatives.

I think they inherited it from me and my mother (Participant 10).

I think he inherited it from her aunt, she is also mental retarded (Participant 6).

Others believe that their children were bewitched. For example:

Just when she was discharged, I took her to a sangoma (traditional healer), who told me that my child has been witched (Participant 3).

I think he had been bewitched by my mother-in law because she does not like me. We had to separate with my father's child because of her. Even though we have separated with her son, she goes around the village gossiping me. So I think she is the one who bewitched him (Participant 4).

Here are other views that the participants had regarding the cause of mental retardation:

I think is because I was drinking alcohol and smoking cigarettes when I was pregnant. Another lady in my village used to tell me that I would give birth to a mental retarded child if I do not quit smoking but I did not quit because I was not ready to have a child (Participant 11).

I think is because there were complications during birth, i could not breathe well (Participant 7).

4.2.1.4. Living with a child with mental retardation: It does appear that living with a child who has mental retardation invokes some considerable emotional pain for the mothers as illustrated in the following examples:

It is very difficult you need all the help you can get. Having a mental retarded child is challenging and demanding, you need all the support you can get from friends, relatives and family members (Participant 4).

It is very hard and painful moreover if you have big dreams for your child. A mentally retarded child is expensive and fragile you cannot make it without support from family members and relatives (Participant 9).

Participants also reported to have problems when it comes to money because most of them are not working.

It is very difficult, you have to be patient. It is hard for me because I am not working, and he does not get a grant. His step-father is trying his best but it is not enough to take care of the whole family and pay for his tuition fees and transport. His father passed away when he was young (Participant 2).

It is very hard and challenging especially if you are not working. Grooming a mentally retarded child is expensive and emotional one needs all the help you can get. My husband is working but the money is not enough to take care of the whole family and pay for his tuition fees and transport (Participant 10).

Based on the above extracts, it does appear that mothers with mental retardation suffer a great deal of emotional pain. Some of them were found to be considerably worried about their poor financial position that makes it hard for them to cope.

4.2.2. Focus group interview results

4.2.2.1. Receiving a diagnosis: It does appear from the focus group interviews that most mothers realised long after birth that their children had mental retardation. This was even more difficult to detect in case of children who did not show any physical features of mental retardation. The following extracts illustrate this point:

I brought mine to Fulufhelo special school after her teacher called me in the school where she was attending before coming here. They told me that she does not perform well at school, she keeps on failing, and she does not listen and cannot read (Participant 12).

Mine was also not passing in the school where she was learning before coming here. She was failing every grade until they condoned her to the next

grade. Then they called me to school, they told me that she is always failing and she cannot write (Participant 3).

Some participants had arrived at the knowledge of their children's mental retardation by comparing them with other normal children as reflected in the following extracts:

She is 19 years but she cannot cook not even soft porridge like other girls of her age (Participant 9).

Mine is 14 but she is unable to do lady's chores like cooking and washing dishes and sweeping the yard (Participant 7).

For some parents, the condition of their children was detected through observation of what appeared to be atypical conduct. For example:

I had my suspicions but I knew for sure when we went to the hospital for the second time that is when the doctor told me (Participant 8).

I noticed some abnormalities few months after birth but I did not take it serious. I knew for sure when I took them to Letaba Hospital (Participant 3).

Most of the children were brought to the two special schools after they were assessed and diagnosed by the professionals. The following examples illustrate this point:

I took him to Malamulele hospital, where many medical tests and examinations were done for several months. After a long wait for test results, they told me that my child is mentally retarded. I was then given a letter to come here and register my child (Participant 10).

I brought my child here after the doctors told me that my child was mentally retarded, and they said that she must not stay at home because she may think that she is useless. They then gave me letter to register her in this school (Participant 4).

The extracts below suggest that all the mothers were hurt by their children's' diagnosis.

It was also difficult for me although I could tell he had a problem, I felt like I was dreaming. I never thought it will happen to me or my son. It was not easy but I have accepted it (Participant 9).

It was also hard for me; it took me months to accept it until I went for counselling. I am fine now, the sessions with the psychologist helped me a lot (Participant 12).

There were mixed reactions from community members upon realization of mental retardation. It does appear that the initial reaction by community members would be rejection which is followed by acceptance afterwards. The following examples demonstrate this:

You know people from a village; they used to laugh at her saying she is stupid, but now they are fine (Participant 8).

The same happened to my child; they laughed and scorned him when they knew about his condition. Everybody was talking about us (Participant 5).

There were also few community members and relatives who were supportive of the mothers and their children.

Where I am from, they were very understanding and my relatives were supportive (Participant 1).

The community members and relatives were kind and supportive (Participant 3).

4.2.2.2. Participants' notions of mental retardation: Mothers of children with mental retardation tend to have different views regarding what causes the condition as reflected in the following extracts:

I think it is a gift from God as we all know that God gives us good and bad things. All we have to do is to embrace them. I admit, it is not ideal to have a mentally retarded child but God knows why He gave them to us (other parents seems to agree with her by nodding their heads) (Participant 7).

I also agree that it is a gift from God because God gives both the good and bad. It does not make me happy that my child is in this condition but only God knows why he gave me a mentally retarded child (Participant 11).

My understanding is that mental retardation is incurable and that my child will be in this condition for the rest of her life. Furthermore, it is not because I am the worse sinner in the world but it is the will of God (Participant 6).

My understanding is that mental retardation is not a curse but anyone, irrespective of age and gender may be a victim of mental retardation (Participant 2).

Some participants found it hard to accept when the professionals diagnosed their children even though they had some suspicions:

It was very difficult for to accept this condition, I did not understand why this happened to me. But through the help of God I eventually understood **(Participant 7).**

It also took me time to accept the condition of my child, because I had a lot planned for my child. Unfortunately the plan did not include this condition **(Participant 9).**

As indicated below, participants constructed mental retardation in terms of the following: 'inappropriate' or 'different' behaviour, cognitive difficulties and physiological problems.

From the focus group discussions, it does appear that mental retardation is understood and explained in terms of behaviour that is inappropriate and different. The following extracts illustrate this:

She is also fragile and sensitive, and always crying unnecessary **(Participant 9).**

He has an infant like behaviour which does not correspond with his age **(Participant 7).**

In some cases, violent and aggressive behaviour appear to be seen as indications of mental retardation. For example:

My child likes playing rough games with other children; he would beat and bite them **(Participant 11).**

He is quick to anger, if you correct him while he is doing wrong; he becomes very angry that he even refuses to eat (Participant 9).

Other mothers observed their children to be more quiet and unable to interact with other children, as illustrated in the following extracts:

She is passive she does not want to play with other children (Participant 4).

He is always quite and passive in class but outside he is a trouble maker and violent (Participant 11).

It does appear that mothers tend to describe mental retardation in terms of cognitive difficulties like poor school performance, difficulties in doing calculations and forgetfulness. The following extracts reflect this:

My child was not performing well at school, she was always failing and could not even read vernacular (Xitsonga) and add numbers (Participant 4).

With my child, they also called at school because he also was not passing and very forgetful. What they teach in class today he cannot recall the following day (Participant 1).

Mine was also not passing in the school where she was learning before coming here. She was failing every grade until they condoned her to the next grade. Then they called me to school, they told me that she is always failing and she cannot write (Participant 8).

In some cases, physical problems and atypical physical features were the seen as indicative of mental retardation as reflected in the following examples:

Her face is disfigured and when she speaks some words are not audible (Participant 11).

He is weak on her body and his hands are not straight, he cannot use the bathroom on his own and he cannot clean his nose (Participant 10).

My child is weak in his body, cannot speak properly, and cannot feed himself. I always have to be around to feed him (Participant 5).

Based on the above extracts it does appear that mothers tend to see that their children have some mental retardation when they show some behavioural and cognitive difficulties. It does also appear that physical problems and atypical physical features are also indications that a child has mental retardation.

4.2.2.3. Participants' causal explanations of mental retardation: There were different views expressed by mothers in terms of what is perceived as the cause of mental retardation. The following extracts illustrate this:

I think she got it from her grandfather from her fathers' side (Participant 3).

His father's aunt is mental retarded so i think he inherited it from him (Participant 5).

Others believe that their children were bewitched. For example:

The sangoma told me that my child had been bewitched by someone very close to me (Participant 8).

I do not know about others but I think my child has been bewitched in that she was well until that day when her legs could not move and bend, I think it all started there (Participant 10).

Other views regarding causes of mental retardation were also expressed:

I think is because he got burnt with hot water when he was 5 years old (Participant 2).

He was seriously injured to the extent that he was hospitalised for months. He started to have a speech problem, being aggressive towards other children and failing after that incident (Participant 7).

My sister in law who is a nurse told me that is because I was over 35 when a gave birth to the twins and that my blood pressure was high when I was pregnant (Participant 2).

It does appear from the focus group interviews that there are divergent views about the causes of mental retardation. Generally, the mothers tended to see mental retardation as a condition that is a result of heredity, bewitchment, maternal illnesses and injuries sustained by the child early in life.

4.2.2.4. Participants' experiences of living with mental retardation in the family: The results of the study suggest that the mothers constantly experience some painful

emotions associated with having to live with a child who has mental retardation. For example:

It is very difficult; you must be patient and strong because a mentally retarded child can be difficult to live with (Participant 9).

It is also not easy for me, because you need to have money for the child to live a good and healthy life (Participant 3).

Financial problems were also mentioned by mothers as a challenge of having to live with mental retardation in the family, as illustrated in the following examples:

When it comes to money issues is worse because he does not get grant and I do not earn enough money to feed the whole family and his father passed away some years back (Participant 11).

The only difficulty is with finances, because she does not get grant. We only have one salary to do everything including paying her school fees and transport. And as it stands this salary is not enough for everything (Participant 7).

It is also difficult for me, particularly when it comes to finances because he does not get a grant. Yet I have to pay for his tuition fees and for his transport (Participant 5).

4.2.3. Integration of individual interview and focus group results

4.2.3.1. Psychological reactions of mothers to a diagnosis of mental retardation: As expected, the mothers who were interviewed for the study experienced a range of powerful emotions in response to the diagnosis of their children. Withdrawal and embarrassment appear to have been common reactions by the mothers as reflected in the following extracts:

Now I can attend funerals and community meetings and parties without being stared at or laughed at (Participant 1).

Nowadays I am able to attend funerals and attend to community meetings and parties because I could leave me alone he needed 24 hours supervision. I do not have to bath him on a daily basis because he only comes home during vacations. I am very grateful this school has helped use a lot (Participant 6).

Nowadays I am able to go to town for the whole day without worrying about her. I can visit my friends any time now (Participant 5)

This school has helped me in that now I can attend funerals and community meeting. Before I could not because I was embarrassed (Participant 8)

It was hard I had many questions without answers, I asked myself if would be able to look after a mental retarded child (Participant 3).

Some mothers were shocked by the diagnosis because they never thought that they would have a mentally retarded child, while others were shocked because their children seemed normal like other children

She was not clever from birth. That is the reason I could tell that she is mentally retarded (Participant 1).

I could tell after been discharged that he was different but I never thought he was mental retarded until they called me at school (Participant 6).

Some participants responded negatively by denying the diagnosis at first. For example:

I did not believe that my child is not normal but as time goes on I came to terms with the situation (Participant 7).

Some mothers tended to blame themselves for their children's conditions as reflected in the following extracts:

I think it is because I was drinking alcohol and smoking cigarettes when I was pregnant (Participant 12).

Another lady in my village used to tell me that I would give birth to a mentally retarded child if I do not quit smoking but I did not quit because I was not ready to have a child. Sometimes I wished I would give birth to a dead baby (Participant 1).

Some mothers felt helpless upon realising that they had a child who is mentally retarded. The following extract illustrates this:

It was hard, but there was nothing that I could do. I had to come to terms with the situation (Participant 8).

Based on the above findings, it could be suggested that the psychological reactions by mothers whose children are diagnosed with mental retardation are varied. These include withdrawal, embarrassment, shock, denial, self blame and feelings of helplessness.

4.2.3.2. Mothers' understanding and interpretation of mental retardation: There were different interpretations given to the causes of mental retardation. For some mothers, mental retardation was perceived as a condition that can affect anyone. In some cases, it was even understood to be a gift from God. For example:

I think it is a gift from God as we all know that God gives us good and bad things. All we have to do is to embrace them. I admit, it is not ideal to have a mentally retarded child but God knows why He gave them to us (other parents seems to agree with her by nodding their heads) (Participant 4).

I also agree that it is a gift from God because God gives both the good and bad. It does not make me happy that my child is in this condition but only God knows why he gave me a mentally retarded child (Participant 9).

My understanding is that mental retardation is incurable and that my child will be in this condition for the rest of her life. Furthermore, it is not because I am the worse sinner in the world but it is the will of God (Participant 6).

My understanding is that mental retardation is not a curse but anyone, irrespective of age and gender may be a victim of mental retardation (Participant 2)

Most mothers explained mental retardation as a learning problem. Most of them explained mental retardation as a phenomenon which is typified by some

behavioural problems, cognitive difficulties and poor performance at school. Here are some of the relevant statements by participants:

He is a slow learner and she cannot write properly, he cannot even write his name (Participant 10).

My child was not performing well at school, she was always failing and could not even read vernacular (Xitsonga) and add numbers (Participant 3).

She is a slow learner. After graduating from crèche she went to learn at Gavaza primary school where she was doing Grade R. At Grade R she could write her name but she pass because the class teacher was our relative. As from Grade 1 she started repeating every Grade twice. After seeing her school reports I started to teach her at home but she failed to learn when I persist she told me that she wants to learn but she cannot (Participant 11).

4.2.3.3. Coping with mental retardation: The mothers' lived experiences: As expected when people are affected by the presence of a mentally retarded child in the family, they tend to use several coping strategies. Below are some of the strategies that most mothers seemed to have employed to cope with mental retardation:

a). Learnt patience: Some mothers reported to have learned to be patient with their children as a coping mechanism. For example:

Yo! It is very hard, is not a child's play you have to be patient (Participant 12)

It is not easy. It is not a child's play. You have to be patient because they can drive you crazy sometimes (Participant 4).

b). Belief in ‘divine intervention’: Belief in ‘divine intervention’ was employed by several mothers to deal with their children’s condition. Most mothers understand mental retardation as a gift from God which would never be changed by human beings, but by God in due time.

My pastor and few other pastors prayed for him several times but he was not healed. I think God will heal him when the time is right (Participant 7).

c). Lowering expectations: Mothers of children with mental retardation tended to lower their expectations as a means of dealing with their children’s condition. For example:

It’s very hard. It is not a child’s play, especially if you have good plan for your child (Participant 5).

It also took me time to accept the condition of my child, because I had a lot planned for my child. Unfortunately the plan did not include this condition (Participant 11).

4.3. Concluding remarks:

Based on the findings in the current study, it is evident that mental retardation in the family is a serious condition that does not only affect the person with mental retardation but also the parents, more especially the mother. Consequently, different coping mechanisms are employed by the mothers to deal with the condition.

CHAPTER 5

DISCUSSION

5.1. Introduction

This chapter will discuss the findings of my study in relation to the literature review and other related information. It also reviews the contribution of the study in terms of the aims set out in Chapter 1. It will also focus on the summary and conclusion of the study, limitations of the study and recommendations. The findings of the study will be presented according to the emerging themes identified in the previous chapter. Consequently the following five themes appear to have emerged from the findings: understanding mental retardation; causal explanations of mental retardation; receiving a diagnosis; reactions of family members to a diagnosis; and, living with mental retardation

5.2. Understanding of mental retardation

According to Helton and Jackson (1997), developmental disabilities are defined as those problems occurring in individuals at birth or before the age of 22 years and also affecting three or more areas of functioning, including such skills as receptive and expressive language, mobility, cognitive and self-care. These conditions generally last throughout the individual's lifetime and require multifaceted, long-term care disorder, mental retardation and Autism.

In my study, participants explained mental retardation mostly in terms of their own personal experiences, making use of the symptoms they experienced during the course of their distress. The explanations given varied from general disturbance of the thought processes, poor or lack of insight, impairment in social functioning to somatic complaints.

My study discovered that mothers' construction of mental retardation was complex. Firstly, mothers constructed mental retardation in terms of religious conviction in that they viewed mental retardation as a gift from God. Most mothers interpreted their children's condition positively by thinking it is the will of God and God will heal them in due time (Lawyer, 2010).

Secondly, few mothers seemed to have a clue of what mental retardation is because they constructed mental retardation as an incurable condition which can be managed not healed. Nicholas (2003) supports this by saying that mental retardation is usually a lifelong condition.

Thirdly, mothers constructed mental retardation in terms of 'different' or 'inappropriate' behaviour on the part of the individual with mental retardation. Such 'different' behaviour is one of the categories reported by Roeyers and Mycke (1995).

The present study found that mental retardation, as expected was also constructed in terms of cognitive functioning. Many mothers explained mental retardation as a phenomenon which is typified by cognitive difficulties, reflected particularly in poor performance at school. This finding is in line with American Psychiatric Association (2000) view of mental retardation is associated with substantial limitation in an individual's present social and intellectual functioning. It also corresponds with Parekh and Jackson's (1997) view that mental retardation is characterised first and foremost by a 'slowed down' version of normal cognitive developmental process.

Lastly, mental retardation was constructed in terms of difficulties with physiological functioning. This corresponds with Kromberg, Mangal, Zwane, Rosen, Venter and Homer (1997), who discovered that many children with mental retardation have other physiological difficulties, including speech problems.

5.3. Causes and causal explanations of mental retardation

According to the findings in the present study, the participants seem to hold varying perceptions and beliefs in as far as the causes of mental illness are concerned. These perceptions appear to be culturally defined. Most participants made use of their own experiences in defining what mental illness is, such as the symptoms experienced during the course of the illness.

The subjective notions of the participants in the study in terms of the events and factors that could have led to their mental retardation indicate that substance use, heredity, witchcraft and social stressors were regarded as the cause of their illness. Each specific cause was dependent on the knowledge of the nature of the disease, one's belief system and particularly own formulations of what could be the cause. Although these individuals have one thing in common, i.e., suffering from a mental disorder, they have their own unique ways of defining what could be the cause of their illness, and these perceptions appear to be culturally defined. This particular finding in the present study is consistent with findings of previous studies that have suggested that there are some regional variations in Africa relating to what can be considered the causes of these conditions (Patel, 1998, Olugbile, Zachariah, Kuyinu, Coker, Ojo & Isichei, 2009). For example, in some African communities in places like Nigeria and South Africa, some mental illness including intellectual disabilities may be seen to be the result of witchcraft and ancestral displeasure ((Jegade, 2005; Sodi, 1998; Hammond-Tooke, 1981; Ngubane, 1977).

It was found that many mothers see heredity as a cause of mental retardation in that some of the parents or their family members are mentally retarded or have some form of mental illness. Few mothers have reported witchcraft as a cause of their children's' condition. While others reported drinking alcohol, smoking cigarettes and social stressors such as burning as cause of their children's condition.

In the present study, it was found that mothers' causal explanation of mental retardation relates to children with special needs and learning problems. Most mothers, when asked to explain the condition of their children, reported their children

to have poor performance at school and to be children with special needs. Almost all mothers seemed not to know and understand mental retardation, its cause, and management from a medical perspective.

According to Read (2000), services provided should give information regarding the causes, treatment and management of diseases after diagnosis. It further states that having a disabled child necessitates involvement with different professionals. The study reveals that mothers of children with mental retardation, who took part in this study, did not get clear information regarding the cause and management of mental retardation. Mothers also reported not to have had counselling before and after the diagnosis. There was no training offered on how to care for their children. They reported to have acquired skills on how to handle and live with their children through their direct interaction with these children.

5.4. Receiving a diagnosis

Many problems are not noticeable at birth but only develop or become noticeable, as children grow older (Kimpton, 1990). My study reveals that most mothers who took part were not aware of their children's condition until later in life. My study also finds that the involvement of school also helped in terms of discovering the condition of most children in the early years of their lives. This is in accordance with Rohrer (2005). Such children were seen as being unfit for a regular or public school and as such parents were advised to take them to hospital. I also discovered that doctors were mainly the first group of professionals mentioned by mothers because mostly they give the initial diagnosis, check on the children and refer to other professionals (Holmes, 2000).

Some mothers of children with mental retardation, whom I interviewed, arrived at the knowledge of mental retardation through comparison. They compared their children

with their 'normal' children. While others arrived at the knowledge of their children's condition through observations.

The interpretation of these findings is that mothers were not informed immediately after the birth of their children about the child's condition. Professionals only did the formal disclosure after the parents have communicated their suspicious and uncertainty about the child's condition. Few of them consulted with the traditional doctors trying to get an explanation of what might be the problem with their child but did not bring any change.

5.5. Reactions of family members to a diagnosis

Marsh (1992) and Davis (1993) states that there is much evidence that family members experience a range of powerful emotions in response to a diagnosis of mental retardation, including denial, shock, anger, grief, guilt, embarrassment, bitterness, sadness, uncertainty, disbelief, disappointment, unhappiness, suffering, numbness, withdrawal, depression and fear.

At the disclosure of the diagnosis, mothers reported to have felt most of the emotions mentioned above. They felt as if the world had suddenly changed. In the present study, mothers reported to have been treated differently from family members and community members. Most of the mothers in the study revealed to have enjoyed support from family members. They reported how their other children, husband and sisters have assisted them in the care of their mental retarded children. Their own spouses and other children were found to be very supportive and encouraging immediately after the diagnosis.

Some mothers reported to have found the community members partially supportive. Mothers emphasized the fact that people are different. Some were supportive and helpful whereas others were not and they often make rude comments and mock their children. The majority of them were found not to be supportive though.

5.7. Living with mental retardation

It was found in the present study that living with a mentally retarded child is difficult. All mothers reported to expressed painful emotions when living with mental retarded children (Heron, 1998). Some used to receive complaints about their children's aggressive behaviour before they went to a special school. Few could not attend funerals, parties and community meeting because they were ashamed of being laughed at. The majority of the mothers reported to have financial problems because they are not working and their children do not get Care Dependency Grant. According to the Mental Health Care Act (2002) children with mental retardation are entitled to Care Dependency Grant.

One area in which disablement makes its impact is that of family finances. Disability usually involves extra expenses, for example, medical care, special school, teaching aid and domestic help. For both unemployed single and married mothers poverty is inevitable (Helton & Jackson, 1997). The White Paper for Social Welfare (1997) states that the financial, social and emotional resources of families are taxed when they have to care for members who have special needs and problems.

Furthermore, the study found found that the families could not afford to educate their children adequately due to financial constrains as such they were owning special school tuition fees. Mothers reported to have financial strain in that they are supposed to pay towards their children's tuition fees, transport fees and all basic needs. The spouses of the mothers did not have decent paying jobs and, therefore, did not earn much to enable them to meet all their financial needs. Consequently,

mothers expressed the difficulties they encountered in satisfying the financial needs of their families and those of their retarded child. It is evident through this report that caring for the child with a mental retardation has never been easy for the mothers who took part in the study.

5.8. Coping with mental retardation: The mothers' lived experiences

When mothers are affected by the presence of a child with mental retardation in their family, they tended to adopt several coping strategies:

- **Resignation and lowering of expectations:** Mothers of children with mental retardation tended to resign themselves and to lower their expectations as a means of dealing with their children's condition. This is consistent with the results of a study by Seltzer and Greenberg (1997).
- **Belief in 'divine intervention':** It was found that understanding mental retardation as God's will, which can or cannot be changed when God wants, was employed by some mothers to deal with their children's condition.
- **Learnt patience:** Some mothers reported to have learned to be patient with their children as a coping mechanism.

5.9. Concluding remarks

The overall findings of my study show that mental retardation does have a great impact on family especially mothers. It also reflects that all mothers handle diagnosis differently from each other and that they view mental retardation differently. I also discovered that it is not easy to have and to raise a mentally retarded child.

CHAPTER 6

SUMMARY AND CONCLUSION

6.1. Summary of findings

In this study I sought to understand the experiences of mother of children with mental retardation were presented. Specifically, the objectives of the study were:

- To understand and describe the mothers' understanding of what mental retardation is;
- To understand and describe the mothers' explanations and views regarding the causes of mental retardation;
- To understand and describe the mothers' experiences of living with children with mental retardation; and,
- To understand and describe the mothers' views regarding how best mental retardation can be managed.

It was found that mothers of children with mental retardation tended to construct mental retardation in terms of behavioural, cognitive and physical problems, including atypical physical features. Most of the mothers arrived at their construction of mental retardation by comparing their mentally retarded children with other children. All mothers were found to be experiencing challenges of having to live with a mentally retarded child. Most of the mothers experienced painful emotions regarding their children's conditions. Consequently, most mothers had to develop coping mechanisms such as learnt patience, belief in divine intervention, resignation and lowered expectations.

6.2. Limitations of the study

The researcher is aware of the considerable limitations of the study of this nature. Firstly, translating the interview data from Xitsonga into English might have led to omissions or inappropriate substitutions of the original rich material provided by the participants.

Secondly, the results of the present study cannot be generalised to the larger South African population since my study was conducted on the sample of mothers of children with mental retardation in two special schools in Mopani and Vhembe district of Limpopo Province. If perhaps other districts and regional special schools in the province were included, the scope would have been broadened, thus making it appropriate to generalise the results to the entire province. The present research could, however, be used as a basis for further research.

6.3. Recommendations

Based on the findings of this study, the following recommendations are made:

- The findings derived from this study could be utilised to help sensitise and inform health policy makers in developing programmes that could cater for the psychological needs of mentally retarded children and their families.
- Families of children with mental retardation should be provided with financial aid for equipment, training, transport and tuition fees since many mothers reported not to have enough money to take care of their children's needs.
- The disclosure of mental retardation must be done immediately after the birth of the child and follow up visits must be made by professionals in that many mothers did not about their children's condition until pre-school.
- Families need assistance in dealing with problems in the bigger society, for example, the issues of stigma and isolation because many children were ill-treated and called with impolite names.
- Parents of children with mental retardation should be provided with adequate facilities to enhance their coping because most of them were never referred to a psychologist for coping mechanisms and therapy.

- Efforts should be made to make communities aware of mental retardation, its causes, and treatment and how it can be managed.
- Families of children with mental retardation should be provided with adequate medical and psychological services whenever necessary to help them to cope better. In this regard, the services of psychology practitioners, medical practitioners, social workers and nurses could be helpful.

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APPENDIX A: UNSTRUCTURED INTERVIEW GUIDE

Interview guide (English A1).

1. As a mother of a child with mental retardation, I would like you to share with me your own understanding of what mental retardation is?
2. Having lived with mental retardation in your family, can you share with me what your understanding is regarding the causes of this condition?
3. Kindly share with me your own experiences of living with a child who has been diagnosed to be having mental retardation?
4. Looking at the condition of mental retardation, what would you consider to be the best way or ways to manage mental retardation?

Interview guide (Xitsonga A2)

1. Tani hi manana wa n'wana loyi a vabyaku emiehleketweni, xana mi twisisa yini hi vuvabyi bya miehleketo?
2. Tani hi leswi mihanyaka na munhu loyi a vabyaka emiehleketweni, xana mi nga va mitwisisa leswaku vubyi bya miehleketo byi nga va byi vangiwa hi yini?
3. Mi nga hi nyika ntokoto lowu mi nga na wona wo hanya na n'wana loyi anga na vuvabyi bya miehleketo?
4. Loko hi languta vuvabyi lebyi, xana mi vona ku ri yini ndlela yo antswa leyi nga tirhisiwaka ku lawula vuvabyi lebyi?

APPENDIX B: FOCUS GROUP INTERVIEW GUIDE

Interview guide (English B1)

1. As mothers of children with mental retardation, I would like you to share with us your own understanding of what mental retardation is.
2. Having lived with mental retardation in your families, can you share with us what your understanding is regarding the causes of this condition?
3. Kindly share with us your own experiences of living with a child who has been diagnosed to be having mental retardation.
4. Looking at the condition of mental retardation, what would you consider to be the best way or ways to manage mental retardation?

Interview guide (Xitsonga B2)

1. Tani hi vanana wa n'wana loyi a vabyaku emiehleketweni, xana mi twisisa yini hi vuvabyi bya miehleketo?
2. Tani hi leswi mihanyaka na munhu loyi a vabyaka emiehleketweni, xana mi nga va mitwisisa leswaku vubyi bya miehleketo byi nga va byi vangywa hi yini?
3. Mi nga hi nyika ntokoto lowu mi nga na wona wo hanya na n'wana loyi anga na vuvabyi bya miehleketo?
4. Loko hi languta vuvabyi lebyi, xana mi vona ku ri yini ndlela yo antswa leyi nga tirhisiwaka ku lawula vuvabyi lebyi?

APPENDIX C1: PARTICIPANT CONSENT LETTER AND FORM (English)

Department of Psychology
University of Limpopo (Turfloop Campus)
Private Bag X1106
Sovenga
0727
Date: _____

Dear participant

Thank you for demonstrating interest in this study that focuses on the experiences of mothers of children with mental retardation in Mopani and Vhembe Districts. The purpose of this study is mainly to understand the mothers own experiences of having a child with mental retardation.

Your responses to this individual interview/focus group interview will remain strictly confidential. The researcher will not attempt to identify you with your responses to the interview questions or to disclose your name as a participant in the study. Please be advised that participating in this study is voluntary and that you have the right to terminate your participation at any time.

Kindly answer all the questions and reflect your true reaction .Your participation in this research is very important .Thank you for your time

Sincerely

Tsakani Glory Rikhotso
Masters Student

Prof T Sodi
Supervisor

Date

Date

APPENDIX C: CONSENT FORM TO BE SIGNED BY PARTICIPANT

CONSENT FORM

I _____ hereby agree to participate in a Masters research project that focuses on the experiences of mothers of children with mental retardation in Mopani and Vhembe Districts.

The purpose of the study has been fully explained to me. I further understand that I am participating freely and without being forced in any way to do so. I also understand that I can terminate my participation in this study at any point should I not want to continue and that this decision will not in any way affect me negatively.

I understand that this is a research project, whose purpose is not necessarily to benefit me personally. I understand that my details as they appear in this consent form will not be linked to the interview schedule, and that my answers will remain confidential.

Signature: _____

Date: _____

APPENDIX C2: Papila na fomo ya mpfumelelano (Xitsonga)

Department of Psychology
University of Limpopo (Turfloop Campus)
Private Bag X1106
Sovenga
0727
Date: _____

Eka vangeneleri

Ndzi khensa ku va mi kombe ku navela eka ndzavisiso lowu wu langutaka vamanana lava va ngana vana lava vanga na vuvabyi bya miehleketo eMopani na Vhembe districts. Xikongomelo nkulu xa ndzavisisa lowu iku twisisa ntokoto wa vamanana lava vanga na vana lava vabyaka miehleketweni.

Tinhlamulo ta n'wina titava ta xihundla. Mula visisi enge boxi mavito ya n'wina naswona ange mi teki koya hileswi mi ngata hlamula swona eka ndzavisiso lowu. Mi tsunduka leswaku ku teka xiave eka ndzavisiso lowu aswi bohi naswona minga tshika nkarhi wu n'wana na wu n'wana lowu mi wu lavaka.

Mikomberiwa ku hlamula swivutiso hinkwaswo hiku tshembeka. Ku teka ka n'wina xiave eka ndzavisiso lowu iswa nkoko swinene. Ndzi khensa nkarhi wa n'wina.

Wa n'wina wo tshembeka

Tsakani Glory Rikhotso
Masters Student

Date

Prof T Sodi
Supervisor

Date

APPENDIX C2: Papila ra mpfumelelo leri fanelaka ku sayina hi vangeneleri

Papila ra mpfumelelo

Mina ndzinga..... ndzi
pfumela ku teka xiave eka
ndzavisiso lowu wu langutaka ntokoto wa va manana lava vangana vana vakuva
na vuvabyi bya miehleketo va le Mopani na Vhembe districts.

Ndzi hlamuseriwile hi vuenti xikongomelo xa ndzavisiso lowu. Ndza swi tiva
ni thlela ndzi switwisisa leswaku a ndzi teki xiave eka ndzavisiso lowu
hikuva ndza boheka kambe ndzi teka xiave hiku swirhandza. Ndzi thlela ndzi
twisisa leswaku ndzi nga tshika ku va xiave xa ndzavisiso lowu nkarhi wo
n'wana na wu n'wana lowu ni wu lavaka swithlela swi nga ndzi vangeli ku
vava.

Ndza switwisisa leswaku ixkongomelo xa ndzavisiso lowu ahi ku vuyerisi mina.
Ndzi thlela ndzi switwisisa leswaku vuxokoxoko bya mina lebyi nga laha
fomeni layi na tinhlamulo ta mina aswi nge humesiwi hikuva a bya xihundla.

Mpfapfaruto:.....

Siku:.....

APPENDIX D: PERMISSION LETTER TO THE DEPARTMENT OF EDUCATION

Department of Psychology

University of Limpopo

Private Bag X1106

Sovenga

0727

Date: _____

The Circuit Manager

Department of Education

Mopani District

Private Bag X 2250

Tzaneen

0970

RE: PERMISSION TO CONDUCT RESEARCH IN TWO SPECIAL SCHOOLS FOR CHILDREN WITH MENTAL RETARDATION IN MOPANI AND VHEMBE DISTRICTS

My name is Tsakani Glory Rikhotso, a Masters student in the Department of Psychology at the University of Limpopo (Turfloop Campus). I am conducting a study on: "The phenomenological experiences of mothers of children with mental retardation in Mopani District, Limpopo Province". The purpose of my study is specifically aimed at exploring the lived experiences of mothers of children in these two special schools.

I do hereby apply to be granted permission to conduct this research in the following two secondary schools in your circuit: Fulufhelo Special School for Children with Intellectual Disabilities and Pfunanani Special School for Children with Intellectual Disabilities. It is important to point out that

the researcher undertakes to maintain confidentiality regarding the identity of the participants in this research project.

The participants will be assured about the voluntary nature of this study and further that they are free to withdraw from the study at any time should they wish to do so.

The methods of data collection will be unstructured individual interviews with the mothers and focus group interviews with the same mothers.

Sincerely

Tsakani Glory Rikhotso

Masters Student

Prof T Sodi

Supervisor

Date

Date