

TRAINING FOR THE MODERATELY RETARDED CHILD

The effects of habilitation work for the moderately retarded child on his social functioning and family acceptability. A preliminary survey, based on material from The Woodlands School, B. C., 1961 - 1962.

by

JOHN ARTHUR CHAPPLE

Thesis Submitted in Partial Fulfillment
of the Requirements for the Degree of
MASTER OF SOCIAL WORK
in the School of Social Work

Accepted as conforming to the standard
required for the degree of
Master of Social Work

School of Social Work

1962

The University of British Columbia

In presenting this thesis in partial fulfilment of the requirements for an advanced degree at the University of British Columbia, I agree that the Library shall make it freely available for reference and study. I further agree that permission for extensive copying of this thesis for scholarly purposes may be granted by the Head of my Department or by his representatives. It is understood that copying or publication of this thesis for financial gain shall not be allowed without my written permission.

Department of School of Social Work

The University of British Columbia,
Vancouver 8, Canada.

Date May 8, 1962

ABSTRACT

Experimental teaching techniques and classroom facilities have recently been brought into use at The Woodlands School, to train the category of children resident in The School who can be described as moderately retarded. An exploratory study has been conducted and the main features of this programme set out, to ascertain whether the progress of the children is significant and whether this has had any influence on their family acceptability.

With the cooperation of The Woodlands School Staff, and from the parents, a sample group of boys, aged eight to seventeen, was chosen for study. The boys are resident at the institution and attend the special training classes; their parents reside within a thirty-five mile distance from Vancouver. A Social Competency Rating Scale was adapted from one utilized in a San Francisco study and applied to two specific times, (a) before the child received training in the special training classes and, (b) after at least one year's training. This scale permits an assessment of the degree of each child's progress in social competency. A second rating scale, designed to assess the degree to which parental acceptability of the child was influenced by the training and its results, was applied by utilizing a projective interviewing technique.

It was found that the social competency of the sample group of boys has improved considerably; coincident with this, there has also been an opening up of areas of knowledge and experience which are stimulating the children to more constructive use of their time, and giving them reward through greater enjoyment of living. Parental acceptance of the children has noticeably increased. The review suggests that more inclusive services, including medical diagnostic and social work counselling, should be made available to parents of retarded children. Residential training facilities should also be extended to non-metropolitan areas of the province.

ACKNOWLEDGEMENTS

Grateful thanks is expressed to Dr. L. A. Kerwood, Medical Superintendent of The Woodlands School, for his generous cooperation. Thanks too go to Mr. Julius Erdelyi for his tireless and invaluable participation in the project. Likewise thanks go to other members of The Woodlands School Staff including J. N. Elliott, Dr. B. Leviczky, J. Markley, J. Wincentowich, T. Fisher, A. O. Morrison, Mrs. C. Hawley, Miss H. Walter and E. M. Coles, for their continued interest and helpful suggestions.

Gratitude is extended to Mrs. Mary Tadych, Dr. D. McGann, Dr. S. R. Laycock and Dr. L. Marsh for their sound advice and heartening support.

Last, but not at all least, appreciation is expressed to the parents who, with such warm interest, gave freely of their time and effort.

Chapter I	<u>The Moderately Retarded Child and his Problem</u>	page
	Causes of Mental Deficiency. Some Clinical Types of Mental Deficiency. The Degree of Mental Defect. The Moderately Retarded Child. Special Training for the Moderately Retarded Child. Method	1
Chapter II	<u>Habilitation and Training of the Children</u>	
	The Purpose of the Institution. The Treatment Team. Casework Services. The Number of Mentally Retarded Persons. The Classrooms	27
Chapter III	<u>Measuring Movement</u>	
	Physical and Family Characteristics. Measuring the Habilitation Progress. Case Illustrations. Evaluation of Training. Positive and Negative Observations of Parents. Home Visits	45
Chapter IV	<u>What Does Institutional Training Offer?</u>	
	Parents Need More Help. The Social Work Liaison Role Between the Retardate's Family and the Community. The Social Work Liaison Role Between the Retardate's Family and the Institution. The Casework Process. The Need for Extended Services. Possible Research Projects. The Challenge	74
Appendices:		
	A. Sample of Letter to Parents	
	B. Social Competency Rating Scale	
	C. Parental Acceptability Rating Scale	
	D. Catalogue of Classroom Activities	
	E. Bibliography	

TABLES IN THE TEXT

Table 1.	Population of Canada and Estimated Numbers of Mentally Retarded Persons	38
Table 2.	Population of British Columbia and Estimated Numbers of Mentally Retarded Persons	38
Table 3.	Social Competency, Ia, Self-Help	48
Table 4.	Social Competency, Ib, Self-Help	48
Table 5.	Social Competency, IIa, Initiative - Responsibility	49
Table 6.	Social Competency, IIb, Social Skills	49
Table 7.	Social Competency, IIc, Communication	50
Table 8.	Parent Acceptability	51
Table 9.	Composite of Social Competency and Parent Acceptability Scales Showing Gains and Losses After Retardate's Training	53

TRAINING FOR THE MODERATELY RETARDED CHILD

CHAPTER I

THE MODERATELY RETARDED CHILD AND HIS PROBLEM

The mentally defective child is not just a symptom of our time despite a prediction that, because of pollution from atomic fallout, his ranks will be increased. From ancient time he has been dealt with as an oddity. Certain cultures such as the Spartan and Roman saw him as an unmanageable threat and destroyed him. Other societies allowed him to live but projected condemning attitudes born in hostility and fear. Ways of attending him were much modified with the coming of Christianity and he was given shelter and more humane care. Stanley notes that

The anatomists and physiologists of the 16th and 17th centuries, who laid the foundations of rational medicine, established and argued the place of mental disorder in the natural order of diseases of the nervous system, and began the slow education of the public mind away from the old savage concepts of the defective as a subhuman being - degenerate, blighted by demonic forces.

However, Masterman states: "It was not until the 19th century, when Itard made his exhaustive efforts to educate Victor, the 'wild boy of Aveyron', that the world saw the beginning of efforts to educate the children of subnormal intelligence."² There has been gradual progress since this time. Nevertheless, even today

¹ Stanley, J. C., Brief to the Royal Commission on Health Services, Saint John, New Brunswick, 1959, p. 2.

² Masterman, Louis E., Attitudes Toward Children of Subnormal Intelligence, Publication No 133, Community Studies, Inc., Kansas City, Missouri, and The State Division of Health of Missouri, Jefferson City, Missouri, June 1961, p. 101.

we find persons thinking of the defective child as one of "les enfants du bon Dieu", or as one "filled with Satan".¹ And parents who produce a defective child often feel the stigma of being of 'a lesser breed'. It seems easier to accept physical handicap, however severe, if it is not accompanied by mental impairment. According to our culture, the retardate is one whose greatest value, his mind, has been disabled.

Within the last few years there has been an increased public awareness of the mental retardation problem. There has been an upsurge of social concern for and from those directly involved. Mass and rapid communication has helped parents discover that their charge, that of a mentally retarded child, is not an unique problem; and it is now realized that mental retardation affects as many Canadian people, directly or indirectly, as the whole population of the Province of British Columbia.² Local and national associations for retarded children have sprung up. Troubles, needs and ideas have been shared. New possibilities for constructive home and community planning have been explored. The interest of fellow community members, including professional persons, has been aroused and abilities enlisted. Medical advances, both in diagnosis and treatment, have resulted in a lower mortality rate, while the birthrate has been increasing. In 1958, the Canadian Association for Retarded Children

¹ Queen, Alfred S., Social Work in the Light of History, J. B. Lippincott Co., Philadelphia, 1921, p. 155.

² First Annual Convention, C. A. R. C., Calgary, Alberta, Sept. 17 - 19, 1958, p. 1.

(herein after referred to as C. A. R. C.), started plans to appoint "a Scientific Advisory Board of eminent specialists to outline and direct an energetic and vigorous program extending into all the basic sciences."¹ More money has been available for research. As a result the problem has been brought into daylight and the public conscience is awakening to the needs of families with retarded children. There is a swing away from thinking that would isolate and emphasize segregation. Realism and more united seeking for methods and resources with which to constructively meet the situation are evident characteristics of this new movement.

Noyes and Kolb define mental deficiency as "such a defect in mental competency, resulting either from an innate fault in developmental potentiality or from an arrest in developmental progress, that it is impossible for the patient to make an adequate and independent social adjustment."² A monograph supplement to the American Journal of Mental Deficiency states:

Mental retardation refers to subaverage general intellectual functioning which originates during the development period and is associated with impairment in one or more of the following: (1) Maturation, (2) Learning, and (3) Social Adjustment Rate of maturation refers to the rate of sequential development of self-help skills of infancy and early childhood such as sitting, crawling, standing, walking, talking, habit training, and interaction with age peers Learning ability refers to the facility with which knowledge is acquired as a function of experience ... (and) Social Adjustment During the pre-school and school years social adjustment is reflected, in large measure, in the level and manner in which the child relates

¹ First Annual Convention, C. A. R. C., op. cit., p. 3.

² Noyes, Arthur P., and Kolb, Lawrence C., Modern Clinical Psychiatry, W. B. Saunders Company, Philadelphia and London, 1960, p. 324.

to parents, other adults, and age peers In actual practice ... it will be found that a great percentage of individuals diagnosed as mentally retarded will be impaired, or have a history of impairment, in all three areas of adaptation.¹

The mentally deficient person operates at a level below that of the general public in his capacity to reason, show foresight and judgment, in his ability to modify behavior in the light of experience, in conceptualization and memory. Noyes and Kolb think that the term intellectually inadequate would be more suitable than mentally deficient or mentally retarded. To them "mind" is: "a collective designation for certain functional activities of the organism, particularly those of the organism as an individual personality."² They point out that some persons who are intellectually deficient are emotionally mature and well adjusted, while some of average or superior intellectual ability are emotionally under developed.³

It is estimated that 30 of every 1000 children born in Canada are mentally defected. Of these, approximately 25 are educatable, and after training may eventually engage in simple occupations and reach a level of self-support. About 4 of the 30 children will fall in the trainable category. These are the moderately retarded, and the subject of this thesis. One of every 1,000 children born will be severely mentally handicapped and will always require help for even the simplest tasks.⁴

¹ Herber, Rick, "A Manual on Terminology and Classification in Mental Retardation", A Monograph Supplement to the American Journal of Mental Deficiency, September 1959, Vol. 64, No. 2, pp. 3 - 4.

² Noyes and Kolb, op. cit., p. 324.

³ Loc. cit.

⁴ Stanley, op. cit., p. 4.

Winthrop and Taylor speak of popular misconceptions regarding the mentally retarded still held by the general public. These include beliefs that mental retardation is curable, that retardates should be sterilized as a means of getting rid of the whole problem. Also they show that there is confusion between retardation and mental disease.¹ In regard to the latter it should be pointed out that a mentally deficient person may, as anyone else, be arrested in emotional development, or become mentally ill; however, it is important to understand that mental deficiency is not synonymous with mental illness. There are serious difficulties which face the retardate in the developmental process - times when he is misunderstood, laughed at, left behind and bewildered. His behavior may become erratic or psychotic as any normal person's might when his emotional strength cannot cope with circumstances.

Causes of Mental Deficiency

Mental retardation is found in all races. It appears that there may be greater incidence of one type in some groups. For instance, Cretinism is more prevalent in Switzerland than in Canada; and Mongolism is more prevalent in Caucasians than Negroes. Age of mothers during pregnancy seems to be a factor (more mongoloid children are born to mothers over thirty), but mental retardation is seen in all ages of children, and both sexes are affected. Also mental retardation occurs in children of parents of all economic

¹ Winthrop, Henry, and Taylor, Howard, "An Enquiry Concerning the Prevalence of Popular Misconceptions Relating to Mental Retardation", American Journal of Mental Deficiency, Vol. 62, No. 2, (1957), pp. 344 - 348.

brackets, and cultural, environmental and educational background.¹

Causes Before Birth. Probably from 50 to 65% of mental deficiency results from causes existing prior to birth. It is now considered that heredity contributes less than was formerly believed. Masland, Sarason and Gladwin say, "In the case of mental retardation, we are not dealing with a single entity or trait, but with a symptom common to many different conditions, some clearly inheritable, some involving inherited susceptibilities, and some in which inheritance plays little if any part."² Noyes and Kolb say: "It is often difficult to determine whether toxic, infectious, endocrine, traumatic, nutritional and other prenatal pathogenic factors operating on the germ cell or within the pregnant mother tended to weaken or distort developmental capacity of the brain."³ RH (Rhesus) factor in the mother's blood may be one of these pathogenic factors.⁴

Antenatal, hereditary or congenital types of retardation are initiated before birth.⁵ Among prenatal factors, virus infection, especially that of rubella during the second or third month of pregnancy may be highly significant. It is also believed that irradiation of the pelvis (x-rays) at this period may cause retardation.⁶

¹ Levinson, Abraham, and Bigler, John A., Mental Retardation in Infants and Children, The Year Book Publishers, Inc., Chicago, 1960, pp. 49 - 50.

² Masland, L., et al, Mental Subnormality, Basic Books, Inc., New York, 1958, p. 35.

³ Noyes and Kolb, op. cit., p. 325.

⁴ Tredgold, R. F. and Soddy, K., A Text-book of Mental Deficiency, The Williams and Wilkins Company, Baltimore, 1956, p. 28.

⁵ Levinson and Bigler, op. cit., p. 55.

⁶ Loc. cit.

Causes At Birth. Difficult labour resulting in birth trauma or accidents can cause brain injury, either through mechanical damage or asphyxia, with resulting anoxia. Prematurity is likewise sometimes associated with cerebral hemorrhage and consequent brain damage.¹

Causes After Birth. Forms of virus and bacterial encephalitis and of meningitis are the most frequent causes of mental retardation after birth. Head injury accounts for brain damage for some in infancy and early childhood. Also, toxemia and vitamin deficiency in infancy and early childhood may produce irreversible changes in the cortex resulting in varying degrees of mental retardation. Again, a reduced ability to receive stimuli can result in a certain degree of mental defect for the congenitally blind and deaf.²

Emotional factors, without organic defect, may be the cause of retardation. The mysterious case of Kaspar Hauser, a sixteen or seventeen year old boy found May 26, 1828 near one of the gates of Nuremberg exemplifies in a dramatic manner the effect of prolonged isolation upon the brain cells. But more recent findings in studies by such persons as Spitz³ and Bowlby⁴ support this view.

¹ Noyes and Kolb, op. cit., p. 326.

² Loc. cit.

³ Spitz, René, and Wolf, Katherine A., "Grief - A Period in Infancy", (film) 3 reels, 35 minutes. Silent. Rene Spitz, 1150 Fifth Avenue, New York 28.

⁴ Bowlby, J., Maternal Care and Mental Health, World Health Organization, Geneva, 1952.

Some Clinical Types of Mental Deficiency

Microcephaly. Microcephaly generally is genetic in origin. However, sometimes microcephaly is caused by X-Ray or radium given to a pregnant woman.¹ The distinctive feature is the smallness of the head which does not exceed 17 inches in circumference. The shape of the head is also characteristic. The forehead is markedly recessed and the back of the head (occiput) is flattened. The chin recedes. The hair is very wiry and grows low on the forehead. The brain is markedly underdeveloped. The individual's stature is small, though the body and face may be well developed.² Intellectual capacity varies considerably. Microcephalics are found in each of the three degrees of mental retardation. Features common to most are "absence of any sensory defect, a general vivacity, restlessness and muscular activity. A considerable capacity for imitation and usually an inability for sustained effort."³

Tuberous Sclerosis. Tuberous Sclerosis is characterized by epilepsy and adenoma sebaceum. Nodules may occur on face and neck and a few pale pink spots on the cheeks.⁴ Though it is congenital, only about 0.5 percent of the retarded suffer Tuberous Sclerosis. Patients are usually backward from birth. Many never learn to walk or talk. Screaming is common in early years. Mental retardation

¹ Tredgold and Soddy, op. cit., p. 328.

² Ibid., p. 271.

³ Ibid., p. 272.

⁴ Ibid., p. 279.

is generally severe or moderate. As the individual grows there is generally progressive mental deterioration and though some survive to adult age, most die before reaching maturity.¹

Phenylketonuria. Phenylketonuria is characterized by a genetic metabolic defect. Phenylalanine and its derivatives, phenylpyruvate and phenyllactate are excreted through the urine, not having been converted for body use. Mental retardation resulting is progressive. Research has recently discovered that a lack of an enzyme necessary for the oxidation of phenylalanine is the cause. A diet low in phenylalanine can control the metabolic defect. Mental deficiency caused by this condition may be prevented if early treatment is given.² Detection of phenylalanine is easily made by a simple urine "damp diaper" test shortly after birth of a child. Though mental retardation may be prevented by early adjustment of diet, brain damage caused before treatment is permanent.

Mongolism. It is estimated that of each 1,000 births, 3 to 4 infants will be mongoloid. Of all children diagnosed as mentally defective during the first year of life, between 40 and 50 percent are mongols.³ Statistics support the observation that the mongoloid is more apt to be born to a relatively older mother. Most mongols are born to mothers over the age of 36.⁴

The Mongol's brain is underdeveloped. Often there are disorders of the endocrine glands and defects of the heart.⁵ He is

¹ Tredgold and Soddy, op. cit., p. 279.

² Noyes and Kolb, op. cit., p. 328.

³ Tredgold and Soddy, op. cit., p. 296.

⁴ Ibid., p. 298.

⁵ Ibid., p. 300.

short in stature. His head is small and round, flattened both at the back (occiput) and the frontal regions. The skin tissue about his eyes is drawn and emphasizes an Asiatic appearance. His tongue which is constantly protruded and withdrawn is often quite large. His nose is broad and short with a depressed bridge; hands are broad and stubby, flabby and clumsy looking. There is an irregularity in the length of fingers; hips are often thick; cheeks often coloured by a bright red flush. Ears may be small and underdeveloped or large and protruding. The skin is soft and smooth in very early life but later becomes rough. The hair is soft at first and later is dry and thin. The abdomen is large. Blood circulation is often poor so that the cold is felt and the individual susceptible to colds and other infections. The voice is often harsh and guttural. He is flabby muscled and loose jointed. He tends to age quickly.

The mongoloid has an inherent "good disposition". He is most affectionate. He cannot understand and is confused by critical judgment directed to him.

Cretinism. It may be that there are two types of cretinism. In one, the mental and physical retardation are definitely due to hypothyroidism, and with treatment the patient becomes normal; in the other, mental retardation is the essential condition, hypothyroidism being an added complication.¹ Early recognition and treatment are very important.

¹ Tredgold and Soddy, op. cit., p, 306.

The child's growth is retarded. He is apathetic and slow, does not easily laugh or smile. His tongue protrudes. Skin is yellowish, loose and wrinkled and frequently puffy. Hair is often scanty. The body is characteristically dwarfed. The head is large. Legs are short and bowed; hands and feet are stumpy and ill formed. The nose is broad and flattened, eyes widely separated; lips thick, mouth partly open and tongue thick, coarse and protruding. The neck is usually short and thick. Balance is poor, gait is slow and all movements are laboured and clumsy. Persons suffering from cretinism are generally apathetic and there is a lack of expression. Some are severely retarded, but most often these persons are high in the moderately retarded range.¹

The Degree of Mental Defect

The severely retarded (idiot) child has an I. Q. of from 0 to about 20. He is a total care responsibility. The fact that in adult years he may develop a maximum mental age of about two years indicates that he will always be highly dependent. The moderately retarded (imbecile) child has an I. Q. of from about 20 to 50. This child may develop a mental age of from three to about seven years. He is, to various degrees, trainable. That is, through a systematic repetitious training process, he may be taught elemental health habits and to do many things which will assist in the economy of self-care. He can learn to enjoy life through

¹ Tredgold and Soddy, op. cit., p. 308.

socialization, and successful contribution to his own needs; and in a limited manner he can learn to contribute to the needs or wishes of others. He will always have defective speech but can learn a few simple words and to communicate in other ways. He has potential for development and in adult years can contribute partially to self-support under supervision. And he can develop self-protection skills to a minimal useful level in controlled environment.¹

The mildly retarded (moron) child has an I. Q. of from 50 to 70 and may develop a mental age of from eight to about ten years. He is able to gain a simple command of the language, learn to do more demanding tasks with less supervision, and perform academically up to about grade 4 in his late teens, and perhaps further in certain subjects. He has little ability for abstract thinking (the lower levels have none). With these various abilities, many can reach a level near to self-sufficiency. Many mildly retarded adults are providing for themselves in our society today. Some are capable of self-maintenance in unskilled or semi-skilled jobs though they require guidance when under mild social or economic stress.²

Those caring for the mentally deficient will need to understand and accept the person's physical and mental condition as it is so that whatever the present rate and potential for social

¹ Herber, op. cit., p. 63.

² Loc. cit.

functioning may be, expectations will neither be too great nor too small.

The Moderately Retarded Child

The moderately retarded child's aggressive, destructive, withdrawn or other unacceptable behavior traits are frequently processes expressing feelings of anxiety, frustration and rejection. This behavior often evokes negative reaction from parents and siblings, and his frustrations are increased. He needs energy outlets which facilitate his being loved, recognized, accepted and successful in some of his endeavours. His mental ability is not great enough to solve problems, but he does have the emotional capacity to become distraught by failure. Not to recognize and meet the retardate's needs will result in self-defeat for both the child and his parents. A child will sense rejection and act out his anxiety. Quarrels between parents, inconsistent discipline, favoritism amongst siblings and indifference, plus the compounding of economic and health problems may well ensue and, if not abated, sooner or later lead to family breakdown.

Laycock lists what he considers basic needs of all children including retardates. The following are related specifically to the retarded. Next to a reasonable degree of physical care, the most urgent need is to feel that he is a loved and cherished individual, especially in his own home but also in the school, church and community. Closely allied is the need to belong, to feel a desired and desirable member of a family group, school group, church group or community group. There is a need for independence. He

has a need to do things for himself. He also has a need to make his own decisions in accord with his present stage of development. There is a need for achievement, the thrill of success which comes from accomplishment. There is a need for recognition. Since the slow learning child has usually had many experiences of failure and has been made to feel inadequate, he often stands in special need of praise and recognition or approval by others. There is a need for a sense of self-worth, otherwise he will spend all his available energy trying to reassure himself. Laycock concludes by observing that every individual has to attempt to understand and relate to the world around him in some fashion. In the case of most retarded children it will largely be a relationship of feeling, not of reason.¹

The Moderately Retarded Child's Role in Family and Community. One of the first questions that often comes from parents of a newborn child is, "Is our baby well?" They look to the child as the fulfillment of great expectations and fond dreams. They have already invested themselves to no little degree in this child. When the child is 'normal', dreams materialize. The parents often respond by modifying their habits, ways of thinking and values, so that these may more worthily encompass the needs of their child. When a diagnosis "this child is defective" is made, dreams may be shattered. Parents experience various degrees of disillusionment and heart-break. The shock is severe even to the strongest of personalities

¹ Laycock, Samuel R., Mental Hygiene in the School, The Copp Clark Publishing Co. Limited, Toronto, 1960, pp. 10 - 22.

and may lead to ineffective living characterized by guilty, hostile and bitter depreciation of themselves and offspring.

The moderately retarded child, who parents expected would be an invaluable asset both to themselves and to society, will always be a burden to himself and others. "The critical life event of having a retarded child is a continuing critical event, not one that happens, then is over and ended."¹ Stages of acceptance range from attitudes which are basically defensive, to anxious and insecure, to realistic and practical. Parents may or may not seek advice on how to care for a retarded child. If they reject the initial diagnosis they may travel far, visit many medical specialists and clinics, become financially indebted, and in the meantime try to force the child beyond his capabilities. Sometimes diagnosis is only partly accepted and parents react to doubts and guilts by being protective or very permissive with their child. If diagnosis is accepted but the implied responsibility shunned, parents may overtly reject their child. On the other hand, it may be accepted in a manner which permits practical planning and warm acceptance of their child as he is.

The parent whose child is moderately retarded finds that much time passes before the child demonstrates growth in his mental process. For example, it will take a child whose I. Q. is about 30, sixteen years to reach his potential mental age developmental level

¹ Blodgett, Harriet E., and Warfield, Grace J., Understanding Mentally Retarded Children, Appleton-Century-Crofts, Inc., New York, 1959, p. 41.

of about four and a half years. He will be ten years old by the time his mental age has reached three years. However, to say that a boy ten years of age with a mental age of three years will behave as a normal three year old child is to oversimplify. Such a retarded child may have developed well beyond the three year old in some ways.

In Chapter III, a brief history is given on boy D of the sample group. This boy is now nine and one half years of age (April, 1962). His I. Q. is about 30, (Cattell Infant Intelligence Scale, April, 1958), his mental age equivalent, 3.7 years (Vineland Social Maturity Scale, April, 1962). Psychologists tell us that one of the main characteristics of the mentally retarded's test results is the scattered score for various categories. Boy D, for instance, in April 1962, tested at about the one year communication level (speech and gesture). During the same test situation he tested at about the five year occupational level (ability to occupy himself unattended). It is obvious, therefore, that though this boy now tests at the 3.7 mental age level, he functions below that point in some ways and above it in others. For instance, boy D is able to attend his toilet care without assistance; the normal three year old child generally requires some help.

Social and emotional concepts are quite important here. A child with an I. Q. of 20 or under cannot be expected to achieve independence in social competency no matter how much training he is given. On the other hand, the moderately retarded child may achieve independence in significant areas and be taught to function in ways

both rewarding to himself and to others. By the time he reaches his potential mental age development (at about sixteen years, if growth has not been interrupted before that time), it is likely he will be able to function at a level well beyond his mental age. Therefore, though psychological tests are useful guides, they complement rather than define the total developmental picture. It will be important for parents or others in charge of the child's care to have an understanding of what might and what might not be expected. Blundering may be thus avoided, and the possibility of negative reaction on the child's part to unappreciative adults, reduced considerably.

What role is the child to play? Can he be accepted on a two to three year old level when he is eight years of age? He is not able to keep up to normal children his own size and is gradually pushed out of their group. When as a big boy he associates with small children, adults in the neighborhood are upset. If they permit their little children to associate, these soon grow past him and he loses his playmates. He is often the object of vicious ridicule and laughter. In a world where the fast moving tempo is often bewildering to the 'average' person, his most frantic efforts to keep up are pitifully inadequate. That he does not understand why emphasizes his dilemma. And if those who care for him do not comprehend and try to force him, trouble is compounded. Often too much is expected of the child and, as a consequence, the child begins to see himself as 'inferior' and 'inadequate'.

At best, a child with an I. Q. of under 50 may develop a mental age of about seven years. Many will not reach that level. This means that he is always going to be somewhat dependent, that he will never achieve complete self-sufficiency. It likewise means that he will need to be amongst those who are on his own level of intellectual functioning if he is to share companionship. It is obvious that he will not be able to play with normal five year olds throughout life. This suggests that some kind of group living, possibly institutional, will be important to him.

Group living in itself will not be enough. The retardate will want to relate to the world about him. He will need, within his capacity, to accomplish things. Only thus can he begin to establish a sense of personal identity, learn to make sufficient relationships, and be motivated to further potential intellectual and emotional growth.

Special Training for the Moderately Retarded Child

The special class examined in this study was set up to provide training in social competence at a level appropriate to the moderately retarded child. Because the moderately retarded child is very slow to learn, many parents do not take seriously the idea of training for training's sake. Indeed, fact may well substantiate this thinking. A recent study in the United States concerning the effect of special day-class training on the social competency of these children, showed no significant findings to support an

hypothesis that training is beneficial in increasing social competence.¹ The reader's unanswered questions here are: "Does the child's poor response to training classes reflect his inability to benefit, or does he need more adequate class settings and better qualified teachers to assist him achieve his potential?" Implication of the study is that the latter is closer to the truth. Children in this category are called 'trainable'. This means that they do have capacity for development. If they can develop there must be ways to assist and speed up this development. The teaching experiment at The Woodlands School is an attempt to find better ways of helping these children improve their social competence. The aim is to help the child progress for a purpose. This purpose involves increasing his ability to care for himself, to grow in understanding of himself, his age peers, adults and the world about him, and to thereby increase his enjoyment in living. In turn, by doing something productive for these children it is hoped that their families will benefit - both from the knowledge that their children are getting something out of life, and by actually sharing improved and increased intrafamily activity.

The Setting. The setting for this study is The Woodlands School, New Westminster, a B. C. Provincial institution for the mentally deficient. The buildings, old and new, overlook the picturesque Fraser River and its busy river traffic. The total

¹ Cain, Leo F., and Levine, Samuel, A Study of the Effects of Community and Institutional School Classes for Trainable Mentally Retarded Children, U. S. Office of Health, Education and Welfare, Contract No SAE 8257, June, 1961, pp. 158 - 159.

patient population is 1,343 and includes persons from infancy to old age, all suffering various degrees of mental handicap. Some are non-ambulatory and completely dependent. Some are non-ambulatory but can do many things for themselves. Others are able to tend some of their own needs, and some make a substantial contribution by performing various simple jobs within the institution.

Patients are segregated into wards according to age, sex, mental and physical handicap, and level of socialization performance. Each ward has its own scheduled programme adapted to the needs, capacities and potentialities of its residents. These schedules are correlated with the overall programme, and patients participate where they are able. This includes nursery classes, special training classes, academic school classes, recreational activities, occupational therapies, sheltered workshops, ground maintenance and entertainment.

From within this large institution a special group has been selected for study. It is a group of ten moderately retarded boys who attend a special training programme daily.

Role of the Social Worker

The social worker has played a relatively minor role in connection with services for the children included in this study. At present the social worker provides a social assessment of his family when application is made for permanent or temporary admission to the institution. He has direct contact with the family if they reside in the Vancouver district, or correspondence with the social

welfare branch social worker or public health nurse if the family resides some distance away. There may be consultation with other social welfare or private agencies and medical and educational sources. At the time of intake diagnostic clinic, the social worker presents his report and consults with other members of the medical team as treatment is proposed for a particular child.

Usually at the initial admission of a child, the social worker provides orientation of parents to the institution in general, and to the particular ward in which the child will be resident. Likewise, parents are introduced to the special class teacher. They are also encouraged to 'sit in' on class activity to get an idea about the special training their child will shortly be receiving. Professional contact commenced at admission between social worker and parents may continue through correspondence, telephone, or in face to face contacts to consider family problems and/or the child and his welfare in the institution. However, to date, service is more of a liaison one between the parents and the institution than a casework relationship. The latter type of relationship is more in evidence in the Vancouver area where supportive casework and orientation service may have been provided the family before initial admission. The fact that admission to the institution necessarily takes place by and large on an emergency basis, where circumstances of the home have become so complex and threatening that parents simply must have relief, has precluded long range planning with parents for admission of the moderately retarded child. Services to parents who anxiously await information that a bed is available

for their child have been for the most part of a 'stop gap' variety. That is, parents are helped to carry on a little longer under circumstances which are formidable and excruciating.

Method

This study is explorative and descriptive. Its purpose is to explore two hypotheses. The first of these is: "Special class training conducted in an institution can increase the social competency of trainable mentally retarded boys." The San Francisco Social Competency Scale Form X 3¹ was adapted² to measure development in this area. The term "social competency" includes four areas of social functioning. These are: self-help, initiative-responsibility, social skills and communication. The San Francisco Study defines these subscales as follows:

- (1) The Self Help subscale is designed to measure the child's manipulative ability or motor skills. The concern here is solely with manipulation and not whether the child must be directed to do the skill or whether he initiates the activity. The greater the child's manipulative ability, as reflected by his Self Help score, the more socially competent is the child.
- (2) The Initiative-Responsibility subscale is designed to measure the degree to which the child's behavior is self-directed. The child who must be directed to an activity is defined as being less socially competent than the child who initiates that activity. It is conceivable that two children of equal manipulative ability will differ in the amount of responsibility or in the self-direction they assume.

¹ Cain and Levine, op. cit., p. 189.

² Prior to becoming aware of the San Francisco Study the writer observed the special class on several occasions. He catalogued class procedure and devised rating scales to test progress in self-help and emotional growth. Upon examination of the San Francisco Social Competency Scale it was decided to seek permission of the authors to use an adapted form of it in this study. The authors generously gave their consent.

- (3) The Social Skills subscale is designed to assess the child's movement toward engaging in interpersonal relationships with other children and adults. The more the child is able to relate to others and to participate in group situations, the more socially competent he is.
- (4) The Communication subscale is designed to measure the degree to which a child makes himself understood to people in general. The greater the child's adequacy in communicating his wants, the greater his social competence.¹

The second hypothesis is: "The improved social competency of the boys will positively affect their acceptability² to their own families and non-institutional communities." There is a need for much more research in the area of attitudes toward retarded children. Blodgett says:

We need to find out some of the most elementary information, not just about the retarded child, but about the families, about the normal children in the families, about the possible reactions (negative and positive) that might be related to the presence of a retarded child in the home. Much of this information is not available, and we believe it is important to the formulation of significant questions yet to come.³

A study completed in June, 1961 by the San Francisco State College on the effects of community and institutional school classes for trainable mentally retarded children, found, as mentioned earlier, that the social competency of trainable children was not significantly affected by present special training, either in community

¹ Cain and Levine, op. cit., pp. 181 - 182.

² Acceptability is defined as the degree of favourable approval and reception represented in expressions of affection for, pride in, and patience with the child, in overall family, neighbourhood and community relationships.

³ Blogett, Harriet E., "Report of a Research Study at the Sheltering Arms, Minneapolis, Minnesota", First Winfield Institute: Research in the Management of the Mentally Retarded Child, Winfield State Training School, Winfield, Kansas, October, 1956.

or institutional schools and that the adaptability¹ of parents to their children was not significantly related to the child's attendance at special classes. However, it did show that adaptability of the parents to the child is related to the social competence of the child.²

A sample group of ten trainable boys was selected for study. Each boy is between the age of eight and seventeen, is without severe physical or emotional handicap, has been resident in the institution and has attended special classes for at least one year; who, after this time, has visited his home for a period of at least five consecutive days and nights. Because all boys in the above category attend special classes in the institution, it was not possible to select a control group. The practicability of using a control group of girls was explored but decided against when in addition to the sex variable, variables of I. Q., emotional health, and age were pronounced.

Other variables in this study forbid analysis of

¹ The authors attribute three components to adaptability. 'Flexibility' is defined in both attitudinal and behavioural terms; it represents an attitude which individualizes the child in the light of a specific situation, as opposed to stereotyping both the child's behaviour and the situation. It also represents the ability to employ alternative means of action. 'Empathy' is defined as the parent's ability to interpret his child's behaviour in terms of feelings, thoughts and motives and to relate this understanding to the specific situation in which the parent and the child are involved. And 'motivation' is defined as a particular form of derived social motive; specifically it is the motivation of the parent to solve interpersonal problems with his child.

² Cain and Levine, op. cit., p. 163.

information gathered for the sake of actually proving either of the presented hypotheses. Rather, information was sought for descriptive and explorative purposes. It is hoped that results substantiate the idea that a more thorough and comprehensive study should be undertaken. Other variables include: differing amounts of time spent in the institution and in the special class; the effect of institutionalization itself, and the living relationship amongst peers of similar intellectual and emotional development; the effect of various other institutional programmes, including occupational therapy, recreational activities and group entertainment; the changing in family matrix and consequential shifting of family pressures, because of discharge of care responsibilities for the child to the institution at the time of and following his admission to the institution.

Procedure. Letters requesting their participation in this study were sent to the parents of each boy chosen to be a member of the sample group (see Appendix "A"). The letters were followed up by telephone calls, at which time interviews with parents in their home were scheduled.

Each family was then visited by the same social worker. The adapted Social Competency Scale (see Appendix "B") was explained and parents were requested to complete the Scale twice. The first time they were to be guided by memory of their boy's social functioning before his permanent admission to the institution. The second time they were to complete the Scale from observation of the child during his recent visits home. The Scale was left with the parents so that they might complete it at their leisure. A

self-addressed stamped envelope was also left so that when forms had been completed, they could be dropped into the mail. After explaining this procedure, the second part of the research, interviewing parents concerning their attitudes of acceptability to the retardate was conducted. A projective interviewing technique was used. Parents were asked to give their impressions as to how other parents in circumstances similar to their own might feel toward their trainable mentally retarded child before and after training in the institution commenced. Before and after feelings were discussed consecutively as each item on the Parental Acceptability Scale (see Appendix "C"), (devised by interviewer), was considered. Four mothers and one father were interviewed alone. Four couples were interviewed together. Interviews lasted from 1½ hours to 3 hours.¹ Each item on both scales was scored from 1 - 4 or 5, on a low to high basis.

The teachers of the special classes were asked to complete Social Competency Scales for 5 of the 10 boys as they now function. This was to check the reliability of parental observation of their child's present functioning. Information from institutional files was used to substantiate parental observation of past functioning.

¹ When, in the course of the interview, the amount of time spent extended over one hour, it was explained to parents that the interview could be terminated and continued on another occasion. However, in every instance the parents preferred to go on. This may be an indication of the degree of their involvement. Only one interview was completed in one hour's time.

CHAPTER II

HABILITATION AND TRAINING OF THE CHILDREN

The Purpose of the Institution

The severely retarded will always require nursing care. Some require complete or specialized nursing care which is available only in a hospital setting. Parents may be able to provide care during early years of life; however, demands will be extremely heavy, and the rewards few. Permanent institutionalization will probably be necessary for most of these patients.

Some parents may lose or never have had the ability to cope with the demands of the moderately retarded. The physical and emotional strain may so adversely affect the home as to seriously disrupt development of normal siblings, inflict impossible financial obligations on the family, engender marital strife, and perhaps lead to complete breakdown of home life.

Day care centres in a few communities provide nursery service for children up to about age seven or eight. And some 50 Associations for Retarded Children chapter Schools provide classes for older children in B. C. Again because of the B. C. Education Act amendment of 1959, more classes for the moderately retarded are being provided in regular public schools. In spite of these services, many families find they cannot carry on and desperately plead for the admission of their children to the institution.

Planning is going ahead in some areas to provide

resources for care of the moderately retarded in the community. For instance, near Chilliwack, B. C., a short stay hostel is to be erected. A few children may stay in residence here and attend special classes. It may be that this type of resource is a forerunner to a permanent community type residence. Here the moderately retarded trainable person will live with others nearer his own intellectual and social ability. It is of interest to note that this venture was started by a private group of persons through their local A. R. C. B. C. chapter. An appeal to the Provincial Government was made for financial help and rewarded by a government grant of 50% of the capital building costs. This has encouraged other chapters to consider building residences too, i.e., on Vancouver Island.

The mildly retarded or educable receive academic training and some vocational instruction in the institution. Most in this group are admitted because of behavior problems or other difficulties that have made it extremely hard for them to constructively fill in their time within the community. C. A. R. C. reports that in about 30% of the mildly retarded, psychiatric disorders complicate the basic handicap. Much of this may be attributed to mismanagement of their care.¹

There are few adequate resources in the community where

¹ Stanley, J. C., C. A. R. C. Report to the Royal Commission On Health Services, St. John, New Brunswick, 1959, p. 4.

the mildly retarded may be given vocational training. For example, The Vancouver Vocational Institute requires grade X for entrance. Nor are there adequately planned social media in which these persons may participate at their own intellectual level. Not being able to cope, many families have found it necessary to arrange institutionalization. Lack of community resources is underlined every day by community requests that the mildly retarded be allowed to take part in the institution's programme while continuing to live at home. This problem has also seriously restricted opportunity for rehabilitation of those living in the institution. For, after receiving training and after maturing emotionally to the point where they might return to the community, resources to assist are inadequate. Because of lack of community resources, such as supervised residential facilities, and lack of employment opportunities, many of the residents of the institution who could live outside its walls seem to be destined to a life of gross dependency within the institution.

The large provincial institution should probably eventually be reserved more and more for the seriously intellectually, physically and emotionally handicapped. Zalelki says: "Ideally there should be very few permanent cases in an institution. Only those so severely retarded that they are unresponsive to training and who would be an unfair burden for the family could be considered as permanent residents. Others should be admitted when there are some specific indications but returned to the community as soon

as possible."¹ At present, however, the institution is making a significant contribution by providing resources which are not existent elsewhere. Not the least amongst these are the training facilities which are helping to establish training curriculum which may be adaptable to community programmes.

Waiting List and Priorities for Admission. There are not enough beds to accommodate all children who seem to be raising formidable obstacles in the path of family living. The institution is often able to admit only on emergency bases. New applications arrive daily. At present, the waiting list at The Woodlands School is more than half the size of the total patient population. As of March 1st, 1962, this list totalled 761, while the patient population was 1,343.

Each application is rated according to the needs of the child and the needs of the child's family. If the family resides in the Vancouver-Lower Fraser Valley area, a social worker from the institution calls at the home and elicits information required to evaluate the need. If the family lives elsewhere in B. C., the local Department of Social Welfare or Public Health Unit is requested to prepare a social history. Information so received is assessed by a rating scale and points assigned. This method assures equal consideration to applications whether the family resides near the school or not. It also affords a measure of protection to the

¹ Zalelki, W. A., "Some Advantages and Disadvantages of Institutionalization", The Fourth Conference on Mental Retardation, C. A. R. C., Vancouver, September 26 - 28, 1961, p. 18.

admitting staff who may be subjected to pressure by parents, local physicians, council members, teachers, or other influential persons.

Though the waiting list is very large, the date of application is only one determinant for admission. Therefore, it is difficult to estimate the length of waiting. For some it may be six months, for others six years. The overall urgency for admission is the main criteria.

Despite a marked change in public and professional attitudes over the past ten years regarding institutionalization of retarded children, there are still some physicians who recommend immediate admission of most children diagnosed mentally defective at birth. This practice is gradually being modified in lieu of the studies mentioned by such persons as René Spitz, John Bowlby and others on the affects of maternal deprivation. For example, The Woodlands School has experienced a reduction in applications to have mongoloid children admitted within the first few months of birth.

Another important piece of knowledge has been emerging as interaction between collateral social and medical agencies is prompted. To the present time, there has been pressure on the institution from many areas to accept the responsibility of difficult mentally deficient children. Community services, such as the child caring agencies and Public Health Units, whose staff members visit families with a child on The Woodlands School waiting list, are accepting more responsibility. It seems the trend is towards

development of community resources. At one time considered the only resource, the institution will probably be only one in a whole spectrum of resources. These include: retarded children's schools (now under The Department of Education), kindergardens (now to be financed by The Department of Education), day centres, hostels, and sheltered work shops. As these resources develop, parents and agencies will have some alternatives to institutionalization.

This trend is partially attributable to public education, much of this by parents' groups; and partially it is due to the hard, cold reality that the institution will never have enough beds, or other facilities to handle the obvious needs.

Legal Requirements. Up to 1954, any mentally defective person could be admitted to a mental hospital by Court Order after committal papers had been duly signed by two registered physicians. In 1954, however, The Mental Defective's Act was modified. Change provided for final decision concerning admission to be made by the Medical Superintendent of the institution. This was a big step forward. It allowed a firm priority basis for admission to be set up. The institution can now screen applicants and refuse admission to those who can be cared for in the community. It also strengthened the responsibility of institution diagnostic clinics, a fact quite evident in the institution's present procedure of admission. Each patient is now admitted on a temporary basis. Examination (including consultation with community collateral when so indicated) is conducted and medical, psychological and social assessments

correlated. These in turn are supplemented by ward and school observations made over a period of time. With such first hand observation, planning for permanent admission or for return to the family in the community is being done on a realistic basis.

Intake. Before any patient is permanently admitted to the institution he is admitted for a temporary period of thirty days. By the time arrangements for this have been made, information has been compiled from various sources. The social worker has prepared a social report. The physician has requested medical information from collaterals who have made previous medical examination. Provincial laboratory tests have forwarded results of the child's urine and feces specimen tests.

When parents arrive at the school with their child, they are met by the physician. The physician gathers further pertinent data, examines the child and arranges placement on the ward. If available, a social worker introduces parents to the ward staff, who in turn show them where their child will reside for the temporary stay. The social worker also answers questions concerning the total function of the institution, population, visiting regulations, and channels of continued contact between the institution and the parents. Often parents have been ill-prepared for this experience and are helped if a social worker is free to discuss feelings and attitudes. This is a vitally important service. However, shortage of staff has made it physically impossible in many cases.

The Treatment Team

The medical superintendent, a psychiatrist, is the coordinator of the team. Ward physicians examine, treat and prescribe for patients. They also conduct medical tests and may call for consultant services. Ward nurses administer medication. Assisted by ward aides, they attend to the nursing requirements of their patients, and observe ward self-help and social behavior of the patients. Clinical psychologists conduct tests to study the mental processes and behavior of the patients. Social workers maintain liaison between treatment staff, families, and community social welfare and health services. Teachers observe the child in the class. Occupational and physiotherapists, and recreation directors observe in their departments.

Toward the end of the thirty day admission diagnostic clinic is held. The medical superintendent presides. Reports are submitted by staff representing his or her treatment area. Medical diagnosis is completed. This is related to observed activity in the institution and social circumstances of the family and community. A prognosis is postulated and plans made for immediate, near future, deferred or no permanent admission.

The conclusions of the clinic are conveyed to the community medical practitioners involved by the patient's institution physician. If the child's parents reside in the local area or are able to come to the institution, social data in the light of clinical assessment is interpreted directly by the institution's social worker engaged for the case. If parents are not able to be

reached in this manner, information is interpreted to the Social Welfare Department and, or, the Public Health Unit concerned, who, in turn, will interpret to parents. If the child is to be immediately admitted on a permanent basis, he (she) is assigned to the appropriate ward according to age, sex, physical and mental classification.

Casework Services

Social casework services to families with retarded children have been sporadic and somewhat inconsistent. Social welfare departments are too laden with other tasks, and on the whole are staffed by personnel lacking sufficient casework training to be able to give this type of service. Children's Aid Societies and Public Health Units have been in a similar position. In practice, most families have been referred to the institution for help - often as an emergency measure and when casework service in itself is an inadequate resource. The institution's social service staff is too limited to consider giving regular casework services to all those who require it. Often its staff is assigned the job of picking up the pieces of shattered family life, a task fraught with failure.

Family pressures, unrelieved over too long a period, mount up. Affection for the retarded child is sometimes lost in the maze of painful demands on parents and siblings alike, and the way opened for serious future family conflict. There has been a tendency to shy away from this problem because it made even

professional people uncomfortable (as mental illness has in the past). Social workers rationalized that the retarded child was really a medical problem. They reasoned that they could not help other than to advise institutionalization and so worked with the family to help them accept institutionalization, and without regard to the fact that there were no beds available! Many physicians approached the problem as one being strictly medical and recommended institutionalization as the only answer, again in spite of the fact that the institution was filled to capacity. Public Health Nurses saw the emotional problems and sidestepped them because they were not caseworkers. Thus families generally have been rejected by professional people and agencies.

There is an emphasis now on provision of service from the community in which the family resides. This, of course, means services will have to be increased, correlated and mutually supportive. The aim is to provide help early enough to prevent family breakdown and to promote community responsibility.

The Number of Mentally Retarded Persons

It has been estimated that of some 4,200,000 children born annually in the U. S. A., 3% (126,000) will never achieve the intellect of a twelve year old child; 0.3% (12,600) will remain below the seven year intellectual level; and 0.1% (4,200) will, if they survive, require total nursing care.¹ Applying these

¹ Masland, L., et al, Mental Subnormality, Basic Books, Inc., New York, 1958, p. 3.

percentages to Canada, it means that of each 1,000 children born, about thirty will be mentally deficient. C. A. R. C. estimates that of these thirty, twenty-five will be mildly retarded, four moderately retarded and one severely retarded.¹ For the estimated numbers of mildly, moderately and severely retarded now living in all of Canada, see Table 1. For those living in British Columbia, see Table 2.

Of the 450,739 live births in 1956 in Canada² it is estimated that 11,268 are mildly retarded, 18,030 moderately retarded and 4,507 severely retarded. The corresponding figures for British Columbia in the same year are (of some 36,241 live births) 906, 157 and 36. There has, of course, been an increase in the birth-rate. The total population of Canada has risen from 16,008,791 in 1956 to 18,238,247 in 1961; in British Columbia, it rose from 1,398,464 to 1,629,082.³ This means that in all of Canada there are now approximately 455,956 mildly retarded, 72,953 moderately retarded and 18,238 severely retarded. The corresponding figures for British Columbia are 40,727, 6,516 and 1,629.

It is of note that to December 31st, 1960, 2,320 retarded children nineteen years and under were registered as residing in their communities in The B. C. Provincial Crippled Children's

¹ Stanley, op. cit., p. 5.

² Canada, Dominion Bureau of Statistics, Census Division, Census 1956, Vol. 1, part 9.

³ Canada, Dominion Bureau of Statistics, Census (Demography) Division, Population Section, Census of Canada 1961, Advance Report, No. AP-1, March 16, 1962.

Table 1. Population of Canada and Estimated Numbers of Mentally Retarded Persons

Age Groups	Population For Age Group	Estimated Population For Mentally Retarded			
		Mild	Moderate	Severe	Total
0 - 4	1983563	49589	7934	1984	59507
5 - 9	1807052	45176	7228	1807	54211
10 - 14	1434594	35865	5738	1435	43038
15 - 19	1162301	29058	4649	1162	34869
19 & up	9693281	242332	38773	9693	290798
Totals	16080791	402020	64322	16081	482423

Source: Canada, Dominion Bureau of Statistics Census Division, Census 1956 - Vol. 1, part 9.

Table 2. Population of British Columbia and Estimated Numbers of Mentally Retarded Persons

Age Groups	Population For Age Group	Estimated Population For Mentally Retarded			
		Mild	Moderate	Severe	Total
0 - 4	156759	3919	627	157	4703
5 - 9	140588	3515	562	141	4218
10 - 14	108518	2713	434	108	3255
15 - 19	86433	2161	346	86	2593
19 & up	906166	22654	3625	906	27185
Totals	1398464	34962	5594	1398	41954

Source: Canada, Dominion Bureau of Vital Statistics, Census 1956 - Vol. 1, part 9.

Registry. According to estimates, there were a total of 14,769 retarded nineteen years and under in British Columbia in 1956. Excluding the total institutional populations of The Woodlands School and its Annex, The Tranquille School (Tranquille, B. C.), these figures would suggest that there are some 11,000 unregistered mentally defective children under the age of nineteen in British Columbia.

The Classrooms

The special classroom, fifty feet by twenty-two feet is situated on the basement floor of a boy's residence. The room is divided only by pillars. Equipment for various activities is ranged in semi-permanent fashion in different areas of the room. This includes a grocery store area, a bus area, a street cross-walk area, a multiple teaching area, and so on. Each area is set up in a manner closely simulating that presently found in the community at large. For instance, the grocery store is decorated by sale pennants, signs, and so on. It is stocked with real merchandise. Special equipment, such as a tape recorder, radio, television, slide projecture, record player and so on are arranged throughout the room without particular built-in protecting devices. The boys are taught to respect property.

Adjoining the special classroom is a self-care room approximately twenty-two feet by twenty-two feet. Its equipment includes a shoe polishing stand, dinner table, chairs, dishes, cutlery, glasses, beds, sink, a clothes rack and hangers, full 'boy

size' dressing dolls, an individual window frame separated from the building as such and containing glass, and so on.

Next to this room is a playroom approximately fifty feet by twenty-two feet. Except for pillars the room is open and provides an area both for play and for practicing washing and cleaning methods learned in the self-care room.

Self-Care Room Activities.¹ While the special classroom and the playroom are occupied, a group of twelve boys come to the self-care section for two hours training. They first go to the wash-room where they practice washing their hands and face, and brushing their teeth. From here they go to the self-care room itself where they cream their faces to avoid chapping. They then practice brushing and combing their hair with the use of a mirror. Approximately one hour's time is spent doing these things. For the next hour, in groups of two, the boys spend approximately five minutes on each of the following activities: making beds, folding clothes, washing window, setting the table, washing dishes, putting on clothes, lacing and shining shoes, and dressing life-size dolls. On some days they are taught how to wash walls and polish floors.

¹ Under the direction of Mr. John Wicentowich.

Special Training Class Activities.¹ Class is begun by a very simple prayer said by the teacher and repeated by the class as a group. Roll call is taken and activities begun. There is no set sequence. It may be that the boys show more interest in some projects than in others on certain days. The teacher is sensitive to their feelings and capitalizes on any evident motivations for learning by encouraging the expression of these.

The motto of the special class, "Play to Learn" is followed (see Appendix "D" for classification of classroom activities). It may be that some games are more popular than others. If the teacher feels that a child lacks interest in a project, he seeks to stimulate it, not only by making the activity as colourful and fun-filled as possible, but by rewarding the child's adequate participation by letting him later do a favourite game. Besides the

¹ Under the direction of Mr. Julius Erdelyi. Mr. Erdelyi was born in Hungary. As a young man he attended Teacher's College there for five years. Shortly before the war he became a member of the Szeged Opera Group and was a baritone soloist. He joined the Army in 1936 and saw action on several fronts. When taken prisoner of war, he held the rank of Captain. After release, he worked as a labourer in Austria for two years and then went to England. There he worked at various jobs including those of ward aid in hospitals for the chronically physically handicapped. In 1957 Mr. Erdelyi came to Canada. He was employed at hospitals in Quebec, then 'came west' and attached himself to The Woodlands School. In retrospect, having become dedicated to his work, Mr. Erdelyi says, "The biggest break in my life came when Mr. Elliott, chief psychiatric male nurse, asked me to start a special class for trainable boys." With a devotion and investment of self surpassed by no other staff member of The Woodlands School, he began his class, personally equipped the classroom by getting donations from interested community members, and besides teaching, has continued to develop classroom procedures, techniques and facilities. He has aroused much community interest throughout the Province of British Columbia, both in parents and professional persons alike. During 1961, nine hundred and forty-seven people visited his classroom.

motivational aspect involved when a child is thus promised a favourite activity for a well done less popular one, most projects are interwoven with others and serve to reinforce and encourage carry over of learning from one area to another.

Dramatic playing is used extensively. Children dress for their special parts. Each has his turn, on different days, to take lead or popular roles. These roles may be: bus drivers (for trips to farm, country, zoo, airport, railway terminal, other institutional settings, park, and so on); mailman (to deliver letters to each of the class members); mailboy (to deliver letters into the classroom mail box, or to deposit official institutional mail in an official mail box); grocer (to select merchandise for shoppers); shopper (to take messages to the grocer for merchandise); telephoner (to send special messages to the grocer); milkman (to deliver milk, and select proper size cartons or bottles); fireman (to prepare for and properly use fire equipment); fisherman (to encourage dexterity); camper (to relate schoolroom activities to actual camping); newsboy (to buy newspaper from classroom honour boxes). Boys are taught to do errands in the classroom. These may involve as many as four of the above activities at once and so, also, the concept of time. For example, a child is instructed to, "(a) Go to the store, (b) buy a big bag of oranges, (c) but before, (d) mail this letter, (e) after, buy a "Sun" newspaper."

Boys are taught traffic rules. They are taught to associate movements and sounds with specific games (as ping-pong,

tennis, rugby and so on). They play several games to stimulate various abilities. These include, "What is missing?" (remembering four objects and one removed), "What is his name?" (guessing class-mate's name from his voice when blindfolded), "What is it?" (guessing articles by smell when blindfolded), "Where does it go?" (putting puzzle pieces in proper order).

Boys are taught to count numerals 1 - 20, and in a variety of ways practice. They are taught how to use steps, to recognize common signs, to tell time, to manipulate window blinds. They are given phonetic lessons. In games they are taught size concepts, colours, shapes, new words, manual dexterity (buttoning, lacing, putting bolts on screws, sawing wood, polishing wood and so on). Drawing and colouring games are related to objects within the classroom - which include, for example, a stuffed duck and a mounted deer head.

The boys are taught the care of pets. Live animals and birds are exhibited in the classroom from time to time. Likewise, they are taught the care of plants, and when weather permits, the care of grass.

The children enjoy forms of simple music. They are taught to recognize and keep time to certain pieces. Audio-visual aids are used to make each "Play to Learn" game as real, stimulating and interesting as possible.

All activities are correlated. Each requires individual and group participation. Each is designed to encourage body co-ordination (motor skills), self-control, self-confidence, initiative,

discrimination, courtesy, sharing and respect for property. Sense perceptions are stimulated and related specifically (sight, sound, touch, taste, smell). Rules of safety are associated with play learning. The use of words and numbers are taught. The process of following directions, completing tasks is facilitated. And throughout all there is encouragement in the care of self, (clothes, grooming, hygiene and so on).

The boys attending the special class participate with enthusiasm and obvious enjoyment. They appear to be secure in the knowledge that they are important members of the group, that they can share friendship, that they are accepted by the teacher and fellow classmates. The emotional climate of the classroom seems to be one in which the boys may both relax and at the same time be stimulated to perform tasks rewarding because of the sense of accomplishment. Those parents who have visited have gone away not a little comforted by the knowledge that their child is a member of this training class.

CHAPTER III

MEASURING MOVEMENT

One of the criteria for the selection of boys for the sample group was that they had visited home after receiving at least one year's training. In other words, each family had to already be showing interest, and each boy had to have the opportunity to use his training in his family home setting.

Physical and Family Characteristics

All families of the boys in the sample group reside within thirty-five miles of Vancouver; and all ten have their own homes. Three of the families are of the lower income bracket and houses are inadequate. All three of these, D, F, and J,¹ are farm homes. One, G, is in an established middle-class neighbourhood in a city. Three, B, G, and I, are older houses in a city working-class area. One, A, is in a relatively new working-class area. Two, E and H, are in new city residential areas. All families but one are dependent upon the father's income, the other on the mother's. The income of two families, D and A, is under \$3,000 per year. The income of five others, B, F, G, H, I and J, is between \$3,000 and \$4,000 per year. For two others, C and E, the income is between \$5,000 and \$6,000. The father's type of employment

¹ Each of the ten boys in the sample group is identified in charts and script by one of the letters A to J. Each boy's family is identified by the same letter.

include: boomman, A; lumber grader, G; roofer, B; construction laborer, F; fireman, E; salesman, H; chartered accountant, C; and farmer, D, F, and J. The fathers represent several nationality backgrounds. These include: Swedish, A; Scottish, B; English, C; Ukranian, H; Irish, E; Dutch, F; Norwegian, G; and Lithunanian, H. The fathers' ages range from forty- four to fifty-eight years and mothers' from thirty-five to forty-nine years. In two instances, parents are separated and the normal children of these unions are now living with their mother. However, the father (A) shows continuing interest in his retarded child and has him home for visits in one case, the mother (I) in the other.

There are siblings in all but one family. They are listed as follows:

- A, aged fifteen, has a sister aged seventeen and a sister aged four and one-half.
- B, aged thirteen and one-half, has a sister aged ten and a brother aged seven.
- C, aged thirteen, has a brother aged seventeen.
- D, aged nine and one-half, has a brother aged seventeen (retarded), a sister aged thirteen (retarded) and the sister's twin, a brother, aged thirteen (normal).
- E, aged seventeen, no siblings.
- F, aged seventeen, has eleven siblings aged eight to thirty-three. Seven of these are at home. Two others are retarded and some of the other siblings have been quite slow in school.
- G, aged seventeen, has a sister aged thirteen.
- H, aged eight and one-half, has a brother aged twenty-seven and a sister aged fourteen.
- I, aged seventeen, has a brother aged eighteen and a sister aged eleven.

J, aged twelve, has eight foster brothers and sisters aged twenty-one to one and one-half years.

Measuring the Habilitation Progress

At the time of admission, except for boys A and J, each parent reported their child to be functioning at a level of dependency inhibiting both to the boys and the family. Among the behaviour problem traits, which affected parental attitudes to the boys, were: hyperactivity, withdrawal, destructiveness, babbling, screaming, biting, running away, noisy and attention demanding at night, anti-social mannerisms, and neighborhood problem activities. Much of this negative behaviour has disappeared since institutionalization. This may be partly due to special training. However, the number of other variables present in this study forbid making any direct conclusions. It is sufficient to suggest that special training may be significantly related to improved behaviour. Some improvement of each boy's functioning in Self-Help (Tables 3, and 4), Initiative-Responsibility (Table 5) and Social Skills (Table 6) was reported by all parents. In Communication (Table 7) two boys (A and I) showed no improvement, and one (E) showed less ability. Parents of A and I noted their boy as having high communication ability before admission to the institution. They assigned the same high rating after training. Boy E's ability to use speech has regressed due to organic deterioration.

Interviews with parents revealed that to all but two parents the boy is more acceptable after institutionalization and training than before (Table 8). Seeing their child do things

Table 3. Social Competency: Ia. Self-Help;
Items: 1: Undressing. 2: Removing outer clothing. 3: Dressing.
4: Putting on shoes. 5: Care of shoes. 6: Washing (hands and face).
7: Care of fingernails. 8: Combing or brushing hair. 9: Brushing
teeth. 10: Blowing nose.

(Comparison of Sample Group, Before and After Training)
Ten cases listed alphabetically.

Items	Before Training										Totals Before	After Training										Totals After
	A	B	C	D	E	F	G	H	I	J		A	B	C	D	E	F	G	H	I	J	
1	4	3	1	1	1	2	2	2	4	3	23	4	4	4	2	4	4	4	4	4	3	37
2	4	3	1	1	2	2	3	1	4	3	24	4	4	2	3	4	3	4	3	4	3	34
3	4	3	1	1	2	2	2	2	3	2	22	4	4	3	2	3	2	4	5	5	2	34
4	3	3	1	1	1	1	2	2	2	4	20	3	3	4	2	4	3	3	3	4	4	33
5	3	1	1	1	1	2	3	1	1	2	16	3	3	3	3	4	3	4	3	4	2	32
6	3	2	1	1	1	1	1	4	3	2	19	3	4	3	3	4	3	3	4	4	2	33
7	3	1	1	1	1	1	1	1	1	1	12	3	1	1	1	1	1	1	1	1	1	12
8	2	1	2	1	1	1	2	3	3	2	18	3	1	2	3	4	3	4	4	4	2	30
9	5	3	1	1	3	3	3	3	5	2	29	5	5	5	3	5	4	5	4	5	3	44
10	4	1	2	1	1	1	2	3	3	1	19	4	3	2	1	1	4	3	4	4	1	27
Totals	35	21	12	10	14	16	21	22	29	22	202	36	32	29	23	34	30	35	35	39	23	316

The meaning of the items, and the "ratings", is explained in the text.

Table 4. Social Competency: Ib. Self-Help;
Items: 11: Eating. 12: Use of knife. 13: Serving food. 14: Passing
food. 15: Clearing table. 16: Cleaning up (liquids). 17: Cleaning
dishes. 18: Opening door. 19: Sweeping. 20: Making bed. 21: Folding
articles.

(Comparison of Sample Group, Before and After Training)
Ten cases listed alphabetically.

Items	Before Training										Totals Before	After Training										Totals After
	A	B	C	D	E	F	G	H	I	J		A	B	C	D	E	F	G	H	I	J	
11	5	3	1	1	3	3	3	3	4	3	29	5	3	3	4	4	4	4	5	5	3	40
12	5	1	2	1	1	2	2	2	4	3	23	5	3	1	1	1	3	4	4	4	3	29
13	5	2	1	1	2	3	3	4	4	2	27	5	4	2	4	5	4	5	4	5	4	42
14	4	4	1	1	1	5	3	4	5	2	30	4	5	2	1	5	5	5	5	5	4	41
15	4	2	2	1	1	3	2	2	1	2	20	4	3	1	3	3	5	4	4	3	2	32
16	3	1	1	1	1	1	2	1	3	2	16	4	2	4	1	4	3	3	3	3	3	30
17	4	1	1	1	1	1	1	2	1	2	15	4	1	2	1	2	4	4	4	4	2	28
18	4	3	1	1	3	3	2	3	3	3	26	4	3	2	3	4	3	3	3	4	3	32
19	3	1	1	1	1	3	2	2	1	1	16	4	3	2	1	2	4	4	4	4	1	29
20	3	2	1	1	1	1	2	2	1	3	17	3	2	3	1	4	3	4	4	4	3	31
21	3	1	1	1	2	1	2	1	2	1	15	4	2	2	1	5	3	5	2	2	1	27
Totals	43	21	13	11	17	26	24	26	30	24	234	46	31	24	21	39	41	45	42	43	29	361

The meaning of the items, and the "ratings", is explained in the text.

Table 5. Social Competency: IIa, Initiative-Responsibility;

Items: 1: Washing hands and face. 2: Brushing teeth. 3: Hanging up clothes. 4: Toileting. 5: Table setting. 6: Cleaning up mess. 7: Playing with others. 8: Initiating tasks. 9: Offering assistance.

(Comparison of Sample Group, Before and After Training)
Ten cases listed alphabetically.

Items	Before Training										Totals Before	After Training										Totals After
	A	B	C	D	E	F	G	H	I	J		A	B	C	D	E	F	G	H	I	J	
1	2	1	1	1	1	2	1	1	2	2	14	3	2	1	2	2	3	4	2	4	2	25
2	2	1	1	1	1	2	2	1	3	1	15	2	2	1	1	2	2	4	1	4	1	20
3	4	1	1	1	1	1	3	1	2	2	17	4	2	2	2	3	3	4	3	4	2	29
4	4	3	1	1	1	1	2	1	3	1	18	4	4	4	4	3	3	4	4	2	2	34
5	5	1	1	1	1	3	4	3	1	2	22	5	3	3	1	4	4	5	5	4	2	36
6	3	1	1	1	1	3	1	2	2	2	17	3	1	1	3	3	3	3	3	4	3	27
7	4	2	1	1	4	1	1	3	2	2	21	4	3	3	2	4	3	2	3	3	2	29
8	5	1	1	1	1	3	4	2	5	4	27	5	1	1	1	3	4	5	3	5	4	32
9	4	4	1	1	1	3	3	2	3	3	25	4	4	1	2	3	3	4	4	3	4	32
Totals	33	15	9	9	12	19	21	16	23	19	176	34	22	17	18	27	28	35	28	33	22	264

The meaning of the items, and the "ratings", is explained in the text.

Table 6. Social Competency: IIb, Social Skills;

Items: 1: Telling time. 2: Sharing. 3: Playing with others. 4: Care of self. 5: Telephone. 6: Going on errands. 7: Traffic signs. 8: Answering door. 9: Behaviour in public. 10: Attending tasks.

(Comparison of Sample Group, Before and After Training)
Ten cases listed alphabetically.

Items	Before Training										Totals Before	After Training										Totals After
	A	B	C	D	E	F	G	H	I	J		A	B	C	D	E	F	G	H	I	J	
1	1	1	1	1	1	1	1	1	1	1	10	1	1	1	1	1	1	2	1	1	1	11
2	2	4	1	1	1	5	2	4	4	3	30	4	1	1	3	5	2	5	3	5	4	33
3	3	3	1	1	4	1	1	2	1	2	19	3	3	2	1	4	3	3	2	1	2	24
4	3	3	1	1	2	2	1	2	2	3	20	3	3	1	1	4	3	2	3	4	3	27
5	3	1	1	1	1	1	1	2	1	1	13	3	2	2	1	1	1	3	3	3	1	20
6	3	1	1	1	1	1	1	1	1	2	13	4	2	2	2	1	2	4	3	2	2	24
7	4	1	1	1	2	1	1	1	1	1	14	4	1	1	1	3	1	3	3	2	1	20
8	4	2	1	1	1	3	2	2	1	3	20	4	3	2	2	3	3	3	3	3	3	29
9	3	2	1	1	4	2	1	4	4	2	24	4	2	3	1	4	3	3	4	4	3	31
10	4	1	1	1	1	1	1	1	3	1	15	5	1	2	1	5	1	3	2	5	1	26
Totals	32	16	10	10	22	15	14	20	20	19	178	35	19	17	14	31	20	31	27	30	21	245

The meaning of the items, and the "ratings", is explained in the text.

Table 7. Social Competency: IIC, Communication;

Items: 1: Delivering messages. 2: Answering questions.
3: Relating objects to action. 4: Use of language. 5: Spontaneous
speech. 6: Following instructions. 7: Speaking to adults.
8: Going places. 9: Playing with others. 10: Communicating
unhappiness. 11: Answering door

(Comparison of Sample Group Before and After Training)
Ten cases listed alphabetically.

Items	Before Training										Totals Before	After Training										Totals After
	A	B	C	D	E	F	G	H	I	J		A	B	C	D	E	F	G	H	I	J	
1	3	2	1	1	2	1	2	1	3	3	19	3	3	1	2	1	3	3	3	3	3	25
2	4	2	1	1	3	2	2	2	3	3	23	4	3	1	2	3	3	4	3	3	3	29
3	4	1	1	1	2	2	1	2	4	2	20	4	2	2	1	1	2	4	3	4	2	25
4	4	2	1	1	2	2	2	2	3	3	22	4	3	3	1	1	3	4	3	2	3	27
5	4	1	1	1	1	1	2	1	4	3	19	4	1	3	1	3	2	4	4	4	4	30
6	3	2	1	1	2	2	2	3	2	2	20	3	2	3	2	3	3	3	3	3	3	28
7	4	2	2	1	4	4	4	4	4	4	33	4	2	3	1	4	4	4	4	4	4	34
8	4	2	1	1	2	3	3	3	3	3	25	4	3	2	1	1	3	4	3	3	4	28
9	4	2	1	1	2	2	1	1	1	3	18	4	3	4	2	2	4	4	1	1	4	29
10	4	3	1	2	3	2	1	3	4	2	25	4	4	3	3	3	4	4	3	4	2	34
11	4	2	1	1	3	3	1	2	3	4	24	4	3	1	1	2	3	3	3	3	4	27
Totals	42	21	12	12	26	24	21	24	34	32	248	42	29	26	17	24	34	41	33	34	36	316

The meaning of the items, and the "ratings", is explained in the text.

Table 8. Parent Acceptability:

Items: 1: Playing with or teaching child. 2: Response to child's affection. 3: Parent's affection. 4: Comparing retardate to normal children. 5: Attitude to in-laws. 6: Attitude to friends or neighbours. 7: Attitude to strangers. 8: Planning after institutionalization of child. 9: Response to child initiating task performance. 10: Response to child's improved task performance. 11: Responses to child's failure in task performance. 12: Attitude to child in public places. 13: Attitude of neighbours to child. 14: Attitude of siblings in play with child. 15: Attitude of siblings to child when friends present.

(Comparison of Parent Sample Group, Before and After Retardate's Training. Ten cases listed alphabetically).

Items	Parents & Others	Parent Acceptability Before Training										Totals Before	Parent Acceptability After Training										Totals After
		A	B	C	D	E	F	G	H	I	J		A	B	C	D	E	F	G	H	I	J	
1	F	3	3	-	1	1	-	3	-	-	-	11	3	3	-	3	3	-	3	-	-	-	15
	M	-	3	2	1	1	2	4	4	4	4	25	-	3	3	3	3	3	4	4	4	4	31
2	F	4	2	-	2	2	-	3	-	-	-	13	3	3	-	3	3	-	3	-	-	-	15
	M	-	4	4	2	2	4	4	4	4	4	32	-	4	4	3	3	4	4	4	4	4	34
3	F	4	2	-	1	3	-	3	-	-	-	13	4	3	-	3	3	-	3	-	-	-	16
	M	-	3	3	1	3	4	4	4	4	2	28	-	4	4	3	3	4	4	4	4	3	33
4	F	3	2	-	1	2	-	2	-	-	-	10	3	3	-	3	3	-	4	-	-	-	16
	M	-	3	1	1	2	2	2	4	2	4	21	-	4	3	3	3	3	4	4	3	4	31
5	F	3	4	-	2	3	-	4	-	-	-	16	3	4	-	4	4	-	4	-	-	-	19
	M	-	4	4	3	4	4	4	4	3	4	32	-	4	4	4	4	4	4	4	3	4	35
6	F	4	2	-	2	2	-	4	-	-	-	14	4	4	-	3	4	-	4	-	-	-	19
	M	-	2	2	2	2	3	4	4	3	4	26	-	4	4	3	4	4	4	4	4	4	35
7	F	3	3	-	1	3	-	2	-	-	-	12	3	4	-	3	4	-	3	-	-	-	17
	M	-	3	1	1	3	3	2	4	3	4	24	-	4	3	3	4	4	4	3	4	4	33
8	F	4	4	-	3	3	-	3	-	-	-	17	4	4	-	4	3	-	4	-	-	-	19
	M	-	4	3	3	4	4	3	3	4	4	32	-	4	4	4	4	4	4	4	4	4	36
9	F	4	3	-	1	2	-	2	-	-	-	12	4	4	-	3	3	-	4	-	-	-	18
	M	-	3	3	1	1	3	2	3	3	3	22	-	4	4	4	2	4	4	4	4	4	34
10	F	4	3	-	2	2	-	3	-	-	-	14	4	4	-	4	3	-	4	-	-	-	19
	M	-	3	2	2	2	3	4	4	3	4	27	-	4	4	4	3	4	4	4	4	4	35
11	F	4	3	-	2	2	-	2	-	-	-	13	4	4	-	4	3	-	4	-	-	-	19
	M	-	3	2	2	1	2	3	4	3	4	24	-	4	4	4	2	4	4	4	4	4	34
12	F	4	2	-	1	2	-	2	-	-	-	11	4	4	-	2	4	-	3	-	-	-	17
	M	-	2	2	1	2	3	2	3	3	4	22	-	4	4	2	4	3	4	4	4	4	33
13	F	3	3	-	2	3	-	3	-	-	-	14	3	4	-	3	4	-	4	-	-	-	18
	M	-	3	1	2	3	2	3	4	2	3	23	-	4	3	3	4	2	4	4	3	4	31
14	F	4	4	-	1	-	-	3	-	-	-	12	4	4	-	2	-	-	4	-	-	-	14
	M	-	4	2	1	-	3	3	4	4	4	25	-	4	3	2	-	4	4	4	4	4	29
15	F	1	3	-	2	-	-	2	-	-	-	8	1	4	-	1	-	-	3	-	-	-	9
	M	-	3	1	2	-	4	2	4	4	3	25	-	4	2	1	-	4	3	4	4	4	26
Totals	F	52	43	-	24	30	-	41	-	-	-	190	51	56	-	45	44	-	54	-	-	-	250
	M	-	47	33	24	29	46	46	57	49	55	386	-	59	53	46	43	55	59	59	57	59	490

The meaning of items, and "ratings", explained in the text.

rewarding to himself and more pleasing to others is instrumental in improving parental feelings about having a defective child. They are less upset when the boy is compared with normal children. They are less embarrassed with the child in the presence of relatives, neighbours, friends and strangers. They have more patience with the child and are more curious about his newest achievements. Siblings are somewhat more accepting. All but two of the parents are quite convinced that special training definitely helped their boy to do more things for himself and prepared the child for more acceptable social intercourse with family and others. One parent (J) stated that training definitely helped the boy do more things for himself but thought his acceptability (which was rated high before training) had not changed. Parent (A) rated the training unfavourably because the child had lost his ability to write his name, a distinction he had learned while attending chapter school before institutionalization. Gains and losses in the boys' social competency and the parents' acceptability are shown in Table 9.

Case Illustrations

For purpose of illustration, two children have been selected. Selection was on the basis of changed parental attitude rather than change in the boys' social competency as such. The boy whose parent has shown the least change and the boy whose parents have shown the most change will be briefly described.

Case A. Johnnie was born May 1st, 1947, in a British Columbia coastal village. He was very slow in reaching his

Table 9. Composite of Social Competency and Parent Acceptability Scales Showing Gains and Losses After Retardate's Training

(Ten Cases Listed Alphabetically)

Cases	Gains of Child						Gains of Parent Acceptability				Gains of Parents and Child		
	Self-Help		Growth and Maturity				Father & Mother		One Parent	Two Parents			
	Ia	Ib	IIa	IIb	IIc	Total I & II							
A	1	3	1	3	0	8	F	-1	-1		A	7	
B	11	10	7	3	8	39	F	13			B	64	
C	17	11	8	7	14	57	F				C	77	
D	13	10	9	4	5	41	F	21			D	84	
E	20	22	15	9	-2	64	F	14			E	92	
F	14	15	9	5	10	53	F				F	62	
G	14	21	14	17	20	86	F	13			G	112	
H	13	16	12	7	9	57	F				H	59	
I	10	13	10	10	0	43	F				I	51	
J	1	5	3	3	4		F				J	20	
Total	114	126	88	68	68	464	F	60				628	
Total	Rating After Training						2170	824				2994	
	Rating Before Training						1039	576				1615	
	Possible Gain						1131	248				1379	

milestones. He suffered epileptic seizures during his fourth year. At five years he was admitted to the hospital for special examination. When he was discharged to his home a few weeks later, his seizures were still uncontrolled. He was diagnosed to have congenital cerebral maldevelopment, non-specific, with epileptic seizures due to encephalopathy of unknown etiology.

Johnnie lived with his mother and father, and a sister two years older than himself. His father worked for a lumber company. Parents considered placement of the boy early in his life but gave up the idea after being advised by the physician to wait until he was six years old. When he reached this age, they made inquiries about the possibility of admission to an institution. His sister was becoming resentful of the amount of attention given him by parents. His mother was nervous and upset. Relationships between parents were strained and deteriorating.

A year later the family moved to a community near Vancouver so that they might be close at hand when Johnnie was placed. No beds were available in the institution. However, the family was assisted in making arrangements for the boy to attend a school for the retarded. By this time (aged seven) his seizures were nearly controlled, he was toilet trained, and he was able to say a few simple single words. Parents willingly accepted plans to keep the boy at home when training was available in the community. He made little progress; however, parents reported home and school circumstances to be quite satisfactory.

Johnnie was eleven years old when his mother called the

institution to ask that admission be granted when possible. A baby sister was now seven months old. Johnnie had become quite a behaviour problem. He still had a very limited vocabulary but babbled continually. He was hyperactive and becoming destructive. He would run away and become lost. He would damage parked automobiles, turn on outdoor faucets when he found them, throw stones, and spit excessively. Other children treated him as a lout and played sadistic pranks on him. He was fed dirt, disrobed, dumped in mud-puddles and generally ill treated. In spite of these things, parents described him as placid and said they would prefer to keep him at home were it not for the indignities suffered by the boy.

A month later, Johnnie's mother requested emergency admission for him. One of her parents, who lived up the coast, had become seriously ill, and she felt compelled to visit and render nursing care. In view of the overall circumstances, the institution granted admission to the boy.

At the institution, Johnnie was reported to be able to feed and dress himself. He also cared for his own toilet though regularly was subject to nighttime enuresis. Seizures were now controlled by medication.

Johnnie was tried in special academic classes for the first year but it was found that he could make no progress. He was transferred to the special training class where for the first six months, his classroom conduct was distinguished by hyperactivity. He cried excessively, was overly sensitive and very

restless. However, he gradually settled down and began to participate. He showed more enjoyment in various activities and began to learn to recognize colors and numbers, as well as how to do various practical things. Though he was able to say a few single words, even these were often incomprehensible. It is felt that he has made some significant strides forward in spite of the fact that the teacher now gives him a rating on the Social Competency Scale which is considerably less than that awarded by his father. Psychological tests in April, 1959, assigned an I. Q. score of 35, (Stanford-Binet - Form L). At the same time, the Vineland Social Maturity Scale was given.¹ Retesting with the Vineland Social Maturity Scale in April, 1962,² it was found that Johnnie shows marked improvement in three areas - ability to receive direction and apply this in self-help, ability to occupy himself without supervision, and ability in socialization.

It is to be noted that though the parents maintained contact with Johnnie and have had him home to visit, neither parent ever visited him in his classroom, or showed inquisitiveness regarding the training he was receiving there. It is noted too, that marital strain in the home continually mounted, and that eventually, when Johnnie was fourteen years of age, the couple separated. Mrs. A. took the two girls with her. Mr. A. has continued to have Johnnie visit for a day once a month and also had him home last

¹ Psychological tests conducted at The Woodlands School.

² Ibid.

Christmastime (1961) for a week. On these occasions he claims that the boy is no better, or no worse than he was before he entered the institution. Mr. A. is strongly critical of the special class because Johnnie, who he claims learned how to print his name in his former school, can no longer do so. His conversation revealed that he obviously placed a great amount of importance on academic achievement rather than on the practical things that the boy might learn to do. In spite of this, he says that the boy is now able to do things around the house, such as washing dishes, sweeping the floor, making beds, and that Johnnie actually enjoys doing these things.

Mr. A., now forty-four, attained Grade 7 education. He is a hard worker, though has been unemployed on several occasions. His parents came from Sweden where they had a small farm, and settled on the British Columbia coast. There he and Mrs. A. grew up and married. They were at a loss to know what to do when Johnnie was born handicapped. However, they received some guidance from a nearby physician. Family strain gradually became pronounced. Johnnie's older sister became upset and jealous. Attempts were made to arrange his institutionalization. Finally the family moved near to the institution and made arrangements for Johnnie to attend a community school for the mentally retarded. There he made little progress, but the family was able to carry on. When Johnnie was ten, a baby sister was born. His behaviour began to deteriorate and over a period of eight months, he became very hyperactive and destructive. Admission to the institution was arranged on an

emergency basis. Yet for all this, the father has been able to observe no advance in the boy's social competency since special training classes began over two years ago.

There are several possible explanations for this. One, of course, is that Johnnie may actually not have advanced beyond his functioning level of social competency as of the time of his institutionalization. However, up-to-date social competency ratings suggest otherwise. It is more probable that parents have expected too much of the boy. He was able to learn to print his name after attending a community school for retardates for almost three years, but he actually made little progress. Whether he knew what he was doing when he printed his name is another question. Perhaps the parents attached little importance to simple skills and more to academic. Gross subjectivity seems to be a possibility in the father's observation of this boy, particularly when he admits that Johnnie now does such things as wash the dishes and that he could not do these things before.

Another possibility, too, is that the marital upset and separation of Johnnie's parents left Mr. A. more defensive. He emphasized how the "good parent" should do this, that or the other thing for his retarded child. He allowed himself to be critical of his other children's feelings about bringing their friends home to visit while Johnnie was also at home. Otherwise, he did not permit himself to show any feelings that were suggestive of rejection.

Though Johnnie did not receive a good progress report from his former community class, perhaps he did make strides ahead

as far as his parents were concerned, at least in their 'mind's eye'. Vision of these strides may have been so advanced as to preclude the possibility of further improvement. In any case, Mr. A.'s projected picture of Johnnie is one of a competent, resourceful, very acceptable boy who is able to perform at a level significantly higher than that observed in day to day special classes by his teacher. Likewise, Mr. A. presented a picture of an all accepting parent rating extremely high on the acceptability scale.

Case D. Tommy was born September 21st, 1952. His parents learned that he was a mongoloid when he was five months of age. He is the youngest of four siblings. One brother, aged thirteen, is normal while his twin sister suffers from hydrocephaly. His elder brother, aged seventeen, is physically well, but mentally retarded.

Tommy's parents were born in Russia. His father, now aged fifty-four, achieved the equivalent of high school standing in Russia. His mother, aged forty-four, came to Canada with her parents as a little child and achieved Grade 8 here. The couple were married in 1944 and have lived since then on his small farm in the lower Fraser Valley.

Mr. D., who was brought up in a Mennonite family, helped care for the children when he was not busy with the farm work; yet he did very little disciplining of the children. His wife had worked hard on her parents' farm up to the time of her marriage and had relatively good health. However, when Tommy was five,

the care of three retarded children proved too much for her. Her health began to break.

The eldest boy, Joseph, who had attended school for five years, had not been able to pass Grade 1. Parents tended to blame lack of progress on the teachers who, they claimed, lacked patience and were too nervous and high-strung to help him. Joseph was difficult but his parents ably cared for him at home. Mary, Tommy's only sister, was suffering more from a deteriorating hydrocephalic condition. Brother Jim was apparently normal.

Conditions in the home were most difficult. The house was extremely inadequate. Six persons lived in three small and poorly furnished rooms. Mrs. D.'s health was breaking under the heavy load of responsibility and worry. Mr. D., though helpful, was not able to discipline the children. Tommy had become a serious behaviour problem. One room of the small house had been reserved for him. Here he was kept caged; the parents were not otherwise able to handle the situation. He was completely dependent. His mother dressed, fed and tended him at toilet. He was incontinent of urine. He was capricious and destructive, and often threw objects. He required constant watching. Parents were most embarrassed by his conduct, particularly by his toilet habits and unpredictable mannerisms. For instance, he learned how to remove his clothing. This proved very upsetting to his parents if neighbours or friends visited. Eventually the family physician requested special consideration for Tommy's admission to the institution because of the mother's poor health and his concern for her.

Tommy was admitted when just over five years of age.

According to his parents, Tommy has made quite significant gains in his ability to care for himself and in maturity growth since his institutionalization. Noting the various tables which record change in the boy, we see that Tommy's gain is considerably less than some of the other children. However, he has moved forward to a recognizable degree. And the important thing in regard to this study is the pronounced change of attitude on the part of parents. Before admittance, they were unable to cope with his demands and were quite rejecting in a number of ways. Though they were rated as the least accepting parents before and after admission of the child, their increased acceptability was greater than any other parents. (See Table 8, p. 51). They now demonstrate this more positive attitude by having Tommy home for weekly visits at relatively short intervals.

This couple make an interesting observation; they note that neighbours may not be withdrawn because of the retarded child. They found that some neighbours had felt "snubbed" because they were not given normal attention by the family and so gave up "calling" themselves. Parents and neighbours finally got together, discussed this point, a gross misunderstanding was cleared up, and social relations were cordially restored.

When Tommy now visits home, he eats nicely with the rest of the family, wants to help by sweeping the floor, wants to polish his own shoes, dresses and undresses himself, washes himself, tends his own toilet, says "hello" to visitors, and is well-mannered in

their presence.

The general relief of care responsibility of this child is a variable we have not tried to measure in this paper. Other points we can suggest may be significant. One is that the family was unable to set limits for Tommy as a little boy. They were overprotective, did not allow the child any chance for accomplishment, and were completely uncomprehending of his behaviour reactions. Training has given Tommy the opportunity to accomplish things and to begin the process of establishing his own identity. Thus, when he now returns home for a visit, he is able to find his place amongst the other family members.

Parents are less embarrassed by him now. Friends may visit without them becoming upset. The family can take Tommy to church school and though he does not understand, neither does he make a spectacle of himself.

Seeing that the boy is actually able to learn, and that when he is at home visiting, he enjoys life as he never did before, parents are considering the possibility of eventually having him home to live with them on the farm. He has learned to identify objects about the farm, the sounds, the animals and birds. His enjoyment of this capacity has given the parents new pleasure and cause for pride. Where once the child seemed to be a 'cross' which could not be borne in addition to the responsibilities already weighting too heavily upon the parents, now Tommy is a person to be enjoyed and given a place in the family equal to that of the other children.

Evaluation of Training

Looking at the various scales, it is quite evident that each boy has made some progress. Several of them have made quite notable progress, at least as far as the parents who made the rating are concerned. Half of the boys were rerated by the teacher of the class and were given a score totalling an average of five points less per boy per area of study. (Tables 3 - 7, pp. 48 - 50). This does not include boy A. who the teacher rated an average of fourteen points less per area of study than did the boy's father.

The general concensus on the part of the parents is that their sons have progressed well; as a result, the boys are able to participate more in the activities of the home and community. This in turn has given parents objective cause for hope that the boys may actually get a good deal out of their lives through achievement at their own level of potentiality; it is hoped that they will also get enjoyment because of their broadened knowledge and experience.

In the institution itself, the boys are noticeably happier and more content. They are now able to perform much of their own self-care requirements. They have improved relationships with one another. The more advanced boys look forward with pleasure to their daily training classes, a fact that has been cheering to several parents. It should be noted that the boy who made the most progress in a comprehensive score of all areas of study, is one whose mother has consistently visited the classroom as well as having the boy home regularly for visits. This might suggest that increased parental interest evidenced by classroom visits could

increase pupil motivation for learning. However, this is another subject and would constitute a separate study for research.

Positive and Negative Observations of Parents¹

Ten interviews were conducted. These included four with couples (fathers and mothers together), five with mothers only, and one with a father only. A total of fourteen persons, nine mothers and five fathers, were interviewed.

Item 1, Amount of Time Spent Playing With or Teaching the Child. Four mothers and two fathers said they feel that the child's training has enabled them to spend more time with him. It was explained that other demands, such as having to dress the child, are effectively lessened. Thus more time is now available for social intercourse. Five mothers feel that there has been no change; four of these had given optimum amounts of time before training, and one, a substantial amount. Three fathers claimed they continue to give the same substantial amount of time as they did before institutionalization. One father is less inclined to spend time than his wife.

Parents noted that another adult in the home is influential. They feel that a mother or father left with full responsibility and without the assistance of another adult would have much less time available and so could not give as much to the child in play and teaching.

¹ See Table 8, p. 51.

Item 2, Response to Child's Expressions of Affection.

Two mothers and three fathers feel they are now able to respond more easily and sincerely to their child's expression of affection. Seven mothers and one father think their feelings, which are very accepting toward their child now, were the same before institutionalization. One father feels it is more difficult to accept the child's demonstration of affection since he has grown considerably physically, and it is now less becoming of a father. One father stated it is harder for himself than his wife, "men are like that."

In one interview, a mother stated that her child (H) was angry at her for several months after being institutionalized. She feels that classroom activities may have helped restore his ability to show affection. He sought to communicate classroom ideas to her and perhaps was thus able to set aside his bitterness.

Item 3, Parental Initiation of Expressions of Affection.

Four mothers and two fathers feel they are now more inclined to spontaneously extend expressions of affection to their child. Five mothers and three fathers feel that they have a high degree of spontaneity now and that this represents no change in attitude. One father felt less able to extend himself to the child than his wife.

Before the institutionalization of their child, one couple was very concerned over their lack of ability to handle the child, and the possibility that he would not develop affection toward them. They feel, however, that training has so improved their boy's behaviour (D) that he now pays attention to them.

They are more able to give affection and he to return it, a fact which is quite a relief to these people.

Item 4, Comparing Retardate to Normal Children. Most parents feel unhappiness over the child's handicap as it relates to themselves (the parents). Several pointed out that it would be most difficult if there were no normal siblings in the family. Training seems to several to have helped increase the competence of the child so that parents can have more pride in him. Seven mothers and four fathers feel this way. Two mothers and one father feel no differently, and both mothers' claims are now given full points for their attitudes. One couple commented that they could now leave the child at home with an older sibling while they went out, and that this was because the boy was better behaved. Another said that because of better behaviour, there is not so much cause for worry.

One couple was quite defensive about training. They had tried and had not succeeded to teach the child things he had later learned in school. This appears to have struck at their ability as parents. However, in spite of feelings here, they were able to observe progress with some gratitude. They poignantly observed that parents who accept their child before he is institutionalized are able to see improvement, and that those who do not might expect and demand more of their child after he has been trained.

Item 5, Attitude of Parents to In-laws. Parents reported very little change regarding their feelings toward these relatives.

Only one mother and two fathers feel more secure in the presence of "in-laws". Seven mothers and one father reported feeling no discomfort now or prior to the child's institutionalization. One mother and two fathers are still somewhat uncomfortable in the presence of "in-laws". Their feelings have not changed.

Variation of acceptance on the part of in-laws is reported by couples and this has affected the degree of comfort parents experience in their presence. One mother reported that her husband's parents were extremely understanding and helpful. Consequently there is no stress when they visit. On the other hand, her own parents still have trouble accepting the retardate's behaviour and as a result tend to upset the household when they visit.

Item 6, Attitude of Parents to Friends or Neighbours.

Six mothers and three fathers feel that their relationships with friends and neighbours have improved. These parents find that their boy's behaviour, especially his manners, has improved a good deal. At the same time, it was noted that public attitudes have been changing because of greater awareness of the mental retardation problem. Three mothers and two fathers think they are very relaxed and secure with friends and neighbours now, but that this does not represent a change in attitude. They felt this way before their boy was institutionalized.

Item 7, Attitude of Parents to Strangers. Of the last three items rated, there was a more pronounced change observable in this one. Seven mothers and four fathers noted positive change in their feelings. These persons feel more secure and less

embarrassed if strangers call or are otherwise introduced while the retardate is present. This is again attributed to improved manners. However, several parents are irritated by the fact that their boy now uses 'choice' (swear) words - not only in the presence of other members of the family, friends and neighbours, but also without discrimination, in the presence of strangers. It bothers parents more when the child swears in front of strangers. There is a tendency to blame the institution for this behaviour and apparently little cognizance of the fact that, as normal children go through 'this stage', so too, it might be expected that retardates will also 'give it a whirl'. Still, the predominant feeling is that the child has 'more sense' after training and does not stand out so much in a negative manner.

Item 8, Total Family Planning after Institutionalization of Retardate. Four mothers and two fathers feel that parents would be more apt to wish the retarded child continue to be an integral part of the family, including having him home for regular visits, after the child has received training. Five mothers and two fathers said they wanted from the time of institutionalization to have their child always to be an important and accepted member of the family and that they feel no differently now. One father's feelings were unchanged and expressed less than optimum acceptance. This same person rated lower than his wife.

With one accord, all those interviewed had difficulty seeing how any parent would institutionalize a child with the plan to forget him. All, of course, had themselves arranged for their

child to visit home.¹ Several feel that parents should look on the institution as a boarding school experience for a boy. They note the child's need to participate in social functioning with others his own level. They observe how glad the child is to visit home and how, for the most part, that the child is pleased to return to the school makes it easier for parents. It is possible that this type of thinking helps fill a need of parents themselves, a need to see the child doing things which reflect normal community behaviour.

Item 9, Parental Response to Child Initiating Task Performance. Ratings for this item were higher than any of the others. All nine mothers and four fathers feel they have more patience with their child when he now attempts to perform tasks. Only one father (A) says there is no change in his feeling, to which he gave top rating before institutionalization. One couple stated that they are able to observe some improvement in their child on every visit home. He now visits home for weekly periods at relatively short intervals. They did not have the knowledge or the patience to train their own child, and see the school as a training mecca. They think other parents will be greatly helped when a trainable child attends such a class. It was observed that parents not so tied to the child, because he is able to do things for himself, are able to enjoy him more and actually are also able to give him more; "The school knows how!"

¹ It is not uncommon for children to be abandoned to the institution.

Item 10, Parental Response to Child's Improved Task

Performance. Six mothers and four fathers feel that training of the child has resulted in them becoming more observant of the child. They are intrigued by what the child has been able to accomplish and now watch carefully for signs of advancement. One parent says, "He is not an ordinary child so we never lose interest in what he can get." Three mothers and one father feel no change in their attitude. These think they have always been very observant of their child's improving performance abilities.

Item 11, Parental Response to Child's Failure in Task

Performance. Seven mothers and four fathers feel they are now more accepting of their child's failure and more apt to encourage the child to try again if a task is within his limits. It was mentioned that parents are not apt to be so tired as they were before (when they had full care responsibility for the child), and that they are not tied down so much. These persons feel they have more patience. Two mothers and one father, who give themselves highest rating for this item, say their attitudes have not changed. One father, who rated less than his wife, said that women have greater expectations for retarded children than men, yet told with no little pride how his son had learned to ride a bicycle!

Item 12, Parental Attitude Toward Appearing with Retarded

Child in Public Places. Seven mothers and four fathers feel more at ease with their child in public places now that he has received training. One couple feels that much depends on the appearance of the child. Another couple feels their child now behaves better

than most normal children, and say they have much more confidence in the child. One mother and one father say their attitude, which they report to be in the top rating, has not changed. One mother says that she had mixed feelings before and still has them. In fact, though training of the child has compensated in that he is able to behave better in public, his mother says it is now more embarrassing to take him to public places. She attributes this to "not being accustomed to taking him out regularly as I did before." Perhaps in her case she took the child out before in spite of her feelings and now, having been freed from his total care responsibility, she does not feel so obligated. Further research would alone answer this question.

Item 13, Attitude of Neighbours to the Child. Seven mothers and four fathers feel that neighbours are more positive in their thinking toward their retarded child. One mother feels neighbours receive top rating for both past and present. She says that when she explained the situation to other parents, and to the neighbourhood children, sympathetic understanding and co-operation were forthcoming. She reports that the children seemed to understand after they had been taken into confidence, gave up their laughing and teasing, and took an active interest in the retardate's school progress and community activity. Another person says that education of the public over the last few years has probably played an important part. One mother and one father say neighbours have always been somewhat aloof and that the boy's training has not changed their attitudes.

Item 14, Attitude of Siblings to Playing with the Retardate. Four mothers and two fathers feel there has been positive improvement in the attitudes of normal siblings. One confirmed this by saying, "He plays and fights just like the others." Another pointed out that her child does not wish to play with other children. Four mothers and two fathers gave their normal children top rating both before and after the child had received training.

Item 15, Attitude of Siblings to Bringing Friends Home When Retardate is There. Four mothers and two fathers feel their normal children are more accepting of their retarded brother now that he has received training. One reported less acceptance and that as their normal children get older and into the teen-age bracket, they became more sensitive, particularly in the presence of their friends. Two other families reported much shame felt by siblings before the child was trained, and that though they were somewhat relieved afterward, parents still emphasize that it is difficult for normal children moving into their teens to have a generous attitude towards a retarded child.

General Question, Attitude of Parents to Special Education for the Trainable Child.¹ Only one parent felt that the special class was of little or no consequence in the child's progress. This parent (A) reported very little change in the child before and after training. At the same time, this parent's rating is in the

¹ For composite of social competency and Parent Acceptability Scales showing gains and losses after training, see Table 9, p. 53.

high point category, thus precluding that gain would take place for any reason. This child was given a significantly lower rating (an average of 14 points per area rated) by his teacher. Still, the teacher is sure that the child has improved a good deal. Likewise, new psychological tests show gain in the child's function. This would suggest little objectivity on the parent's part. Twelve of the other thirteen parents gave the training programme the highest rating possible and the other one, the second highest.

Home Visits

Approximately 10% more of trainable boys are visiting home on any basis now than were at the beginning of the training programme.¹ Score indication would suggest that boys have become more acceptable and families are therefore more interested in having the boy visit, less anxious about possible negative social consequences. It appears then, that training may be a significant factor in the increased involvement of boys in home and community social intercourse. However, several parents were not aware that their child was attending special class. They all expected that some training was going on, but were not sure what. Attempts to discover progress of the child generally ended in short discussions with the ward nurse when the child was picked up for the home visit, or when returned from home to the institution. Only three of ten families interviewed had examined the special classroom facilities or observed while class was in session.

¹ From The Woodlands School.

CHAPTER IV

WHAT DOES INSTITUTIONAL TRAINING OFFER

This study has examined the effects of special training for boys who are in the trainable category of mental retardation, and whether improved social competency has influenced the child's acceptability to his family.

Each boy has shown improvement in his social functioning and several, pronounced improvement. It has been emphasized that there were too many variables involved to allow for firm assessment of the reasons for improvement. However, since improvement occurred coincident with special training in the institution, it would seem that training probably has played a significant part.

Most of the children now admitted to The Woodlands School are admitted on an emergency basis. And this emergency refers not just to the condition of the child who may require medical treatment, but also to the other members of the retarded child's family - who, in many instances, have through the responsibility of caring for the child, become depleted of physical, mental, emotional and moral strength. When the child is admitted to the institution, the release from the burden of his care at last provides the family an opportunity to gather its strength once again.

Because of the pressing nature of demands prior to the child's admission and the great need for rest and recuperation

immediately following, release from responsibility for the care of the child may seem at first almost too good to be true. And perhaps it is too good to be true for many parents. Being freed from responsibility for the care of the child does not necessarily solve all their problems. In some instances, it provides time to think about them and to worry about their position as the parents of this child - the decision they have made regarding his institutionalization, what kind of continuing relationship there will be, and whether or not they, the family, can salvage unbroken pieces of family life and sort them out in a way that will provide some kind of hope and aspiration for the future. Not a few families have, for one reason or another, decided to forget their child completely after he has been institutionalized. Others have maintained superficial contact. Still others have tried to keep close and intimate the relationship between their retarded child.

There is indication that release from the responsibility of caring for a child in the home is an extremely important factor influencing the attitudes of parents. However, parents also indicate that their child has become more acceptable to them in the home after he has received specialized training in addition to being institutionalized. In other words, the factor of training may be an important element in increasing acceptability of the child to the parents because the child's potentialities have been encouraged to an extent that he is able to participate in family and community social intercourse in a more acceptable manner. The emphasis here is that the child is more acceptable when he is at

home. The emphasis after institutionalization only, is that the child is more acceptable when he is away from the home. Here is an important implication for future social work.

There must be consideration of and planning for the need of continued social services to parents after a decision has been made to apply for institutionalization of their child. And, in the event that institutionalization is necessary, social services should be made available to families on a regular and continuing basis following admission of the child.

Parents Need More Help

Judging from this study, parents may actually feel more inclined to include their retarded child in various family activities after he has received training in the institution. But how long did it take them to find out this fact? How many parents who have had their children institutionalized have considered the fact that training for their child may make it possible for them to continue family relationships in a manner that will include the retarded child? Not one of the parents interviewed in this study could see how any parent could possibly abandon his child to the institution. However, it must be emphasized that the sample families interviewed had maintained a continuing interest in their child since his institutionalization. Why they maintained this contact is another question, and perhaps a subject for future research. The point is, that these parents found their children more acceptable after training.

Some significant questions follow. Would these parents have progressed more quickly, and to a greater extent of acceptability, were they to have had casework support and interpretation both before and after the time of their child's institutionalization? Would the parents who have abandoned their children or who have been showing relatively minor interest in them, have been able to and desired to have contact with their child in a manner which would have been rewarding both to themselves and the child? In other words, would family interrelationships of a positive and inclusive nature have been fostered had interpretive and supportive services been available? It would appear that an attempt to provide such services should be made, at least on an experimental basis.

Indication of Need for Extended Casework Services. In the case of one parent included in this study, acceptability of the child did not improve in one particular area, that of willingness or desire to have the child accompany her in public places. In fact, she now feels more embarrassed to have him accompany her. Why? The child himself has shown considerable improvement because of his training. A general assumption, because of this, might be that a parent would therefore be more ready to have her child accompany her to public places. Is the answer to be found in this lady's own attitudes or life experience? Did she take the child with her before because this was easier than facing the guilt she would feel for denying the child in the presence of others? Has she resolved this guilt through the institutionalization of her

child and being rid of the responsibilities so entailed? Does the fact that the child is more capable now frighten her, make her feel that she may be expected to again reassume responsibility, start all over again in the process of caring for her child? There are other hypothetical questions that could be asked. The implication is that this woman and probably many like her should have had the opportunity, if she wished, to discuss and to work out her feelings, and to have received guidance in terms of long-range planning both for her child, and for herself and other members of the family.

Casework interpretation of behaviour probably could help parents adjust their responses. However, the child's potential ability for positive social functioning is often kept in abeyance because parents are unable to give consistent loving stimulation and training. Allport states that "praise and recognition not only help learning but appear to increase the capacity for it."¹ He also says, "to maximize the child's intelligence, we must maximize his ego."² This does not mean that the level of mental development can be changed. However, it does support a view that virtually all trainable children, with the possible exception of the seriously ill, have the capacity to utilize their abilities in a manner more satisfying to themselves, their peers, their siblings, their parents and others.

¹ Allport, G. W., Personality and Social Encounter, S. J. Reginal Saunders and Company Ltd., Toronto, 1960, p. 83.

² Loc. cit.

In the study it was brought out that teenagers seemed to be extremely sensitive to a handicapped member of the family in the home, particularly when their community friends are involved. The fact is that teenagers are often sensitive. They are growing physically and emotionally. They are going through a difficult period in their lives when the establishment of their own identity, feelings of self-worth, evolving roles, their position in regard to the expectancy of adult family members and the community and cultural values, all weigh heavily upon them. If parents are in a position to benefit from social work casework services, indications are that other family members, perhaps particularly the teenagers, could also be helped considerably. Teenagers will be struggling to resolve thinking concerning the handicapped member of their family, perhaps especially, thinking about how having a handicapped member of the family will affect them, particularly in relation to their friends and other community members.

Siblings are often caught in and contribute to the family emotional chaos. It is quite possible that their own developmental needs have been neglected, that because of the constant demands of the defective child on parents, siblings have been deprived. Often emotional disturbances accompanied by various symptomatic reactions will occur. Parents may be aware of what is happening, feel incompetent to alter circumstances. They may experience compounding guilt for neglecting their 'healthy' children, and bitter resentment that these children are having their lives ruined despite

desperate efforts to alter the situation. On the other hand, they may be unaware of the needs of these children or feel that they are compensated by their very normality.

The sibling who is older may make a helpful contribution towards family care of the retardate. However, he may be burdened with too many responsibilities. As an adolescent he may be self-conscious and ambivalent. On the one hand he may be overprotective of the child; on the other, he may be defensive, as he moves amongst his peer group. Blogett and Warfield feel that serious conflicts about marriage and reproduction can be caused.¹ In children more nearly the age of the retardate, rivalry and jealousy involving parents, other siblings and the defective child, may leave marked imprints on the personalities of these youngsters.

In Case A., the parents said that they would have liked to have kept their boy at home if it had not been for the difficult circumstances to which the child was exposed. When we consider that the parents seemed to be highly subjective and that they quite possibly over-rated the boy's ability, we would ascertain that such a statement may well have been a form of defense. However, if it were not, and the parents were actually anxious to have their boy remain at home, it would seem that services to help them do this should have been provided. It may be that they were motivated more to have their child remain at home than to have the child

¹ Blodgett, Harriet E., and Warfield, Grace J., Understanding Mentally Retarded Children, Appleton-Century-Crofts, Inc., New York, 1959, p. 55.

institutionalized. Social work services could assist parents making similar decisions, to sort out their feelings and help them to weigh the pros and cons of the various influences which have brought them to the point of seemingly finding it necessary to have their child admitted to an institution. If these influences center around their own attitudes, perhaps casework may help. If they center around the attitudes of community members, perhaps social work, interpretive services and liaison between family and community members could be of assistance. If difficulties center around advice given by other professional members of a society, perhaps that advice could be put in perspective. The implication is that the parents required help at the time institutionalization was being arranged, and that had they had continuing help prior to this time, circumstances may well have been different. This goes back to the time when parents have a handicapped child born to them.

In each of two families interviewed, there were three retarded children. This would indicate the strong possibility of heredity factors being involved. It would seem from comments parents make that most question their sense of self-worth when a handicapped child is born to them. When more than one handicapped child is born in a family, these feelings may well be very emphasized. Social work interpretation of clinical findings and of what this will mean to the family as a whole, and their planning for the future, would appear to be an important service. This service should be made available not just at the request of parents,

but as part of diagnostic and total assessment services to any parent with a handicapped child.

The Social Work Liaison Role Between the Retardate's Family and the Community.

Earlier it was mentioned that social stigma can add to the burden of parents. Casework help in handling this is important, not only on a personal but also on a group and community level. Parents, often already overly sensitive to pain causing stimuli, whose sense of self-worth has been depreciated, can hardly be unaware of the critical, sometimes contemptuous expressions of fellow citizens. On the other hand, judgmental relatives and friends may have little appreciation of the total pressure exerted upon the family, or of the near heroic attempt it has made to keep some order and balance. Parents may not have felt free or able to discuss their problems. Perhaps they would have felt better had they been able. The caseworker could assist them to look at the reasons for keeping to themselves, and perhaps open the way for sharing.

Some of the parents interviewed feel quite strongly about the attitudes of neighbours. In two instances, parents found that after explaining the situation to neighbours and neighbourhood children, community circumstances improved a good deal. It is quite possible that community attitudes would improve or change more in some localities than in others. Perhaps we should not be overly optimistic about enlisting the support of the general

community. However, the fact that in certain areas improvement has been noticeable suggests that families might very well benefit by a systematic attempt to enlist the understanding and support of neighbours and other social acquaintances. The implication here is that the social worker may act as liaison between family and other persons and thereby help facilitate improved community attitudes.

The stigma problem sometimes comes to a head when friends and neighbours learn that the parents of a retarded child are considering institutionalization. They (friends, etc.) may interpret this as overt rejection of the child and symptomatic of a heartless refusal to accept responsibility. An experiment could be tried concerning the handling of this problem. The aim would be to help encourage the sharing of non-confidential information between parents and friends. This might be done on a group discussion basis. Discussion could involve the exploration of the reasons behind consideration of institutionalization, what the results might be, and so on. This would be a helpful supplement to individual family casework service.

Through such a process, doubts may be dissipated and a genuine interest in the problem of parents with mentally retarded children aroused. The parents could be supported in that their troubles may be better understood and their motives for considering the institutionalization of their child defended. While recognizing the natural interest of friends and relatives, parents could, at the same time, promote more positive and continuous contact with

these people - people who might well help share their burden. Again, if the parents are members of the local Association for Retarded Children, it may well be that those who have shared with them in a special group session could be recruited to help in community programmes.

This type of counsel need not be confined to adults. The peer group, and other children in the community may respond well to an invitation that they be given the opportunity to learn of some of the difficulties connected with the care of the retarded. A helpful resource of prospective baby sitters may be found in both groups - provided some basic training into the care and handling of the child be given. The whole effect of this programme could be to encourage a 'conspiracy of love', a creative community force which would effectively help dispell prejudice, fear and cruelty.

The Social Work Liaison Role Between the Retardate's Family and the Institution

In this study, three of the parents interviewed were not aware of the fact that their boy was attending a particular type of training class in the institution. They felt that as the other children, their boy would be receiving training at his own level but they had not been informed about a specific programme. Several of the parents have not explored the type of training being given their boy though they have made inquiries regularly as to the general progress of their boy. Perhaps parents feel there is little status as such for them to have their boy attend a special class

in a school for retarded children. Perhaps they would not anxiously claim to friends, family, neighbours, that, "My child is one of the top boys in the special training class for retarded children." So it may be that the fact that some have not specifically inquired, or made obvious attempts to participate in classroom activities themselves by observing, is of less significance than that they have limited expectations for their child.

Information suggests that, because of training, parents will have more cause to be proud of their child, will find him more acceptable in the home, and will find neighbours, friends and relatives more accepting of him. Therefore, parents should be directly informed of the institutional programme. They should also have clearly indicated for them where and when they as parents might participate by observing the child in action, or by discussing his progress with the teacher, social workers and other staff members.

The social worker could be an effective liaison between the training class and the family. In the first instance, he would be able to inform families concerning various activities engaged in by their child and through discussion of these activities provide parents the opportunity for ventilation of their general concerns and thoughts respective to the child and other members of their family. In other words, the service could serve not only to facilitate greater family participation in the boy's welfare, but also to prepare the road for that participation by helping parents sort out their feelings. Highly-charged ambivalent feelings

of the parents could be eased to a considerable degree. Perspective is often lost because of the pressing closeness and acuteness of problems.

After the child has been admitted to the provincial setting, casework with parents should continue for an indefinite period of time. If adequate preparation has been made for the admission of the child, parents will have already been oriented to the setting and introduced to members of the staff most likely to be involved in the care, treatment and training of their child. But there will be need for continued interpretation of routine activities and particularly of the special training class. This continuing relationship will be important for both child and parent. The child needs to maintain a sense of belonging to and being loved by his family. If these attributes are not established when the child is admitted, then it would be hoped that they could be. Prearranged visits to the class-room could encourage both child and teacher, and help the parent keep abreast of the child's growth. The parent who has observed the emotional climate of the special class-room, as well as teaching techniques, equipment and goals, may gain valuable insight. Parents and family may be able to follow the child's progress and give him emotional support. It will be reassuring for them to see that the child is physically comfortable, is able to be friendly with others, is gaining confidence, is experiencing the security of success and knows that he is accepted and liked. The parent will see too, that the child is learning to get along with classmates and grownups, that life has

rules and routines, and that there are many things to feel good about.

The caseworker's continued contact with the parent will allow for ventilation of guilt feeling, both resulting from 'putting him away' and from observation that in the new setting the child's improved behaviour and progress in social function takes place so readily. This latter point can be disturbing and emphasize feelings of parental inadequacy. Again, continued contact allows for expression of parental responsibility - a sense that may be seen in an entirely new perspective once the child's potential has been tapped, his emotional strengths grouped and directed, his behaviour more acceptable and even rewarding. Encouraged parents may try having the child home for visits from time to time and may well have some of their original hopes for the child restored when they see him act in a manner both pleasing to neighbours, themselves and himself. Also, they may be encouraged by the fact that he has new vistas opened, new possibilities for enjoying life, and that he can actually make some, however small, contribution to his fellowmen. Goals and accomplishments should be repeatedly presented to and discussed with parents - not only to keep them informed but to enlist their continued support, an invaluable asset to the teacher. Parents would be compensated by knowing that their contribution is an integral part of the child's new life. In turn they could be encouraged by assurance that the child is being met and accepted where he is, as he is.

Casework should be a regular service to parents, one that

is scheduled and not dependent upon sporadic periods of interest or special study. It may be that study of the reasons why families are now actually participating by maintaining close contact with the child in his class would be of value. Some of the parents interviewed knew about the class, but did not visit it. Service at the institution today includes, when possible, orientation of parents to the various areas of activity and training throughout the school at the time of or before the time of the child's admission. It may be that because of the child's actual condition, the whole family matrix and circumstance, parents just have not been able to participate. It may likewise be that parents who do participate do so out of their own emotional need. We know who visits and who does not visit. But we do not know the meaning of this behavior. This would indicate that there is a need for social work assessment of family behavior to ascertain its meaning, to help families plan in terms of their thinking and circumstances, and to help families alter or rearrange circumstances seemingly too formidable for them to face, or perhaps facts accepted as unchangeable, which, in fact, may be changed.

This present study has involved only parents who have had their child home for visits. There are a number of families that do not have their child visit home at all. We must ask why. Is it because of their own conflicting feelings? Is it because they have not been encouraged? Is it because they have not received reports of the child's progress? Is it because they have not had an opportunity to discuss their problems of acceptance or

rejection of their child's handicap? Again, indication is that whether or not services can now be made to parents who have lost contact with their children, an all out effort should be made to facilitate continued contact between parent, child and other family members when institutionalization now takes place.

The Casework Process

A social assessment of the total family is the first requisite in the casework process. Many values and roles are badly threatened when a defective child is born into a family. Yet where the threat is most felt will vary. The emotional maturity of parents, their education, type of father's employment, financial and social status, cultural background, age, physical health, extended family and relatives, number, age, sex and interests of siblings, the physical, mental and emotional development of the retardate, attitudes of neighbours and friends and business associates, religious inclinations and political interests all have a bearing on the kinds of problems experienced, all have a bearing on the way problems have been handled, how they may be handled in the future.

In making a social assessment of the family, it will be important to be explicit concerning both parents. Each are different personalities. Each will have somewhat different outlooks. Each will have their own emphasis in the interpretation of the problem, goals to be sought and home care methods to be followed. It may be that feelings about the retardate are projected to the

marital partner. "A profound disagreement between the partners about a child ... if it cannot be resolved ... acts as a dangerous infection in the entire family, often culminating in a severe emotional crippling of all members."¹

Before casework service may adequately proceed, the child and his family social assessment will need to be presented at a multi-discipline, medically oriented diagnostic clinic. Parents may have never received precise knowledge about their child's disability and the personal and social implications. In fact, "defensiveness in parents may have been built up because of a former unfortunate contact with an emotionally immature and insecure professional person."² When a total diagnostic picture is received the caseworker will convey the findings to the parents.

Mrs. Max Murray, herself the mother of a retarded child, gives an interesting perspective to the problem situation when she describes, from a layman's point of view, deep seated needs of parents with defective children. She says:

After talking to hundreds of parents it is my feeling that more real damage has been brought about by the inability to share their problem than by any other single factor ... The greatest single need of parents of mentally retarded children is constructive professional counselling at various stages in the child's life which will enable the parents to find the answers to their own individual problems to a reasonably satisfactory degree.³

¹ Mandelbaum, Arthur, and Wheeler, Mary, "The Meaning of a Defective Child to Parents," Social Casework, Journal of, July, 1960, p. 329.

² Murray, Mrs. Max, "Needs of Parents of Mentally Retarded Children," American Journal of Mental Deficiency, Vol. 63, No. 6, May, 1959, p. 1082.

³ Ibid., p. 1084.

As the interpreter of diagnostic findings, the social worker will need to be aware of his own reactions and feelings to the totality of stress experienced by the family. Does he have underlying guilt and frustration about having to interpret the condition of the child to the parents? Or does he feel angry that it is he who has to inform parents of limitations and handicaps? Being aware of his own feelings and at the same time confident in his professional position and outlook, he will be able to "individualize this understanding".¹ With honesty and integrity he shares his strength with the parents and helps them to accept, insofar as they are able, the findings of diagnostic clinic. He can encourage by giving reason for hope based on a realistic prognosis of the child's potential for personal and social development.

Further Resources. There are other resources that the social worker should use whenever feasible. If parents are not members of the local Association for Retarded Children, the social worker should introduce them to this group. To be able to share their problems with parents who themselves have retarded children, is extremely encouraging, helps bolster their sense of self-worth, is a social outlet and makes available an avenue by which the parent can make his contribution to the general cause.

Again, through consultation and cooperative service, Public Health Nurses may be engaged to supplement casework services by teaching and assisting in nursing and other care techniques. To the mother who is overwhelmed by the care of her mentally retarded

¹ Kelman, H. R., "Some Problems in Casework With Parents of Mentally Retarded Children," American Journal of Mental Deficiency, Vol. 61, No. 3, January, 1957, p. 596.

child, in addition to other family responsibilities, the Public Health Nurse can be a most welcomed help.

After commitment of their child it is sometimes helpful for parents to have the opportunity for service in the cause of mental retardation. Much of their daily time (and nightly) particularly the mothers, may have been taken in caring for their child. Freed of this responsibility idle time can emphasize separation from the child, and the fact that social contact with the community has been restricted. These persons, many of whom have waited desperately for relief from responsibilities of caring for their child are very much aware that resources are terribly limited. Often they are willing to give generously of their time to serve through their local Association for Retarded Children. The social worker can help encourage these activities by providing consultative services to the groups involved as well as continued personal casework in individual instances.

The Need for Extended Services

There is a need for more definite policy regarding who will be responsible for supplying social and diagnostic services to parents. At present, parents must make application to have their child admitted to a provincial institution before its diagnostic, temporary admission or social services become possible resources. But all parents should have the opportunity to receive counsel at the time of, and on a continuous basis after, the retarded child is born. Our society has not yet decided who will

be responsible for this service. It is certain that the institutions cannot provide it, simply because the demands for service are too great. It would seem, therefore, that provision should be made easily available in the local communities. Some procedure should be worked out to provide for counselling services coincident with the registering of these handicapped children. Definitions of responsibility should be clearly indicated and appropriate community agencies appointed to carry out these functions.

The focussing of the casework process upon support or modification of the ego of parents with retarded children is not enough. Nor will extra help with friends, relatives, and neighbours suffice to assist them over their seemingly insurmountable problems. They also need some guidance to help them face more successfully the everyday chores of the living situation.

Here two points emerge. The caseworker should (a) be oriented and indoctrinated into the methods and practices of the training class and be thoroughly familiar and experienced in ways and means of teaching and interacting with mentally retarded children and (b) he should facilitate utilization of the training class as a training area for parents, reinforcing learning by casework service and direct help in the home or community play and training classes. Where this is not possible because of geographical distance, an expert teacher and social worker should be available on a travelling team to spend necessary time in centres where resources are not now available, help set up the same, train teachers, encourage parents, and facilitate liaison with the

central resource. Here the social worker could play an important liaison part. Better informed parents would lead to re-enforcement of classroom activities in the home. As it is, though parents are grateful for general improvement in the child's behavior, they are somewhat at a loss as to how they can help, what they might expect from the child, and actual methods which might be used in the home to encourage improved child behavior. This is particularly borne out by case example G. The mother of this boy has shown a great deal of interest in his activities in the schoolroom and has visited the classroom on regular intervals. This boy has shown a significantly higher level of improvement in all areas studied than any of the other children. This may or may not indicate that closer liaison between teacher and family would help facilitate the child's learning.

Far too often, families become so upset that if severe and permanent damage is to be avoided, emergency measures to grant relief must be arranged. A temporary admission program which is operating at The Woodlands School can be used in a limited number of cases. This service has been able to give to some parents the opportunity for a holiday, a much needed rest after the demanding care responsibilities which they have borne over many months. It would seem reasonable to propose that steps be now taken to permit as many parents as wish to have the opportunity to receive such help. This type of service should be over and above temporary admissions granted for diagnostic purposes. It would mean, of course, an extension of residential facilities, preferably in

decentralized areas of the province.

Foster home programmes, sometimes provide relief for parents when there is no other help available. This service may also be gradually more extensively used to reintroduce retardates now residing in institutions to the community. However, to make such programmes reliable, extended supervision services are required. Another resource not as yet used extensively enough, is the trained homemaker. The homemaker could be used effectively to assist the mother meet not only the retardate's needs, which often take a disproportionate amount of her time, but the needs of the other children. If the homemaker is carefully selected and trained so that she is able to withstand the demands and criticisms of tired and anxiety-ridden parents, she may well not only make a significant contribution toward the handling of household tasks, but also towards easing family tensions. Experience and skill in working with a social worker, including an ability to accept and use interpretation, can make her a major defence against home breakdown.

The aim, of course, should be to use all resources in a preventative rather than stop-gap manner. As services to the parents of mental retardates increase, more and more emphasis will need to be placed on early planning and preparation of the parents for the time when, as will probably be the case with most moderately retarded children, institutionalization will be required. Parents will need the opportunity to ventilate their feelings and help to see the needs of all members of the family in clear

perspective. Assistance in accepting not only inevitability of institutionalization but also of the advantages and possibilities involved will need to be given.

Possible Research Projects

A number of research questions could be followed through with profit for all concerned.

Casework Services. This study has emphasized the need for extended casework services. Some may doubt the value of this to parents of retarded children. As mentioned previously, services are now often supplied only on an emergency basis and when attempts to bolster family abilities to cope with their problems are fraught with failure. It is suggested that an experimental group of families be selected for study on the basis that they have a new born retarded child. Continued casework services could be supplied to these families for the first six to eight years. Family assessment at the end of this period could be compared to similar families who have not received regular casework help.

Family Participation in Training Programmes for the Moderately Retarded. In the study it was observed that only three of ten families have actually visited the special classroom of their retarded child. The unanswered question is, "Why?" It was also observed that one boy in the sample group progressed almost twice as much as others, and that this boy's mother regularly visits the classroom. A second unanswered question thus arises: "What are the effects of parental participation in the child's special

classroom activities on his overall progress?"

The Special Training Class. Judging from this study, a more extensive study using control and experimental groups of moderately retarded children, should be conducted to determine in a substantiated manner the effects of this particular type of training on the child's social competence, and whether this in turn influences parental acceptability.

The Challenge

Specific research projects should lead to the provision of specific services. The unmet special and common human needs of mental defectives and their families challenge thoughtful people. This issue should claim precedence for extended social services over many community problems because of the excruciating mental and physical suffering of the human beings involved.

It has been estimated that about three percent of the population is mentally retarded. Many more will fit into the category of 'borderline' or 'dull normal'. The multiplying care demands and the erratic behaviour of retardates cause stress which too often becomes unbearable to parents and results in overall family emotional and physical deterioration. Mothers and fathers become enervated, exasperated. Formerly controlled areas of marital disagreement or incompatibility break down. Normal siblings are caught in a mesh between the parents and the retardate (or retardates), suffer emotionally and consequently in all their social relationships. The retardate, having less and less of his emotional need satisfied

reacts by behaving in a more and more negative manner. A relatively normal family exposed without adequate guidance to the care of a retardate may become a multi-problem family.

There is little resource for help. Social services are peripheral. Institutionalization is possible for emergency cases only, cases when home care is completely out of hand. And in many instances, in spite of emergency conditions, admission cannot be granted. School opportunities for the educable retardate are increasing, but resources for the trainable are negligible. Day care centers for the more severely retarded are practically non-existent. Although the Association for Retarded Children of British Columbia is active and doing a credible public relations job in communities, there is much need for community education. Professional persons, including physicians, nurses, teachers and clergy on the whole are poorly equipped to give understanding guidance.

It has been shown by this and other studies that something can be done for retarded children and their families. Inroads are now being made. It is up to those interested to interest others that forces may continue to be joined together in greater efforts to help a large and needy segment of our population.

APPENDIX "A"

SAMPLE OF LETTER TO PARENTS

Vancouver, B. C.,
March, 1962.

Mr. and Mrs. John Doe

Dear Mr. and Mrs. Doe:

As a student of the University of British Columbia, on leave of absence from the Social Service Department of The Woodlands School, I am examining the self - help and social progress of several children in residence at The Woodlands School. Each child's family is being asked to help by giving its impression.

I hope to include your son in this study so would very much appreciate your participation. All names will be kept anonymous.

Within a few days I will telephone to ask if I may visit you in your home. If you approve we will arrange this to suit your convenience. About two hours time will be involved.

Many thanks for your favourable consideration of this request.

Yours sincerely,

APPENDIX "B"
SOCIAL COMPETENCY SCALE

(Retarded Children)

I. Self-Help

Ia. Personal

1. Undressing

- A. Cannot undress self.
- B. Takes off most clothing but cannot unbutton or unzip.
- C. Takes off most clothing and can unbutton and unzip.
- D. Completely undresses self.

2. Removing Outer Clothing

- A. Cannot take off outer clothing.
- B. Can take off outer clothing such as coats and jackets.
- C. Can take off outer clothing such as shirts, pull-over sweaters, blouses, shoes, etc.
- D. Can remove all outer clothing, including undoing back buttons, belts, etc.

3. Dressing

- A. Cannot put on any clothing.
- B. Usually someone else must partly redo and complete the job (e.g., button correctly, put shoes on proper feet).
- C. Adult must check job and frequently adjust clothing.
- D. Job must be checked by someone else and necessary adjustments made by the child.
- E. Dresses self adequately without having to be checked.

4. Putting on Shoes

- A. Cannot put on shoes.
- B. Can put on shoes and pull laces tight.
- C. Can put on shoes and make first part of the knot.
- D. Can put on shoes and tie bow.

5. Care of Shoes

- A. Cannot wipe shoes.
- B. Can wipe shoes but cannot brush or polish.
- C. Can wipe and brush shoes but cannot polish.
- D. Can clean, brush and polish shoes.

6. Washing (hands and Face)

- A. Although the child goes through the motions of washing hands and face, they must be redone by someone else.
- B. After washing hands and face they must be partially redone by someone else.
- C. Usually washes hands and face so that they do not need redoing, but child needs to be checked each time.
- D. Can wash hands and face without having to be checked.

7. Care of Fingernails

- A. Cannot clean or file fingernails.
- B. Can clean nails with better hand but needs help with other hand.
- C. Can clean nails on both hands.
- D. Can clean and file nails on both hands.

8. Combing or Brushing Hair

- A. Will not attempt to comb or brush hair.
- B. Combs or brushes hair but it must be redone by someone else.
- C. Combs or brushes hair so it does not need redoing but needs to be rechecked each time.
- D. Combs or brushes hair without help or having to be checked.

9. Brushing Teeth

- A. Cannot hold toothbrush.
- B. Can hold toothbrush but cannot brush teeth.
- C. Can hold brush, makes brushing motions, but does not brush properly. Cannot apply paste.
- D. Can hold brush, apply paste and get to mouth, but must be aided with actual brushing.

E. Can brush teeth unaided.

10. Blowing Nose

A. Cannot blow nose.

B. Can blow nose but usually needs wiping.

C. Can blow nose but sometimes needs wiping.

D. Can blow nose, including wiping.

Ib. Things

11. Eating

A. Cannot feed self.

B. Can hold utensils but can use only spoon in feeding self.

C. Successfully uses a spoon but sometimes spills with a fork.

D. Feeds self with a fork and spoon without spilling.

E. Can use spoon and fork and cut with knife in eating.

12. Use of Knife

A. Cannot hold knife.

B. Can hold knife but cannot use.

C. Can spread butter or jam with knife.

D. Can cut soft food such as sausage, hamburger patties, french toast.

E. Can cut up meat if trimmed and removed from bone.

13. Serving Food

A. Cannot carry food without spilling.

B. Can carry only solid foods without spilling.

C. Can carry semi-solid foods without spilling.

D. Can carry a pitcher or glass of liquid without spilling.

E. Can carry and pour liquids without spilling (e.g., milk, juice, coffee).

14. Passing Food

- A. Cannot pass food.
- B. Can pass bowls with solid food only.
- C. Can pass plates with solid food only.
- D. Can pass bowls with liquid or semi-liquid food.
- E. Can pass all items, including platters and trays with food on them.

15. Clearing Table

- A. Cannot clear table of unbreakable dishes.
- B. Can clear table of unbreakable dishes and silverware but cannot scrape dishes and stack.
- C. Can clear table of breakable dishes, glassware and silverware, but cannot scrape dishes and stack.
- D. Can clear table, scrape and stack breakable dishes for washing.

16. Cleaning Up (Liquids)

- A. When cleaning up spilled liquids he smears over larger area, making a bigger mess.
- B. Blots up some liquid, but job must be completed by someone else.
- C. Blots up liquid but area requires finishing touches by someone else.
- D. Cleans up liquid and does not require someone to finish job.

17. Cleaning Dishes

- A. Cannot stack or scrape dishes.
- B. Can stack dishes but cannot scrape.
- C. Can stack and scrape but cannot wash dishes.
- D. Can wash and dry dishes.

18. Opening Door

- A. Cannot open door.
- B. Cannot open door requiring turning knob, but can push door open.

- C. Can open door when knob turning is required.
- D. Can open or lock door with key.

19. Sweeping

- A. Cannot sweep floor.
- B. Can sweep floor where there are no obstructions: unable to pick up dirt in dustpan.
- C. Can sweep under desks or tables but cannot pick up dirt in dustpan.
- D. Can sweep under desks or tables and can pick up dirt in dustpan.

20. Making Bed

- A. Cannot make or undo bed.
- B. Can undo but cannot make bed.
- C. Can spread sheets and blankets on bed, but cannot tuck or put pillow in case.
- D. Can completely make bed, including tucking and putting pillow in case.

21. Folding Articles

- A. Cannot fold any laundry items.
- B. Can fold washcloths, towels and pillow cases with help.
- C. Can fold washcloths, towels and pillow cases without help.
- D. Can fold washcloths, towels and pillow cases without help, and sheets, blankets and bedspreads with help.
- E. Can fold all of above items without help.

II. Growth and Maturity

IIa. Initiative Responsibility

1. Washing Hands and Face

- A. Does not wash hands and face without being told.
- B. Sometimes washes hands and face without being told.
- C. Usually washes hands and face without being told.
- D. Nearly always washes hands and face without being told.

2. Brushing Teeth

- A. Brushes teeth only when directed to do so.
- B. Sometimes brushes teeth without having to be told.
- C. Usually brushes teeth without having to be told.
- D. Nearly always brushes teeth without having to be told.

3. Hanging Up Clothes

- A. Does not hang up clothes without being told.
- B. Sometimes hangs up clothes without being told.
- C. Usually hangs up clothes without being told.
- D. Nearly always hangs up clothes without being told.

4. Toileting

- A. Does not wipe self.
- B. Sometimes wipes self.
- C. Usually wipes self.
- D. Nearly always wipes self.

5. Table Setting

- A. Does not place silver, plates, cups, etc. on table.
- B. Simply places silver, plates, cups, etc. on table.
- C. Simply places items around table, not necessarily where they belong.
- D. Places plates, glasses, and utensils in positions he has learned.
- E. Places all eating utensils, napkins, salt, pepper, sugar, etc. in positions he has learned.

6. Cleaning Up Mess

- A. Does not take initiative in cleaning up own mess.
- B. Sometimes takes initiative in cleaning up own mess.
- C. Frequently takes initiative in cleaning up own mess.
- D. Nearly always takes initiative in cleaning up own mess.

7. Playing With Others

- A. Does not initiate play with others.
- B. Occasionally initiates play with others.
- C. Frequently initiates play with others.
- D. Nearly always initiates play with others.

8. Initiating Tasks

When given the responsibility for a task (e.g.: table setting, washing dishes, cleaning room), he:

- A. Does not initiate task.
- B. Seldom initiates task.
- C. Sometimes initiates task.
- D. Usually initiates task.
- E. Nearly always initiates task.

9. Offering Assistance

- A. Does not offer assistance to others.
- B. Sometimes offers assistance to others.
- C. Frequently offers assistance to others.
- D. Nearly always offers assistance to others.

I Ib. Social Skills

1. Telling Time

- A. Cannot tell time.
- B. Can tell time to nearest hour.
- C. Can tell time to nearest $\frac{1}{2}$ hour.
- D. Can tell time to nearest quarter hour.
- E. Can tell time to nearest five minutes.

2. Sharing

When other children wish to share his favorite toy, he:

- A. Watches passively or cries.
- B. Protests.
- C. Shares if both play together with the toy, but otherwise does not share.
- D. Shares, sometimes giving permission for others to play separately with the toy.
- E. Shares, frequently giving permission for others to play separately with the toy.

3. Playing With Others

- A. Usually plays by self.
- B. Plays with others but limits play to one or two children.
- C. Occasionally plays with a larger group (three or more children).
- D. Usually plays with a larger group (three or more children).

4. Care of Self

- A. Adult must be with or near child at all times.
- B. Child can be left alone in his own room with adult in the house.
- C. Child can be left in the house but adult must be close by (e.g.: in the yard).
- D. Child can be left alone in the house while adult visits neighbor or goes to the store (short period, 20 - 30 minutes).

5. Telephone

- A. Cannot answer telephone.
- B. Answers telephone, but unable to take message and/or call appropriate person.
- C. Answers telephone, calls appropriate person. Cannot take message.
- D. Answers telephone, calls appropriate person and takes message.

6. Going on Errands

- A. Cannot be sent on errands to other people.
- B. Can be sent on errands with note to other people.
- C. Can be sent on errands without note if only one object is desired.
- D. Can be sent on errands without note if not more than two objects are desired.

7. Traffic Signs

- A. Doesn't understand any traffic signals or signs.
- B. Understands a few traffic signs which do not require reading.
- C. Understands most traffic signs which do not require reading.
- D. Understands a few traffic signs which require reading.
- E. Understands many traffic signs which require reading.

8. Answering Door

- A. When door bell rings or there is a knock, child does not answer door.
- B. Answers door bell or knock, does not take message, does not call appropriate person.
- C. Answers door and calls appropriate person, but does not take messages.
- D. Answers door, calls appropriate person, and, when required, relays simple message such as, "Mr. A was here."

9. Behavior in Public

- A. Cannot be taken to public places because he cries, becomes restless, or frightened, etc.
- B. Can be taken to public places but must be held by the hand or given constant reassurance.
- C. Can be taken to public places but sometimes requires reassurance.
- D. Can be taken to public places and seldom, if ever, requires reassurance.

10. Attending Tasks

- A. Pays attention to task if time does not exceed five minutes.
- B. Pays attention to task if time does not exceed ten minutes.
- C. Pays attention to task if time does not exceed 15 minutes.
- D. Pays attention to task if time does not exceed 20 minutes.
- E. Pays attention to task even if time exceeds 20 minutes.

IIc. Communication

1. Delivering Messages

- A. Cannot deliver messages by gesture or other means.
- B. Can deliver a simple message by gesture only (one thought or action).
- C. Can deliver a simple message verbally.
- D. Can deliver a more complex message verbally (more than one thought or action).

2. Answering Questions

When asked a question, he:

- A. Does not respond.
- B. Responds by nodding, pointing, or other gesture.
- C. Responds by combination of gesture and speech, but oral response is limited (e.g.: yes, no, etc.).
- D. Verbally answers question with complete sentence.

3. Relating Objects to Action

- A. Cannot name objects in pictures or story books.
- B. Can name objects and people in pictures but cannot indicate actions.
- C. Can relate object to action but unable to connect actions into a story.
- D. Can connect actions in a picture to tell a story.

4. Use of Language

- A. Says no words - gestures only.
- B. Says a few specific words (e.g.: water, mother, father).
- C. Speaks in complete sentences (e.g.: "I want a drink," "I want the toy," etc.).
- D. Speaks in more complex sentences, connecting a number of actions or statements.

5. Spontaneous Speech

- A. Rarely speaks spontaneously in group situation, even when question is directed to him.
- B. Responds in group situation only if question or command is directed to him.
- C. Sometimes speaks spontaneously in a group situation.
- D. Usually speaks spontaneously in a group situation.

6. Following Instructions

- A. Cannot follow familiar instructions.
- B. Can carry out one familiar instruction.
- C. Can follow new instructions given one at a time, as well as familiar ones.
- D. Can follow several new instructions given at the same time, as well as familiar ones.

7. Speaking to Adults

- A. Does not speak to adult friends or adult visitors.
- B. Speaks only to close friends of family.
- C. Speaks to adult visitors if he has met them before.
- D. Speaks to most adult visitors, even if he has not met them before.

8. Going Places

When he wishes to go someplace:

- A. Indicates by gesture only.
- B. Indicates by using simple words (e.g.: "zoo", "store").

- C. Indicates by using short phrases (e.g.: "go store," "go zoo").
- D. Indicates by using complete sentences.

9. Playing With Others

- A. Does not ask to play with other children.
- B. Indicates by gesture his desire to play with other children but does not name people or activity.
- C. States his desire to play with other children but does not name people or activity (e.g.: "I want to play").
- D. States his desire to play with others, naming people and/or activity (e.g.: "I want to play ball with John," or "I want to jump rope with Mary").

10. Communicating Unhappiness

When unhappy, he:

- A. Cries or runs away without explaining reason for his unhappiness.
- B. Kicks or screams at offending object.
- C. Seeks help by crying and searching out an adult, but is unable to explain his unhappiness.
- D. Expresses his feeling and the cause of his unhappiness.

11. Answering Door

- A. Does not gesture or speak, just stands there.
- B. Indicates that someone is at door by gesture only.
- C. Indicates that someone is at door by gesture and limited speech, (e.g.: "Man here").
- D. Indicates that someone is at door by using complete sentence.

APPENDIX "C"

PARENT ACCEPTABILITY SCALE

1. How much time might the parents spend playing with or teaching their child?
 - A. None. Could not tolerate the simple level of the child's activity and would be too occupied with more important things.
 - B. Very little time. Only when urged by the other parent or to escape the continual requests of the child.
 - C. A fair amount of time. Little desire, but would play with or teach the child out of a sense of duty.
 - D. Quite a lot. Would enjoy playing with or teaching the child and make time available.
2. When the child hugs or kisses his parents they might:
 - A. Be repulsed and unable to return a show of affection.
 - B. On very rare occasions return the hugs or kisses.
 - C. Quite often accept the child's affection and return it if others are not present.
 - D. Warmly accept and on most occasions return the hugs or kisses.
3. Would parents hug or kiss their child before he did this to them?
 - A. Never. Would be too difficult.
 - B. On very rare occasions to a slight degree.
 - C. Sometimes when others not around.
 - D. Often. Would feel like hugging or kissing the child, so do it.
4. When parents compare their child to normal children, they may feel:
 - A. Bitter, the victims of injustice.
 - B. Very hurt, can expect little but pain and sorrow from their child.
 - C. Mixed feelings. Sometimes enjoy their child but have difficulty feeling any sense of pride as parents.
 - D. Quite happy. Would be affected more by what the child can do than by what he cannot do.

5. When "in-laws" visit, parents would feel:
 - A. Extremely apologetic, unworthy and ashamed.
 - B. Very apologetic, unworthy and ashamed.
 - C. Somewhat apologetic and ashamed.
 - D. Relaxed. Accepting of parenthood without apology or need for apology.
6. When friends or neighbours call at their home, parents may:
 - A. Be extremely ashamed and make sure the child is confined to another part of the house.
 - B. Be very ashamed and attempt to direct attention away from the child.
 - C. Be somewhat ashamed. Would introduce the child and apologize for him.
 - D. Acknowledge and introduce the child without any sense of shame.
7. If strangers visit their home, the parents may well be:
 - A. Extremely embarrassed and make sure the child is confined to another part of the house.
 - B. Very embarrassed and try to direct attention away from the child.
 - C. Somewhat embarrassed and when introducing the child, apologize for him.
 - D. Relaxed and introduce the child without any sense of embarrassment.
8. After a child is admitted to an institution (permanently), what might parents think best both for the child and for the rest of his family?
 - A. To forget about the child.
 - B. To occasionally send gifts but never have any personal contact with the child.
 - C. To often send gifts, occasionally speak to staff members about the child's progress and sometimes visit the child in the institution.
 - D. Send gifts at appropriate times. Often speak to and closely cooperate with those who care for the child. Have regular visits with the child both in the institution and at home.

9. What might parents be expected to do when their child attempts to do something for himself?
- A. Stop him because he only makes things worse.
 - B. Allow a few extremely simple things. However, watch closely and prevent from trying more.
 - C. Allow some reasonably demanding things, watching and instructing the child at all times.
 - D. Encourage the child to do what he can by himself, being ready to help if there is a request.
10. If the child shows improvement in ability to do things or in behaviour, the parents might:
- A. Expect no change and so ignore the child's self-endeavours.
 - B. On rare occasions be able to see change and give the child praise.
 - C. Notice very obvious change and praise the child.
 - D. Watch for and often see the slightest change and give immediate praise on each occasion.
11. When the child fails to accomplish a task, his parent may:
- A. Have no patience or tolerance for failure, so stop the child from again attempting the task.
 - B. Have very little patience and warn the child not to try again.
 - C. Be somewhat patient and sometimes encourage the child to try again if the task is within his limits.
 - D. Help the child accept his failure without undue feelings of inferiority and definitely encourage the child to try again if the task is within his limits.
12. Would parents consider taking their child to public places such as supermarkets?
- A. Never. Amongst other things it would be too embarrassing.
 - B. Only on exceptional occasions. The slightest interest expressed by others would be very embarrassing.
 - C. Once in a while. It would be somewhat embarrassing.
 - D. Often. It would not likely be embarrassing.

13. When neighbours meet the child on the street, they may:

- A. Treat him as being repulsive and completely avoid except to command child to stay off their premises.
- B. Be very cautious and view the child as a threat to person, property and the general well being of the community.
- C. Somewhat aloof. Talk to the child in passing, but not encourage further contact.
- D. Accept him with warmth. Talk to in a friendly way and sometimes invite him to visit their home.

14. What might the brothers or sisters do if the child wants to play with them and their friends?

- A. Refuse to allow to join the group or to watch activities from close by.
- B. Not let the child participate in any of the group's activities but allow to watch from the side-lines.
- C. Begrudgingly accept the child and allow minor participation.
- D. Accept into their group and encourage participation whenever he is able.

15. How do you think brothers or sisters would feel about bringing their friends home?

- A. Too ashamed to bring their friends home.
- B. Very ashamed though would bring friends home on rare occasions. Would avoid questions about the child.
- C. Somewhat ashamed though would often bring their friends home. Would give non-specific answers to questions about the child.
- D. Quite relaxed, would easily accept the child in the presence of their friends and acknowledge questions about his handicap with specific answers.

D

D

D

[illegible]

APPENDIX "D"

CATALOGUE OF CLASSROOM ACTIVITIES

"PLAY TO LEARN"

A. Prayer

Each class begins its session with prayer - the teacher leads, the group repeats after him to their ability: "Dear God, please help me to play with all my friends in a happy way. Amen."

B. Roll Call

Each child stands when his name is called -

If he speaks, he says, "Here, Sir."

If he does not speak, he raises his right arm.

C. Dramatic Play Activities

1. Trips.

"Let's go to the farm" or "Let's go to the zoo" or "Let's go for a holiday" - on train, ship or airplane.

a) Equipment:

- i. Regular bus stop sign.
- ii. Umbrella, golf clubs, tennis rackets, etc.
- iii. Bus driver's seat, steering wheel, fee box, and change plate, bus driver's cap, lunch box.
- iv. 35 mm slide projector and daylight screen, slides of general countryside, farm, sights at the farm.
- v. Tape recorder and tape containing sounds of bus' engine starting and running, travelogue music, sounds at the farm including trains, aeroplanes, cars, tractors, farm animals, and so on.
- vi. Large colour picture of farm - farm buildings, animals, machinery, background with cars, train, aeroplane, etc.

b) Action:

- i. One child occupies bus driver's seat. He will conduct the tour.
- ii. Children line up at bus stop. They carry umbrella, golf clubs, etc., as adults in community carry parcels.
- iii. They enter bus in single file. Bus driver says, "Good morning - put money in box". Child answers, "Good morning", puts money in box. Child takes his seat.
- iv. Tape recorder is turned on. Children hear sound of bus engine starting and driver "drives" off turning steering wheel.
- v. Room lights are dimmed. Projector is turned on. As each picture is shown, tour conductor says, "This is a road, lake, train, airplane, dog, horse, etc." and after each statement the whole class repeats, shouting "road", "lake", "train", and so on.
- vi. At different stops a new driver comes on duty (as in real life) and over a period of several days, each child has a chance to conduct the tour.
- vii. The teacher gives instructions: "Show me a big horse, a little horse, a flower (telling colour), parts of an object" - e.g. as doors, windows, roof are part of a house, and so on.
- viii. After the trip is a review. The lights are turned on. A large picture of farm is located at front. The tape recorder is turned to various sounds and different children are asked to point out from all the objects the animal or other objects making the sound.
- ix. A similar process is followed when the class "visits" the zoo, park, holiday trips and so on.
- x. When possible, actual outdoor visits to these places are made.

c) Aims:

To duplicate real life community experiences as closely as possible and thereby to facilitate, respect for property; polite manners; routine expected behaviour; speech practice and memorization of new words; sounds and connecting these; learning colours; learning objects and animals; learning concepts as big, small; counting, and so on. Each boy gets recognition as a person and for

accomplishment, both from school teacher and fellow class members. Along with this is the thrill of participating in group dramatic play, and so the lesson that life can have enjoyment.

2. Delivering Letters.

a) Equipment:

- i. Postman's hat.
- ii. Carrying bag.
- iii. Letters with pictures of members of class attached.

b) Action:

- i. A boy with postman's hat, and carrying postman's bag containing letters stands outside of the room and knocks. He is told to enter. He says, "Good morning". Class answers, "Good morning, Sir".
- ii. The postman looks at the picture. If he can speak, he calls the boy's name, saying, "Mr. Brown," etc., and delivers letter. If he cannot speak, he just delivers letter. Each boy receiving says, "Thank you, Sir."

c) Aims:

Here the boys learn to recognize others and self by pictures. Also, they practice etiquette, learning to say MISTER when speaking to a man.

3. Mailing Letters.

a) Equipment:

- i. Actual mail box.
- ii. Letters.

b) Action:

- i. The mail box is moved to different parts of the room on different days. The boys find and post letters. The teacher often takes class to post institutional letters.
- ii. The boys, when supervised, pick up letters at the central office and put them in the regular mail box. On this trip, they practice etiquette by saying, "Good morning", (good afternoon), "sir" (madam), "thank you", etc., at appropriate times.

c) Aims:

To familiarize boys with letter mailing procedure.
Boys also associate ideas from other games to reinforce learning.

3. Grocery Store.

a) Equipment:

- i. Shelves with real can goods, fruits, vegetables, clothing articles, etc.
- ii. Signs including posters, decoration flags, etc.
- iii. Push cart.
- iv. Telephone.
- v. Grocer's apron and hat.

b) Action:

- i. A boy is sent to store to be store keeper. He is dressed in white. Another boy shops.
- ii. Another boy pushes cart. If he bumps any person, he must say, "Excuse me, please".
- iii. When the boy gets to store, the teacher remembers another article and instructs a third boy to phone a message. This boy goes to a regular phone booth, which is located in the classroom, turns handle (old fashioned type of ringer) picks up phone, says "hello" and gives instructions to the store keeper - "bag of oranges", "bar of soap", etc., says "thank you" and "goodbye", and puts phone back in place.

c) Aims:

This teaches use of telephone and right language. The store keeper selects the articles by recognizing them, or if canned goods, by the pictures on the cans. The shopper collects the goods, pays for them and returns. Many words are learned, the colours of objects, size concepts and shape concepts. Also, signs are recognized - particularly SALE and its meanings. Manners and etiquette for public places are facilitated.

4. Milk-Man.

a) Equipment:

- i. Milk-Man's hat.
- ii. Milk-Man's carrier.
- iii. Cartons and bottles of milk.
- iv. Coins.

b) Action:

Boy delivers milk as instructed and receives payment.

c) Aims:

The boys learn new shapes, sizes, and the words - milk and cream, big, small carton, bottle and so on. Good manners are practiced.

5. Fireman.

a) Equipment:

- i. Bell.
- ii. 2 Fireman's helmets.
- iii. 2 Fireman's coats.
- iv. Length of fire hose and nozzle.
- v. Wall connection.
- vi. Wrench.

b) Action:

- i. Two boys are appointed firemen. Fire bell is rung.
- ii. Boys quickly put on fireman's dress, roll out hose, attach it to wall piece, and stand 'spraying' the fire with water. The boys visit actual community firehall to see real firemen, trucks and their equipment.

c) Aims:

The game is designed to increase speed of dressing and dexterity. Also the boys learn to be alert to the danger of fire, recognize the meaning of the fire bell, and the urgency required in fighting and for escaping from fires.

6. Let's Go Fishing.

a) Equipment:

- i. Actual fishing poles equipped with reels and magnetic 'hooks'.
- ii. Straw hats.
- iii. Paper fishing pond.
- iv. Metal 'fish'.

b) Action:

- i. A paper pond is layed out on classroom floor.
- ii. The "fishermen" put on fishing hats (to protect from sun), use fishing pole and 'hooks' objects which are in the pond.
- iii. The teacher tells which object to fish.

c) Aims:

To interest boys in fishing as a sport (several have gone to fish with teacher in nearby waters). Game also teaches hand-eye coordination.

7. Let's Go Camping.

a) Equipment:

- i. Safety helmets.
- ii. Saw.
- iii. Sawhorse.
- iv. Branch wood.

b) Action:

- i. Teacher says, "Let's go camping" - "Let's go saw wood."
- ii. Two boys put on safety helmets, arrange branch wood in sawing position on sawhorse and together saw wood. In the summer, some boys actually go camping.

c) Aims:

To help boys recall actual camping experience and to associate tasks with that experience. Also, they learn to take safety precautions.

8. Buying Newspaper.

a) Equipment:

- i. Newspaper honour boxes which represent two local daily newspapers.
- ii. Newspapers in each box.
- iii. Coins.

b) Action:

- i. A boy is given instruction to buy a Sun (or Province) newspaper.
- ii. He goes to the newspaper honour box (which he distinguishes from other newspaper honour box by its colour), places coin in proper slot, removes newspaper from box and returns to the teacher.

c) Aims:

The boys learn they must not take a paper before putting coin in box. They also learn how to perform the errand of getting a newspaper - i.e., to carry out errand instructions.

9. Association of Ideas - Errands.

a) Equipment:

The various areas and equipment of the special classroom.

b) Action:

A boy is instructed by the teacher to do several things in sequence, e.g., "a) Go to the store, b) buy a big bag of oranges; but c) before you go, d) mail this letter, e) after you go to the store, f) buy a "Sun" newspaper."

c) Aims:

Boys learn ideas "before" and "after" and to remember sequence of words and activity. He practices speaking, polite manners, etc.

10. Traffic Light Street Crossing.

a) Equipment:

- i. Actual traffic light with switch operated lights.
- ii. Street cross walk painted on floor about 20' long.

b) Action:

- i. Song is sung - "Hippity hop, hippity hop, green says go, red says stop"..
- ii. Boys stand and wait when red light is on. They cross at green signal.
- iii. Instructions are given by the teacher to: "Take long steps"; "Take short steps"; "Take running steps"; "Go fast"; "Go slow"; "Walk on tip-toe".
- iv. Crossing at a regular pace is practiced at a regular community intersection.

c) Aims:

The traffic light game teaches not only how to cross a street safely, but also several words and six ideas. These ideas and words may be used in other class and community activities.

11. Steps.

a) Equipment:

Wooden platform with steps and rails on either side. There are no stairs in the institution.

b) Action:

The boys ascend and descend steps, sometimes carrying objects.

c) Aims:

They learn the meaning of the words "up-stairs", "down-stairs". They improve their balance by carrying small objects (such as trays).

12. Competition.

a) Equipment:

Large box of assorted men's and women's shoes.

b) Action:

- i. The boys are asked to sort; big - small, and various colours of men's and women's shoes.
- ii. The teacher tries to put shoe in a box - if it is too big, the boys say so - if it fits, they say so.

- iii. The teacher tries to put on shoe. If it is too big, too small, or for a woman, the boys tell him.

c) Aims:

The game teaches the boys to recognize the concepts of size and purpose, as well as giving practice in action which improves dexterity.

13. Competition.

a) Equipment:

Wooden shapes (square, circle, triangle, $\frac{1}{2}$ circle, star) are mounted vertically on table. Each shape is painted several different colours. Each shape has several bolts and nuts of various sizes attached to the back.

b) Action:

- i. Each boy is instructed to stand in front of a shape.
- ii. He tells or points to different colours, depending on whether he can speak.
- iii. There is competition between boys to undo the bolts and to replace them.

c) Aims:

Boys learn shapes, sizes, new words, to increase manual dexterity and practice the selection of colours.

14. Manipulation of Window Blinds.

a) Equipment:

Classroom window blinds.

b) Action:

Two boys participate. One gives instructions, "Open blind, please", the other follows instructions.

c) Aims:

To acquaint boys with a common household task, to help boys learn how to communicate ideas in a clear, yet polite way, and to provide practice in manual dexterity.

15. Music.

a) Equipment:

- i. Record player and records.
- ii. A set of chimes.
- iii. Other rhythm-band equipment.

b) Action:

- i. A few simple songs are repeated often.
- ii. Boys 'sing along', keep time with their feet, hands and band equipment.
- iii. When the chimes are used, each boy has a number. The teacher calls a number, a boy strikes "his" chime. A favourite tune is "The Bells of St. Mary's."

c) Aims:

To teach rhythm, and encourage musical enjoyment.

16. Telling Time.

a) Equipment:

- i. A large clock face with times designated by numerals and colours.
- ii. A small clock face for each boy.
- iii. A small clock equipped with a bell.

b) Action:

- i. One boy sets the time on the large clock face as instructed by the teacher.
- ii. Each other boy also sets his own smaller clock face.
- iii. Besides speaking the time after it has been set, the boy tells the colour.
- iv. After this, the bell on the small clock is rung. The boys count the number of rings.

c) Aims:

To teach how to recognize the time at the full hour. Boys also practice speaking, counting, and telling colours.

D. Parallel or Associated Objects

Children are given one thought, idea, and associate it with two or three activities.

1. What game is this?

The teacher makes the batting movement of a ping-pong player. The class recognizes movement. One boy selects a ping-pong bat from other equipment. Teacher asks, "Where is ping-pong ball?" A boy selects it. The boy is told to put the ball in a large cloth bag. By the same process a golf-ball, a soft-ball, a tennis-ball, a hockey-puck are placed in the bag. A boy is then asked to "put hand in bag, get golf ball", and so on. Ideas are associated and the sense of feeling is practiced.

2. What is missing?

Several common objects, as pipe, fork, bell, comb, are placed on a table together. A boy is asked to remember them. He is sent to another part of the room while the teacher removes one object. He is called back and asked, "What is missing?" He tries to recall. Ideas are associated and the sense of memory is facilitated.

3. What is his name?

A boy is blindfolded and turned about 2 or 3 times. Another boy from the group is instructed to say to him, "Good morning, Sir". He must guess the boy's name. The sense of sound is facilitated.

4. What is it?

A boy is blindfolded. He guesses objects by smelling them - soap, orange, apple, etc. The sense of smell is facilitated.

5. Where does it go?

Competition is arranged between 2 boys. They fit different sized - different coloured cylinders together. They also place knives, forks and spoons in the proper places in a drawer container. This teaches speed, and seeing size and shape concepts.

6. Learning to Count.

(a) Numerals:

There are numerals 1 - 20 on separate pieces that may be hung on a wall. A boy uses pointer and counts.

(b) Counting-board:

A counting-board contains different numbers of real objects, such as cups, oranges, cans, etc. Each item in a row is exactly the same. A boy is asked to switch numeral values to the row opposite the right number. For example, if there are nine cups, the boy counts nine, finds numeral 9 and places it beside the 'cup row'.

(c) Bouncing the ball:

- i. The teacher bounces the ball. The group tells how many times he bounces it.

ii. A boy bounces the ball. The group tells how many times he bounces it.

iii. A boy bounces the ball and the same boy counts how many times he bounces it.

(d) Rolling the dice:

Large coloured dice are rolled. A boy counts the dots turned up.

(e) Weight scale:

Objects weighing from 1 to 25 lbs. are placed on scale. A boy reads the weight.

(f) Coloured cloth sets:

Coloured cloth sets with buttons and button holes.

Boys match colours and button pieces together.

They count the number of buttons, tell the colours, practice buttoning.

7. Signs.

At various class activities, signs are used. These apply to different activities and are used to increase child's general knowledge and alertness. Signs are: "Men", "Women", "Stop", "Out of Order", "Bus Stop", "Sale".

8. Speech (Phonetic lesson).

The boys are taught to distinguish between and say closely related sounds: Ball - bell; window - elbow - yellow; door - floor; head - red; hair - chair, and so on.

9. Drawing and Colouring.

The boys join numbers in sequence with a pencil to get

a picture. They colour the pictures. These pictures are of other objects in the class room - as traffic light, fish, bird, etc.

10. Care of Pets.

Budgie bird is fed and watered, and the cage is cleaned daily by the boys.

From time to time, other live animals and birds are shown to the children; i.e., chickens and rabbits at Easter time.

11. Care of Plants.

The boys water the plants daily.

12. Care of Grass.

During warm Summer weather, the boys are taught the care of grass - (cutting and raking).

APPENDIX "E"

BIBLIOGRAPHY

- Allport, G. W., Personality and Social Encounter, S. J. Reginal Saunders and Company Ltd., Toronto, 1960.
- Blodgett, Harriet E., "Report of a Research Study at the Sheltering Arms, Minneapolis, Minnesota", First Winfield Institute: Research in the Management of the Mentally Retarded Child, Winfield State Training School, Winfield, Kansas, October, 1956.
- Blodgett, Harriet E., and Warfield, Grace J., Understanding Mentally Retarded Children, Appleton-Century-Crofts, Inc., New York, 1959.
- Bowlby, J., Maternal Care and Mental Health, World Health Organization, Geneva, 1952.
- Cain, Leo F., and Levine, Samuel, A Study of the Effects of Community and Institutional School Classes for Trainable Mentally Retarded Children, U. S. Office of Health, Education and Welfare, Contract NO SAE 8257, June, 1961.
- First Annual Convention, Canadian Association for Retarded Children, Calgary, Alberta, September 17 - 19, 1958.
- Herber, Rick, "A Manual on Terminology and Classification In Mental Retardation", a monograph supplement to the American Journal of Mental Deficiency, September, 1959.
- Kelman, H. R., "Some Problems in Casework With Parents of Mentally Retarded Children", American Journal of Mental Deficiency, Vol. 61, no. 3, January, 1957.
- Laycock, Samuel R., Mental Hygiene in the School, The Copp Clark Publishing Co. Limited, Toronto, 1960.
- Levinson, Abraham, and Bigler, John A., Mental Retardation in Infants and Children, The Year Book Publishers, Inc., Chicago, 1960.
- Mandelbaum, Arthur, and Wheeler, Mary, "The Meaning of a Defective Child to Parents", Social Casework, Journal of, July, 1960.
- Masland, L., Sarason S., Gladwin, T., Mental Subnormality, Basic Books, Inc., New York, 1958.
- Masterman, Louis E., Attitudes Toward Children of Subnormal Intelligence, Publication No 133, Community Studies, Inc., Kansas City, Missouri, and The State Division of Health of Missouri, Jefferson City, Missouri, June, 1961.

BIBLIOGRAPHY (continued)

- Murray, Mrs. Max, "Needs of Parents of Mentally Retarded Children", American Journal of Mental Deficiency, Vol. 63, no. 6, May, 1959.
- Noyes, Arthur P., and Kolb, Lawrence C., Modern Clinical Psychiatry, W. B. Saunders Company, Philadelphia and London, 1960.
- Queen, Alfred S., Social Work in The Light of History, J. B. Lippincott Co., Philadelphia, 1921.
- Stanley, J. C., Brief to the Royal Commission on Health Services, Saint John, New Brunswick, 1959.
- Tredgold, R. F., and Soddy, K., A Text-book of Mental Deficiency, The Williams & Wilkins Company, Baltimore, 1956 (ninth edition).
- Winthrop, Henry, and Taylor, Howard, "An Inquiry Concerning the Prevalence of Popular Misconceptions Relating to Mental Retardation", American Journal of Mental Deficiency, Vol. 62, no. 2, (1957).
- Zaleski, W. A., "Some Advantages and Disadvantages of Institutionalization", The Fourth Conference on Mental Retardation, Canadian Association for Retarded Children, Vancouver, September 26 - 28, 1961.

Special

- Canada, Dominion Bureau of Statistics, Census Division, Census of Canada, 1956, Vol. 1, part 9.
- Canada, Dominion Bureau of Statistics, Census (Demography) Division, Population Section, Census of Canada, 1961, Advance Report, NO AP1, March 16, 1962.
- Spitz, René and Wolf, Katherine A., "Grief - A Period in Infancy", (film), 3 reels, 35 minutes. Silent. René Spitz, 1150 Fifth Avenue, New York 28.