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GUILT; ANXIETY REACTION OF PARENTS IN HAVING AN

INTELLECTUALLY HANDICAPPED CHILD

An Independent Project presented in partial
fulfilment of the requirements for the degree
of Master of Arts
in Applied Psychology
Massey University

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1977

ABSTRACT

Chronic Guilt: Parents emotional attitude response to having a mentally defective child.

The aim of this project is two-fold

- (1) To propose that most parents who have a mentally defective child suffer from a pervasive psychological reaction, chronic guilt, and that it is not always recognized by the professional personnel - physicians, psychologists, and social workers, who attempt to help them
- (2) To suggest some of the implications of the phenomenon of chronic guilt for parent counselling processes.

Chronic guilt is a complex emotional attitude of long term duration and generally involving emotional conflict, grief, fear, love, anxiety, anger, hatred, protection, sympathy and defensive elements, and arising out of real or imagined contravention of moral and social standards in act or thought.

Most, if not all, of these parents suffer from chronic guilt throughout their lives regardless of whether the child is kept at home or 'put away'. The intensity of this guilt varies from time to time for the same person, from situation to situation, and from one family to another. Chronic guilt may be more intense for one parent than the other in the same family. Many factors such as parents personality, ethnic origin, religion and social class can influence the intensity of this feeling. Although chronic guilt may be felt by some parents of minimally retarded children, the phenomenon is almost universal among parents of severely or moderately retarded children, that is those children who would be regarded as retarded in any society or group.

The reality faced by the parents of severely retarded children is such as to justify the chronic guilt. When a parent is asked to accept mental deficiency it is not clear just what he is asked to do. The stress placed on acceptance may suggest to the parent that he is expected to see his or her child from the point of view of the professional. This expectancy can make the parent both resentful and resistant.

The first part of this study reviews some of the important literature published during the past twenty years, and suggests that trait factor analysis could be a basis for the chronic guilt syndrome.

The second part of the study is a field investigation of Wolfensberger's theory that guilt can be a positive attribute. From a small New Zealand sample of parents of handicapped children, who were referred or visited over one month (Kimberley Hospital) and asked to complete the 16 PF, four trait factors were extracted to support the contention and underline the complexity of the chronic guilt.

ACKNOWLEDGEMENT

To Dr D. Clarke who supervised and gave invaluable help throughout the project.

INTRODUCTION

The American Association for Mental Deficiency defines mental deficiency as below average general intellectual functioning, originating in the developmental period, associated with impairment of adaptive behavior, (Clarke and Clarke 197). According to the World Health Organisation's definition (1974) mental subnormality consists of two categories,

- (1) That due to environmental causes with no CNS impairment (mental retardation) and
- (2) That due to CNS disorders (mental deficiency)

Statistically 16% of individuals will have IQ's below 85 IQ points and 2% below 70 IQ points. Mental retardation may be classified according to IQ, developmental characteristics, potential for education or social and vocational adequacy. (Table II)(Appendix I)

There is no valid way of measuring social adaptability, but it is a far more reliable indication of a child's eventual outcome as an adult, than his IQ (Solomon and Patch, 1974). Many children with low IQ's fit in well into community setting as adults because of their good social adjustment, whereas others with higher IQ's end up in institutions because of their deviant behavior. Classifications have been based primarily on intelligence testing, but in assessing the potential for socially adequate adjustments in individual cases, the physicians, social workers, teachers, and psychologists, observations and judgments are as important as the objective ratings by IQ scores; this is assuming empathic acceptance of the handicapped child and not rejection in toto.

The effective support of parents in their care, acceptance, love and rearing of their handicapped child is very dependent on the empathic understanding of the support services, which can make or break the relationship, it is suggested. Much has been written on the care, education, and services available for the handicapped child, (Johnson and Myklebust, 1967; Peter, 1965; Wolfensberger, 1967; Deutsch, 1967; Gunzburg 1968; etc.), but little is written on the needs for understanding and support that the parents need throughout their care, placement, whether in schools or training facilities and later work or vocational and residential settings for their dependent offspring.

As is the case with normal children, the upbringing of the retarded child is primarily the task of the parents, then the day care centres, schools or training centres. Specialists can only assist the child, his parents, and his teachers to solve problems they have been unable to manage. Periods of crises when families may need additional help include

- (1) the first suspicion of the diagnosis and this may be divided into two categories
 - (a) from birth to twelve to eighteen months of age, and
 - (b) from four to six years or older
- (2) the period when diagnostic studies are being made
- (3) enrolment at school or training centre
- (4) adjustment problems with peers and siblings
- (5) family crises
- (6) vocational placement whether in sheltered workshop (SIH); sheltered employment, or institution.

Placement requires the parents to make a decision and having made the decision it does seem that the regret phase which follows emphasises the feelings of guilt and self-accusation which have lain dormant for some time and there is a need for further support and working through the anxiety of having a handicapped sibling.

Guilt may be defined as 'the emotional feeling associated with the realisation that one has violated an important social, moral or ethical regulation.' According to the psychoanalysts, guilt need not be conscious, and some guilt may be imaginary; and in the latter case it is assumed that the imagined guilt is symbolic of real repressed guilt; (Chaplin, 1970). Drever (1969) defines guilt as a 'sense of wrongdoing, as an emotional attitude generally involving emotional conflict, arising out of real or imagined contravention of moral or social standards in act or thought.' Throughout this paper the theme of guilt which evolves into chronic guilt in parents of handicapped children, Drever's definition in which he emphasises the emotional attitude and emotional conflict whether real or imagined, is accepted as the meaning for chronic guilt.

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CHAPTER I

Anxiety Reaction of Parents

Management of the parents' reaction and potential guilt feelings should begin when the diagnosis of mental retardation must be conveyed to them. This is the first period of maximum stress and a lot more must be done than just reporting the facts; parents must be given help with their feelings as the anxiety caused by the diagnosis of mental retardation or mental handicap results in a period of emotional disintegration. Areas of concern involve the marital relationship, mother's emotional health (greater post natal) and personality characteristics in stress situations, father's emotional health and reactions; siblings attitudes and due regard to grandparents' acceptance or rejection influencing the parents. (Carr, 1975).

J. Winterburn (1958) refers to four stages that parents go through in their reactions to the discovery; firstly, the stage of shock, followed by a stage of disbelief; then comes the stage of fear and frustration and then hopefully the final stage of intelligent inquiry, coupled with acceptance of the fact and adjustment to the situation. Solomon and Patch (1974) group the period of shock, disbelief, fear and frustration into a period of emotional disintegration; and the period in which parents learn to accept the diagnosis and resolve to help their child, they call the period of reintegration. Further they accept there are residual feelings which can hamper the parents' efforts to rear the child in the most acceptable way and it is suggested that it is the residual feelings which are possibly the most significant in the 'pathological reactions' which occur in their relationship with the handicapped child.

Solomon and Patch (1974), refer to a later phase as the period of mature adaptation in which the parents learn to ultimately accept and love the retarded child and deal with him constructively without significant emotional stress. It is further suggested that where a severely or profoundly handicapped child has been placed in the first few weeks of life because of rejection and emotional disintegration of the parents or parent, the period of working through for both parents may take years, but still needs to be done, on three counts:-

- (1) Parents' emotional health, and the marital relationship;
- (2) Needs of the child over his life span;
- (3) Lack of adequate facilities for placement so that the

parent will periodically be faced with decisions as to where to turn next for a placement for their child.

The question then arises, when does a parent leave off interest and a feeling of responsibility for his or her child; and conversely, when does a child lose interest in his or her parents? It does seem that some parents feel the "ache in their arms" even after the death of a young child (comments made by mothers after many years when their sons or daughters have died within the first five to ten years of life (Personal experience 1970-1977)).

Table 1 Classification of Mental Retardation (Solomon and Patch 1974).

American Psychiatric Association		World Health Organisation		American Association of Mental Deficiency	
I.Q.	Terminology	I.Q.	Terminology	I.Q.	Terminology
70-85	Mild Mental Deficiency	50-69	Mild Subnormality	70-84	Borderline
				55-69	Mild
50-70	Moderate	20-49	Moderate	40-54	Moderate
0-50	Severe	0-19	Severe	20-39	Severe
				0-19	Profound

During the early period of soul searching by the parents and the questions that are asked as to why this traumatic event happened to them and their child, personal and marital relations can become strained and help is needed to work through the pathological reactions of blame, whether self or spouse, guilt, sorrow and grief. It is suggested that the parent of the mentally defective child 'suffers' from chronic guilt. By this it is meant that the emotional attitude involving emotional conflict, arising out of moral or social standards in act or thought and reinforced by apparent social and professional contacts whether real or imagined is a natural response to a tragic event. If the professional worker accepts chronic guilt as a natural, rather than a neurotic response over time, he or she can be more effective in helping the parents achieve the goal of increased comfort in living with and managing a handicapped child.

Repond (1955) investigated the reactions of parents to their subnormal

children and found that invariably whether the situation was realised at birth or later the most serious problems are aroused by parental guilt at having produced such a child. Parents return again and again to the question - what was it in us that produced this? Repond found too that stable couples bound together with mutual love and understanding and, it is suggested, by religious bonds, are brought closer together by the experience. The danger is that the parents will form a close defensive triangle with their baby so that even their other children may tend to be excluded. On the other hand if the marriage bonds are weak or strained, a seriously subnormal baby can have a disrupting effect, as each parent will blame the other, dissension will increase, and each may deny further children to the other. Marriage can break down.

Main Types of Parental Reaction

Adams (1960) suggests that there are three main types of parental reaction to the birth of a subnormal baby; acceptance; rejection; and over-compensation, and it is further suggested that one of the reactions of over-compensation is hyperpaedophilia; or the excessive love of a handicapped child by parent or parents. Throughout all counselling and support the aim to be worked for with parents is acceptance and adjustment to reality. The more mature and emotionally secure parents will have the necessary insight to react positively and such people need to be given all the factual information about their problem over time as they are able to assimilate.

Parents of the child who are apparently able to accept the diagnosis emotionally may react with a period of depression, i.e. mourning for what might have been, Lewis (1934) considered depressive states as a paradigm of adaptive reaction of the organism to an intolerable situation. This interpretation seems well suited to explain certain reactive depressive states and can perhaps be applied to depression following the severe traumatic effect of the birth of the handicapped child. It appears that during this period of depression the parents incongruence evoking experience which has been sudden and intense, if at the birth they are confronted with the knowledge, or slow and fraught with frustration as in the case of later knowledge such as at school enrolment, produces extreme incongruence and high anxiety in which the defences are unable to operate and the result is disorganised

behaviour which is resolved by denial of the self concept or an altered self concept. The Humanistic perspective of which Carl Rogers (1963) is perhaps the best known adherent, maintains that the person may adopt certain defensive behaviour as a way to cope with his or her vulnerability. This defensive behaviour serves to distort the view of the experience and is thus an attempt to restore congruence between self and the experience. This concept relies heavily on conditions of worth as the predisposing factor and it is the concept of self worth which is under extreme pressure at the birth or discovery of a handicapped child.

Psychoanalytical Viewpoint

Fenichel (1946) from the psychoanalytic point of view states "the loss of self esteem is so complete that any hope of regaining it is abandoned. The ego sees itself deserted by its superego and lets itself die. To have the desire to live evidently means to feel a certain self-esteem, to feel supported by the protective forces of the superego." (pp 400-01). It is suggested that most mothers and some fathers during the phase of depression do feel a tendency to suicide during the early years of the child's life and this appears to be associated with thoughts of infanticide. The suggestion then is that the depressive phase is recurrent over several years and is associated with the period of mourning or chronic grief (Olshansky 1962). Though few parents will actually admit to these feelings until much later, even years later, it is a period in the depressive phase which must have cognizance and awareness of the supporting services. It does seem from comments made by parents over some seven years (Personal Experience; K.H. & T.S. 1970-77) that the underlying feelings of frustration, despair and the loss of their self concept, as well as the grief felt, contributes to their thoughts of suicide and infanticide. If these feelings are not taken cognizance of and the parents encouraged to face the reality of their deep feelings then the chronic guilt felt by parents will deepen and become or remain pathological. The guilt feelings then have complex origins and many factors contribute to the establishment of chronic guilt.

The Phenomenon of Guilt

Early Parent Reactions

Dally (1976) writes of the three stages of mothering. The first stage of enclosure and its physical counterpart is pregnancy but it

starts and ends later. Further Dally maintains that the period of enclosure begins with the first awareness of pregnancy and continues throughout infancy. It does seem that a few mothers during the third trimester feel that something is wrong with their baby and will seek counsel of their doctor; and in the years 1973-76 four parents mentioned this when interviewed for placement of their profoundly handicapped child into Kimberley Hospital and Training School (Personal Experience; K.H. & T.S. 1970-77) within the first seven years of age. The stage of enclosure is when the child is physically dependant on the mother and it is usually intensive until the child is two or three years of age. However, with the severely or moderately retarded child this period may last for five to twelve years or for the handicapped person's lifetime. It is instinctive and can be disrupted easily by adverse conditions either within the mother or outside. It does seem that the long period of enclosure that occurs with the mentally retarded child of the lesser abilities that this period can be a contributing factor to the chronic guilt of the parental response; i.e. the dependency phase of the child can become an onerous burden for parents who have many demands placed upon their time by social, family, and marital responsibilities, and though they love their handicapped child the demands on their energy and/or tolerance level to frustration, etc., reaches crisis levels and they feel guilty at apparently reducing the amount of care and attention they feel their handicapped child should have.

The second psychological stage is the stage of extension which corresponds to the physical stage of infancy when dependence is at first total and diminishes slowly over two to three years. It is the stage at which the mother becomes aware of the child as an extension of herself. It is during this period that the child goes through the stages of trust, mistrust, autonomy, etc. (Erikson 1968) but with the severely and moderately handicapped child these developmental milestones are delayed and with some children may never be reached. This, it is maintained, adds to the concern of parents and the burden of continual care, and dependency, creates reactions in which rejection and/or over-compensation are the end products of the slow and insidious onset of realisation that though the child may grow physically his achievements are small and slow.

The third stage is the stage of separation and Dally states that this represents the stage in which mother and child are separate people and

usually occurs near the age of 12-14 years and in which both adolescent and mother recognise and respect each other as separate people. This would not occur except in the institutionalisation of the profoundly and severely handicapped child and then it is an abnormal separation, but if counselling is available for the parents, this period can be worked through to ease the feelings of grief, rejection, and guilt at the feeling of relief and remorse that are felt by parents when the decision to place the child is made. With the mild mental retardate the parents come to this stage later and though it is important for the adolescent who is mildly retarded to be able to lead his or her own individual life, the problems of over-compensation and rejection on the part of some parents need the supporting services to relieve the family crises that ensue when the adolescent or young adult seeks the support and social interaction of his or her peer group.

Reaction to Trauma

It is during this first stage of enclosure and though the boundary lines between first and second stage are not clearly defined but may merge into one another, that the birth of a mentally handicapped child is a traumatic event for the mother and father and possibly more so for the mother. The initial reaction of shock can be associated with grief and rejection if the baby is obviously deformed and the diagnosis is positive at birth. It is suggested that in this initial phase of response to the birth of the mentally handicapped child that the first feelings of guilt occur when the parents question their own contribution to the defect or blame the other partner in the marriage.

Following the initial shock the reactions which follow vary in intensity from parent to parent as many factors such as personality, religion, social class, ethnic group and closeness of the marital partnership influence the intensity of the reaction which varies from grief, fear, frustration, and rejection to withdrawal and disbelief (Carr 1975).

Parents of the retarded child who do accept the diagnosis emotionally may then react with a period of depression, anger, and guilt, Anger at the medical profession, or fate, or God who has allowed them to have this child. This period may be one of learning how to love and protect the handicapped child or a period in which the parents seek a cure or placement for the retarded infant. Individual reactions of parents vary and depend on the closeness of the marital relationship. If the marital relationship is fragile (Adams, 1960; Younghusband, et. al. 1970)

it could be that this will mean the separation of the parents with one parent accepting the child, and though their reasons are suspect and include guilt and over-compensation, or self-punitive reaction in which the visitation of the handicapped child is regarded as retribution or punishment for past wrong doing, the solo parent endeavours to care for the retarded child. Fenechal (1946) states 'sometimes the ego seems willing to take punishments, acts of expiation, and even ... to an astonishing degree,' (pp 292). The ego's 'need for punishment' is in general subordinated to a 'need for forgiveness', punishment in the form of the handicapped child being accepted as a necessary means for removing the pressure of the superego.

Pathological reactions are frequently seen, and parents sometimes refuse to accept the diagnosis in the face of irrefutable evidence (Adams 1960; Solomon and Patch 1974). The denial by parents may allow them to accept the child into the family and continue a normal family pattern and relationship with the infant but this can expose the child to inordinate expectations and interfere with the parents' ability to deal effectively with their child's problems of development and adjustment and can lead to over-protection in later years as well as emotional problems in the handicapped child.

Solomon and Patch (1974) refer to the parental reaction of transferring their guilt feelings to others in the community such as the doctor, nursing staff, etc., as projection. Some parents are able to project onto other individuals their chronic guilt feelings and in this sense can ease the stress situation for long periods of time but eventually need to face their own share of responsibility when they have to make decisions as to ongoing care and support of their handicapped child even not making a decision it is suggested is a decision in itself. In moments of family crises then, the blame is recalled and bitterness and anger are projected onto the individual who is considered the cause of their grief, sorrow and guilt.

Parents may also displace their emotional needs onto the community, becoming active in the movements such as S.I.H. or Crippled Children Society, to promote understanding of the handicapped child; or they may become involved in other community activities as a means of denial of their handicapped child and this aids them in the placement decision, often supported by professional people in their contribution to society

as being more productive than caring for their mentally retarded sibling. Often baffled by their deviant child parents cannot call upon their own childhood experiences in deciding how to handle him, and this uncertainty may be reflected in over-protection or in unrealistic demands in performance. Each new stage in development leads to exacerbation of parental anxiety that may require counselling and support.

Other areas of concern

During the early years of the child's life, parents often encounter or feel they encounter, criticism and stares of the people they meet or come in contact with in their sojourns into the community. This period is often exacerbated by the toddlers or child's reaction to the stimuli, noise, and crowds of people around and most of the children do become cross and fretful or very demanding of mothers attention in these situations for some time. Mothers frequently state that they feel hurt by the stares of people and the voiced and non vocal criticisms they feel sure people are making of their handling of their child. It is suggested that most children do go through a stage of fretfulness when confronted by the many and varied stimuli in the towns and cities, how much more fear provoking it is for the handicapped child who needs the time to adjust and absorb what is going on around him?

As time passes and the needs of the child become more complex, often mothers feel inferior or are made to feel over-anxious when they want to know why; or what else can be done for their child; or is it possible for their child to be seen by other specialists. Too often professional staff react adversely and consider that a mother is complaining or over-anxious when, in her reality, she is only seeking reassurance that all the parents' care, concern, and anxiety for their child is respected and that they have the support and empathy of those whose role it is to support, advise and aid them in their care of their handicapped sibling. It is also the role of the supporting services to make sure the parents are wisely counselled as some parents will so cushion a child's life so as to provide a satisfactory life even for the profoundly handicapped child and though these parents are in the minority, self-sacrifice of money and resources would be expended at the expense of most of those things that make family and marriage worthwhile.

However, most families require practical assistance in the care of their child, either in the form of physical aids and/or financial assistance for those extra financial commitments that occur in their ongoing care of their child, e.g. modifications to the house and property in the way of fences, safe play areas, and privacy for other members of the family, particularly those siblings who are studying for examinations or doing their homework. This is also an important factor for both parents as they too need their privacy from the unremitting attention a demanding and very active child needs.

Problems of Training and/or Education

The dilemma faced by parents when a child, for social and practical reasons, is not fit for school by the age of five, and over-age placements in day care facilities or kindergartens is a God-send at this point in time. Some parents may need the services of institutions to facilitate a child's progress and/or to aid the parents over the stressful crises that can result when confronted with the knowledge that their child is not ready for school. In this situation the facilities provided by some of the S.I.H. branches make a very useful contribution, as the placement of a child in an institution is a very difficult and traumatic decision for parents to make. The stigma associated with the State institutions is far-reaching and the siblings in the family often meet rejection and peer group frustration if their sister or brother is placed in one of the few Hospital Board institutions. This adds to the guilt feelings of the parents and initiates a crisis in which the handicapped child is often rejected from family life.

The big advantage of the community facilities for short stay and parent relief or even long term placement away from the family is the community acceptance. The stigma associated with placement in Hospital Board institutions, though not as obvious as some five or six years ago, is still evident and parents and siblings can be confronted with peer projection i.e. a young child may be rejected by his or her peer group and no longer allowed to play with her or his friends because of their handicapped or 'mental brother or sister'.

Another area of concern for parents is the non-verbal communication of the handicapped child who finds the family life too constricting or too stressful. It does appear that some of the children who have short stays away from the family do eventually want to stay where the life

style is geared to their achievement and ability level. Often a child will indicate by his deviant behaviour on his return home that he wants to return to the Hostel or the institution and it is a very difficult time for the parents. Guilt feelings which have lain dormant for some time are again to the fore and mothers often comment that it is their fault and they are just not able to cope or look after their child any more. It is at this time that supporting services must be able to cope with the parents' grief, guilt and feelings of inadequacy and be able to help the parents to understand what the child is trying to tell them, as well as aid and assist them in finding a suitable placement for their child.

Questions of Long Term Guardianship

Fear for their handicapped child is part of the chronic guilt syndrome in that all parents wonder who will look after their child should anything happen to them. This is possibly one of the basic fears for all parents and they do need reassurance. Often the knowledge that their child's name is on a waiting list or that they are enrolled for Hostel accommodation is sufficient for parents of children of severely or moderately retarded children. There is a big gap in the facilities available to parents of children who do require some form of oversight but who can live a productive and relatively self-supporting life within the community, for example those who are mildly retarded but because of ability levels are unable to manage their own affairs. At this point in time there is no statutory or voluntary agency which accepts guardianship of the mental retardate for the entire life span as is the case in Sweden, Norway, etc. It is understood that this area is under consideration but it will take some two or three years before New Zealand Laws move in this direction. This move has been instigated by Mr Justice Beattie (1976) and it is hoped that this gap in society will be closed by 1980, with provision for the State to appoint a guardian for every mentally retarded child. Whether or not it is to be a parent, relative or other individual will depend on the individual child's circumstances, needs, and level of ability.

Reactions of Siblings of a Retarded Child

Solomon and Patch (1974) maintain that well-integrated and functioning families can almost always adapt to a retarded child, and state that "this is easier for families in the lower socioeconomic levels of society than for middle class families with social or professional

aspirations." However, as stated earlier it appears that the acceptance or otherwise by other siblings does depend very much on the mother and father's attitude, and where there is a stable marital situation in which the parents are secure in their relationships this is reflected in their siblings attitude. However, it is important that each sibling is not under pressure to care for their handicapped brother or sister as over time this causes resentment, particularly as the teenagers develop other interests and contacts outside the family circle. (Adams 1960; Winterburn, 1958, Younghusband, et. al. 1970)

The emotional impact of seeing a retarded child's deviant behaviour can cause anxiety reactions in the younger siblings and they may wonder if they will be as their handicapped older brother or sister when they reach their age. The other reaction which is common among the adolescent 'normal' siblings is to wonder if they too will have handicapped children when they marry and in turn have children. If the mother transfers the responsibility and care of the retarded child onto the oldest daughter, this too can cause resentment and guilt.

Often too the other sibs in the family resent the care a mother has to give to a demanding moderately and severely retarded child, as the excessive demands on her energy and time often leave her feeling inadequate, and with little patience to deal with the normal siblings. This too adds to her feeling of guilt that she is unable to give as much as she would like or as she feels is expected of her to all the members of her family. Fathers, too, in this situation feel guilty if they do not share the care and attention of their handicapped child and some fathers go to great lengths to take over the responsibility of their inadequate child when they are at home, often bathing, feeding and bedding the child to save their wives a little of the very onerous burden. Winterburn (1958) maintains that while the 'normal' children may have to give up something, they should not be expected to make big sacrifices. This is possibly the hardest area for the supporting services as too often one finds one of the siblings giving up more than can reasonably be expected, for the 'normal' children have ahead of them socially useful and fruitful lives. To make the intellectually handicapped child the centre of the family life style is an error which too often occurs and the family revolves round the demands and apparent needs of the dependent sibling. This creates its own problems and though it is easy for the supporting services to encourage families to

lead a balanced life style it is very difficult to achieve, but a few do, to the social advantage of the handicapped child.

Sharing Information

Three other factors call for comment

- (1) The other children in the family should be told frankly according to their level of understanding about their brother or sister's handicap so that they grow up accepting the 'normality' of people who need and require special assistance in the way of education, living conditions, and eventually placement according to their needs and wishes even though these may be assumed from non-verbal communication or for reasons of stress and tension engendered by the onerous care of a very dependent child or adult.
- (2) This attitude - of acceptance or rejection or frustration - will be largely determined by the parents attitudes. This is one reason why it is necessary for the parents to avoid over-compensation, over-emotionalism in the way of chronic grief and guilt, and a disproportionate interest in the handicapped member of their family.
- (3) If the handicapped infant is the first child in the family, parents are usually advised to have other children. This, to the writer, is inappropriate unless adequate safeguards for the parents have been undertaken - too often are parents advised to have another child without adequate safeguards. The reason advanced by Winterburn et al (1958) is that the parents face a very real danger that their lives may become so intensely wrapped up with their handicapped offspring and this is not good for any one of the three people involved. However, it is suggested that this occurs infrequently (see Table 4) and the more important field of supporting services is to ensure that parents face future pregnancies with the knowledge that they have covered the present fields of knowledge and that they are reasonably sure that they can produce a 'normal' child.