In Malaysia, there is a growing awareness and recognition that counselling can be effective in special counselling populations such as people who abuse drugs and alcohol, people with AIDS, people with disabilities, victims of abuse, people with marital disharmony, etc. In this article, we shall discuss how to counsel to the parents of mentally disabled children. This article includes the definition and type of disability, concept of mental retardation, parental reactions after knowing the disability of the child, stages of the process of counselling and barriers in counselling.

**Disability: Definitions**

Disability is a question that has often been discussed among the family members as casual conversation at the dining table, in the professionals at the clinics and hospitals. The value attached to this concept does not only revolve around the disabled or handicap persons but also with the families and society. Disability of any kind does not only affect the individual, but also affects the family, organization and society.
According to the United States Department of Commerce (2007), a person is classified as having a disability when he or she has difficulty with any of the following:

1. Normal body functions, for example, seeing, hearing, talking and walking.
2. Activities of Daily Living (ADLs), such as bathing and dressing.
3. Performing certain expected roles, like working in a job, household chores or school work.
4. Performing usual activities like driving a car or taking a bus.

The Asia-Pacific Development Center on Disability has defined the term ‘handicap’ as used by the Malaysian Census of 2000 which was conducted by the Statistics Department, Malaysia as “Persons who experience losses, changes or abnormality either physically, body structure, nervous system, functions of an organ and mental or physical disability. It may happen before or after child birth either on temporary or permanent (defined as handicap for more than 6 months). The condition either fully or partially hinders the social and community needs of an individual in terms of the cultural and physical environment”.

The Department of Social Welfare, Malaysia and the Ministry of Health, Malaysia uses the World Health Organization definition for people with disabilities to define the term disability: Any person unable to ensure by himself wholly or partly, the necessities of a normal individual and or social life, as a result of deficiency either congenital or not, in his physical or mental capabilities, which may have happened before or after childbirth.

According to the Department of Social Welfare, Malaysia the total number of people who were characterized as disabled in June 2002 were 108,000 and this was based on the “voluntary registration system”.
### Types of Disability in Malaysia, Department of Social Welfare, 2000

<table>
<thead>
<tr>
<th>Type of Disability</th>
<th>Category</th>
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</thead>
<tbody>
<tr>
<td>Visual (sensory)</td>
<td>Congenital or Environmental/blunt, Trauma</td>
</tr>
<tr>
<td>Auditory (sensory)</td>
<td>Conductive and Sensorineural, Deafness</td>
</tr>
<tr>
<td>Mental</td>
<td>Mental Retardation, Emotional disturbance (anger, anxiety)</td>
</tr>
<tr>
<td>Physical</td>
<td>Stroke, Heart Attack, Diabetes, Cancer, Musculoskeletal-limb injury and loss, Burns, Skin conditions, HIV/AIDS, Chronic pain</td>
</tr>
<tr>
<td>Psychiatric</td>
<td>Schizophrenia, Bipolar Mood Disorder</td>
</tr>
<tr>
<td>Speech/Verbal</td>
<td>ADHD, Autism, Dyslexia</td>
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The definition of disability, following the Malaysian perspective, clashes with the western concept of disability *i.e.*, the duration of six months is emphasized here whereas in the western countries it is not time bound. Disability can exist throughout one's human adult life.

### Mental Retardation

DSM-1V-TR presents four levels of mental retardation: mild, moderate, severe and profound. Borderline intellectual functioning, according to DSM-1V-TR, is not within the diagnostic boundary of mental retardation and refers to a full-scale IQ in the 71-84 range that is a focus of psychiatric attention. Mild mental retardation (IQ range, 50-55 to 70) represents approximately 85 percent of persons with mental retardation. In general, children with mild mental retardation are not identified until after first or second grade, when academic demands increase. By late adolescence they often acquire academic skills at approximately a sixth grade level. Specific causes for the mental retardation are often identified in this group. Many adults with mild mental retardation can live independently with appropriate support and raise their own families.
Moderate mental retardation (IQ range, 35-40 to 50-55) represents about ten percent of persons with mental retardation. Most children with moderate mental retardation acquire language and can communicate adequately during early childhood. They are challenged academically and often are not able to achieve academically above a second to third grade level. During adolescence, socialization difficulties often keep these persons aloof, and a great deal of social and vocational support is beneficial. As adults, persons with moderate mental retardation may be able to perform semiskilled work under appropriate supervision.

Severe mental retardation (IQ range, 20-25 to 35-40) comprises about four percent of individuals with mental retardation. They may be able to develop communication skills in childhood and often can learn to count as well as recognize words that are critical to functioning. In this group, the cause for the mental retardation is more likely to be identified than is in milder forms of mental retardation. In adulthood, persons with severe mental retardation may adapt well to supervised living situations such as group homes and may be able to perform work-related tasks under supervision.

Profound mental retardation (IQ range, below 20 or 25) constitutes approximately one to two percent of persons with mental retardation. Most individuals with profound mental retardation have identifiable causes for their condition. Children with profound mental retardation may be taught some self-care skills and learn to communicate their needs given the appropriate training.

DSM-IV-TR lists mental retardation, severity unspecified, as a type reserved for persons who are strongly suspected of having mental retardation but who cannot be tested by standard intelligence tests or are too impaired or uncooperative to be tested. This type may be applicable to infants whose subaverage intellectual functioning is clinically judged but for whom the available tests (e.g., Bayley Scales of Infant Development and Cattel Infant Scale) do not yield numerical IQ values. This type
should not be used when the intellectual level is presumed to be above 70.

Parental Reactions

Parents express the following reactions after knowing the disability of the child.

**Shock:** Stunned by the news.

**Denial:** Refuse to believe the news that the child has any disability.

**Bargaining:** Any kind of possibility of cure of the disability through medicine or even surgery.

**Depression:** Getting the information that the disability cannot be treated, feel guilty, negative thinking as it is a result of their own fault.

**Acceptance:** Gradually accept the child with his real abilities.

Parents have their own perceptions, expectations, prejudices, likes and dislikes about their disabled child. We noticed that some parents are fault-finding, unsympathetic, uncooperative and disinterested in the welfare of their child. The counsellor sees the disabled child actions without bias and seeks the parents' cooperation for doing something positive for the child. The parents may defend their child's actions. In all such cases, the counsellor should behave with great caution and professional experience to win over the confidence and trust of the parents and help them to see the short-comings or the problems of their child in an objective manner. This requires a considerable amount of sympathetic understanding of the parents toward their child. Once the parents' confidence and trust are achieved, it becomes easy to seek their cooperation.

Some parents have difficulty in expressing their children problems. They may be reluctant to talk. The counsellor has to first establish a warm relationship with the parents to open up the
possibilities of free communication by talking about the major life crisis of their disabled child. It is necessary because the parent's perceptions about his child may be very different from the manner in which the counselor sees it. The important objective of a parent-counsellor interaction is to gain insight into the child's behaviour to get a proper perspective from the point of view of the home environment. Understanding insights can help a great deal in reducing the tensions and anxieties of parents as well as the child.

**Parental Counselling**

It is aimed at helping parents sensitive to the possible adverse effect of their behaviour on their children. By helping the parents gain a better understanding of themselves and their own personalities much harmony could be affected. Parental counselling deals with the dimension of parent-child interaction and dependence-independence. Most parents are deeply concerned about the well-being of their children. Hence they become overprotective which is resented by the children. Counselling can be a valuable for the family of a retarded child to help parents cope with painful feelings about the child's condition, and with the extra time and patience needed for the care and education of a special-needs of the child. Parental counselling, thus, is one of the important services that can help and foster a healthy home atmosphere.

The focus of counselling depends upon the needs of the disabled child and his parents. The counselling process may involve the following stages:

1. **Involvement of the Parents**

   Parents should be given proper information about the capability and incapability of the child *i.e.*, condition of the child.

   Parents need to learn how they can adjust their own time with the special needs of the child.
Parents should be motivated to behave as normal as they do with other children of the family.

Parents should be motivated to accept the child's capacity and not to compare with other children.

Parents should be guided to assure the level of involvement of disabled child in household work.

Parents need to develop the positive attitude towards their disabled child.

The role of parents is most vital in the life of a disabled child. All the members of the immediate and extended family, the neighbourhood and the community at large are important in training disabled child.

2. Identification Schedule (Below 4 years)

Initial counselling of parents of retarded children should be centered primarily on the discussion of diagnosis and etiology of immediate problems. Counselors should create awareness through educating the parents regarding their role in screening out the problems of their children.

<table>
<thead>
<tr>
<th>Item</th>
<th>Normal Age Range</th>
<th>Milestone delayed if not achieved</th>
</tr>
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<tbody>
<tr>
<td>Responds to name/voice</td>
<td>1-3 months</td>
<td>4th month</td>
</tr>
<tr>
<td>Smiles at others</td>
<td>1-4 months</td>
<td>6th month</td>
</tr>
<tr>
<td>Holds head steady</td>
<td>2-6 months</td>
<td>6th month</td>
</tr>
<tr>
<td>Sits without support</td>
<td>5-10 months</td>
<td>12th month</td>
</tr>
<tr>
<td>Stands without support</td>
<td>9-14 months</td>
<td>18th month</td>
</tr>
<tr>
<td>Walks well</td>
<td>10-20 months</td>
<td>20th month</td>
</tr>
<tr>
<td>Talks in 2-3 word sentences</td>
<td>16-30 months</td>
<td>3rd year</td>
</tr>
<tr>
<td>Eat/Drinks by self</td>
<td>2-3 years</td>
<td>4th year</td>
</tr>
<tr>
<td>Tells his name</td>
<td>2-3 years</td>
<td>4th year</td>
</tr>
<tr>
<td>Has toilet control</td>
<td>3-4 years</td>
<td>4th year</td>
</tr>
<tr>
<td>Has fits</td>
<td>Yes No</td>
<td></td>
</tr>
<tr>
<td>Has physical disability</td>
<td>Yes No</td>
<td></td>
</tr>
</tbody>
</table>
If the child is found to be delayed in any one of the items given above and has fits or physical disability, suspect mental retardation.

3. Suggestions for the Parents

Subsequent counselling of parents of retarded children should be directed toward the problems of future care.

The following suggestions are important for parents of retarded children:

1. Your attention to the child's wants and feelings.
2. Provide sufficient time to monitor the behaviour of disabled child.
3. Positively reinforce appropriate behaviours in child through members of the family.
4. Your expectations are to be made appropriate to the children's skills and potentials.
5. Understand and tolerate the child's minor misbehaviour.
6. Avoid labeling children either positively or negatively.
7. Praise your child often.
8. Do not discuss child's inappropriate behaviour with others in his presence.
9. Use your facial expressions and other body language to communicate to your child.
10. Be democratic in parenting style, like less aggression, loving goodness and greater overall psychosocial adjustment.
11. You must accept that your child's disability may exist for the entire life.

Barriers in Counselling

It is generally agreed that counselling with parents of disabled children takes more effort and time than does the counselling to
Counselling to the Parents of Mentally Disabled

the parents of normal children. There are a number of reasons for this.

First, emotional disturbance of the parents (i.e., stress and anxiety).
Second, anxiety over speedy recovery.
Third, religious and cultural beliefs of the parents.
Fourth, misconceptions and false beliefs of the disorder.
Fifth, the personality characteristics of the parents.
Sixth, the assessment of motivation, attitude and awareness of the parents.

These barriers need to be minimized in counselling.

CONCLUSION

Changing the attitude of parents is the hallmark of counselling program. Counsellors need to deal with a broad spectrum of issues while counselling to the parents of the mentally retarded. Sometimes parents have trouble bonding i.e., establishing a close and loving relationship with a child who is retarded. The main role of the counsellor should be for the removal of misconceptions and false beliefs about the disability and to provide social support to the parents of mentally disabled at the initial and subsequent counselling stages. Parental adjustment with the mentally retarded children requires a good foundation in basic problem solving skills. Moreover, the counselling should be directed toward the problems of future care.

REFERENCES

Asia-Pacific Development Centre on disability project paper:
http://www.apcdproject.org/countryprofile/malaysia/malaysia_current.html