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ON MENTALLY RETARDED CHILDREN

A PHILOSOPHY OF CONCERN

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EACH YEAR approximately 126,000 infants are born who will be identified either at birth or in infancy as mentally retarded. Parents of these infants — and no one is exempt from this possibility — face at that time one of their worst fears: their infant is handicapped and will not be a normal child. But each parent, either at that time or over a period of time, to the best or worst of his ability, must acknowledge in his own heart not merely his child's tragedy but his own sense of personal tragedy. Franklin¹ describes it aptly: there are "two moments in time to be bridged — the last in which the parents look with joy at their new baby and his future, and the first when they know his tragedy in their hearts."

A sense of tragedy evokes not only a fervor of grief and sorrow but also feelings of self-pity, fear, resentment, guilt and perhaps de-

sire for retribution. Usually such feelings soon pass. Occasionally they reappear, or they may persist and multiply, and grow deep and wretched. In such instances, along with an increasing sense of individual helplessness and apartness, some parents take personal refuge in their grief and sorrow and seek not a life of positive spiritual thought and action but one of obscurity and of useless attitudes of self-deceit and prejudice. Unfortunately these parents may become incapable of accepting both fruitful counsel and useful information concerning their child, but more importantly they render themselves incapable of understanding and confidence and of growth in peace of conscience.

Feelings, as well as attitudes — and this serves to emphasize the complexity and individuality of each case of mental retardation and of each family and each involved professional person — are influenced and affected by factors both spiritual and material: faith in God and self, firmness of character and love, and one's personal expectations in his economical, cultural and social life. Different persons accord these factors widely varied values. Nonetheless, they serve in great measure to determine whether parents of retarded

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¹ Franklin, A. W.: Care of the Mongol Baby, *The Lancet*, 1: 256, (February) 1958.

children will be shown capable of persevering in fortitude and peace of conscience; or whether they will take self-protective recourse in fear and guilt, in bitterness and cynical disillusionment toward those around them.

Either course, however, is inextricably bound up with the philosophy of concern we professional people have for mentally retarded children. For how parents face and acknowledge mental retardation in one of their own is eventually not as significant as the nature of our concern and understanding of the retarded child and his needs.

THE FULLEST EXTENT

Usually the first person to inform parents, or to confirm the fact that their child is mentally retarded, is the physician. But the physician's role is not merely that of informant and diagnostician, it also is that of counselor, for it extends beyond scientific and technical capabilities. It extends into the subtle but immensely important realm of attitudes and interest, and serves to determine the adequacy of professional assistance and of professional and personal relationships.

The physician in his initial evaluation of a child suspected of retardation is bound to look soberly at the diagnostic possibilities. Concern first is expressed to the parents; and logical, and perhaps useful, laboratory measures are suggested. In addition, expert consultation in order to have another opinion plus his own is recommended. But it is not enough

merely to arrive at a diagnosis, however easy or difficult, and pronounce it to the family. It is not enough to make an immediate and sometimes biased recommendation: either the immediate placement of the child in an institution, nursing home, or foster-care home, or under no circumstances the removal of the child to a facility for placement care. This extent of professional assessment and interest is not only unrealistic, it is untenable. For it severely restricts and limits lines of responsible action professionally fulfilling medical objectives of a therapeutic, social, psychological, educational, yes, even economic nature. Therefore, the question we physicians should ask ourselves is not simply, "What is the extent of our professional obligation?" but rather, "What is the *fullest* extent of our concern and interest?"

Basic needs of children, despite race, creed, age and intelligence, are identical, and have to do with their physical, mental, emotional and spiritual growth and welfare. We are obliged to know and understand them, and be aware of their implications. But we should not overemphasize one at the expense of the others. We can help parents define goals for a retarded child, and assist them in their assessment of the limits of the world in which he will live. But we should neither violate nor infringe upon responsibilities and obligations which belong to parents themselves. We can enlist the cooperative help of community resources and provide parents of a

retarded child useful and practical assistance in adjusting the child's environment. But we should neither ignore nor reject those parents who want to acquire this information and experience on their own.

THE WAY AND THE MANNER

Most reasonable persons accept a physician's diagnosis, however grave and disabling, or even certain its bonds of inheritance, if it is of a physical condition and does not involve the brain. But a disorder concerned primarily with intelligence, a unique human attribute, or involving the brain and affecting mentality, is something different. Indeed, it is painfully different, and nothing can be done to alter the plight of parents when one of their own is mentally defective. But their plight is not merely emotional, it is one of grief and of arduous difficulty in understanding and adjustment. Thus belief of such a diagnosis, let alone its acceptance, never is easy, nor is it ever the same. Parents may or may not accept the physician's diagnosis. They may or may not carry out his recommendations. But, whether they face up to the child's handicap and all its implications or not, they may finally rest staunchly on the physician himself and his sense of retarded children. The way we physicians establish our findings and the manner in which we relate them to a family may determine not only their acceptance of the diagnosis but also their eventual understanding of the child and of themselves. For the attitudes we hold toward

mental defectiveness, or toward a particular defective child, even toward his parents, may shape permanently the attitudes parents hold toward themselves and their child and physician.

Parents of retarded children turn to the physician not just for scientific and technical counsel but for understanding and for help and assistance. In order, however, to reconstruct and work out the practical exigencies of their new life we physicians should at the very start convey to parents the kind of concern and interest that respects not only their child but also their own feelings and concern, indeed their own burdens and hardships. This will be apparent both in the gentleness and in the thoroughness and skill of our clinical history and examination, and in our unhurried assessment of details of the child's developmental and behavioral history. It will also be evident in the time and consideration taken to explain the diagnosis and its implications, and in our awareness that not one interview but often repeated interviews are needed in order for parents to learn what they want to know and indeed have the right to know.

What most parents in their anguish want to know varies little: What really can be done and can't be done? How long will he live? What will he be like as he grows older? Will he have to be "put away"? Why did it have to happen to us? How did it happen? What ever did we do? How will it affect our family and friends? Who will care for him after we're

gone? If we have other children will they be normal?

It may not be possible to answer all these questions, but parents should be given what information is available and explanation in a way which is not an affront to human dignity but is simple, kind and factual. There should be full discussion of the nature of the disorder at their level of comprehension and understanding. For if misunderstood it is not helpful, and however detailed and lengthy, can be harmful. Parents need time: time to believe the diagnosis, and above all, time to accept it. But even to understand often is not enough because intellectual understanding of mental retardation is not the same as emotional acceptance. Therefore we should neither force nor suggest a time limit, nor impose our own emotion and feeling on parents. Parents have right to time, time in which to know and believe their child is retarded. Even then, intellectual understanding may be a snap compared to emotional grasping.

AWARENESS AND UNDERSTANDING

Increased knowledge of causes of mental retardation is a result of continuous clinical and fundamental research. But innumerable causes and treatment of mental retardation remain unknown. Technical accomplishments, however, often put into clear focus the nature of our impersonal concern for the very persons whose problems have created so much scientific interest. St. Thomas Aquinas remarked: "Some withdraw themselves from works of mercy lest

they be involved in other peoples' misery." Therefore we professional people, however subtly molded in our own insensible feelings and attitudes and bound to a hierarchy of values, need from time to time to take stock of ourselves and our own attitudes. We need to review our own personal feelings toward mental retardation and the influence and effect of mental retardation upon us as physicians and professional persons. We need to reaffirm our awareness that retarded children and their families are human beings and that they also have struggles and hardships in the society of which they are a part. Indeed, we may need to take stock of our own practice of the virtues of patience, humility and tolerance. Without them we may respond impulsively and improperly to families reacting with grief and despair or showing hostility and belligerence to those around them, who in the parents' minds are closely associated with their misfortune. That this may include the physician must be accepted understandingly and sympathetically. For there is no reason to expect gratitude from persons who have been told a difficult truth, or above all who have not been provided proper help and guidance at the right time.

Obviously an ideal situation cannot always be achieved. Nor would we expect it. For no amount of understanding, charity and genuine assistance can aid certain situations. Some represent almost insoluble problems. Nevertheless, ample effort to achieve what is

right and to attain the maximum in personal and professional obligations should not be abandoned or neglected.

In 1959 Waskowitz² reported results of interview with young and middle-aged, intelligent parents of mentally retarded children — how they thought they had been treated by their physicians and whether or not they had experienced difficulty in obtaining information about their children. Many parents reported that they felt uncertainty about the diagnosis first, but later plain distrust. These feelings, however, were often traced not to professional incompetency but to the manner in which physicians had talked to them about their child. The parents also reported that they were confused by the doctor's lack of definiteness and by the different emphasis or significance individual physicians place on various diagnostic tests and procedures.

In our experience the question of how definite or absolute one can interpret diagnostic tests, or diagnosis, is not the problem. It is the manner in which tests and diagnosis are discussed, and the way parents are told. Categorical, terse answers and reasons can rarely be given. But this is not so undesirable because failure to be absolute is not the reason why laymen start unrealistic quests for nonexistent answers. Nor is the reason usually a lack of scientific and clinical thoroughness. Instead it often is

simply a neglect of the feelings and concerns of parents. In addition, we may fail to make clear — in the context of the retarded child — that clinical evaluation is not therapy and that tests and studies are not synonymous with solutions. But more importantly — and anyone is remarkably sensitive in this regard — we physicians, however well we know the diagnosis and all its implications, may actually *not* relate it to parents: we fail to be truthful. Or we pass this responsibility on to another physician, the consultant. On the other hand, we may relate the diagnosis sternly and swiftly, jumping quickly to a conclusion without adequate study, and abruptly make a mandate that the child must be placed in an institution.

Parents often are heard to say, "We've had our child to more than a hundred different doctors, and we've spent thousands of dollars for many specialists." Oftentimes the quest continues because of a paucity of communication and understanding between themselves and their physician: parents may not be capable of communicating to the physician the real nature of their concern, and the physician may not be sensitive to the obscure way in which their concern may be shown. Therefore, what such parents are searching for may become apparent in the parts of this article concerned with communication between parents and physicians and with continuing parental grief and anger, and sometimes guilt.

² Waskowitz, C. H.: The Parents of Retarded Children Speak for Themselves, *J. Ped.*, 54: 319 (March) 1959.

THE TASK

One of the most difficult and arduous problems in human communication in medicine is to inform parents that their newborn infant or child is mentally retarded. Neither formula of words nor predetermined manner of communication ever lessens the task. Waskowitz² emphasized the parents' viewpoint: "It's like someone coming to you and telling you your child is dead . . . you stop living!" Spock³ related a viewpoint he as a physician felt at times — when he even experienced a sense of personal guilt: "I felt almost as if I were the creator of the defect!" Then, to paraphrase Dr. Spock, he would put on his severest professional face, itself, despite choice of words and phrases, a grim but foreboding means of conveying an unfavorable diagnosis.

Whatever our choice of words we should speak truthfully and kindly. We should call not on degrading and pithy terms but on those indicating feeling and respect and confiding the prudent judgment of our professional experience and heritage. In life, and at death, human beings, despite age and the nature of their disability, have right to both material and spiritual dignity. Yet, all too often — and even at times when the feelings of a person are respected — the sheer mention of mental retardation may evoke a series of

² Cf. Page 57.

³ Spock, B.: *On Being a Parent of a Handicapped Child*, The National Society for Crippled Children and Adults, Inc.; 1961.

protests, however valid their meaning, from parents:

. . . they tell you your child is a idiot and everything else . . . I feel that the doctors brushed us off . . . We did not find anyone who would sit down and tell us what the problem was . . . they just push you from one person to the next . . . the doctor didn't want to be bothered . . . the doctor didn't like him, and didn't mince any words about it . . . the doctor said I should have him in an institution because it would be better for the child and everyone else . . . the majority of professional persons we dealt with left us with the feeling that if you have a child who wasn't normal you should be ashamed of it . . .²

OUT OF LINE

The viewpoint of some professional people that all retarded children should be written off as hopeless idiots, or as dead losses, and that someone else must simply look after them is out of line with principles of both medical and social morality. Abilities of children who are retarded vary considerably: their intellectual and social capacities vary widely. Franklin writes succinctly: "That he (i.e., the physician) imparts a bias of his own to the course of events is inevitable, but there is no place in all this for the doctor who always recommends the same solution . . . nor for those to whom the consultation is no more than a rapid exercise in clinical diagnosis."

Franklin notes further: ". . . who the doctor is, is less important than the sort of person he is . . . let him be one who feels deeply about this problem, deeply enough even to pray before the interview and to weep afterwards." Thus, for professional persons to show a sense of compassion — not emo-

² Cf. Page 57.

tion nor reluctance and defensive fear to relate truth about the child — is a show of respect for the superior good of human life. For above all else, a child, however slow to learn and quick to forget, is not merely a child of parents, he also is a child of God. Both create him. But this does not mean that either God or parents create the child's defect and handicap. Parents often need reassurance in this regard. For with unrelieved notions of personal guilt, whether scrupulous or not, they are apt to seek out not only innumerable physicians but also persons in quackery and faith-healing, searching not for a cure of the child but for assurance they are without fault for his defect. Some parents, of course, are searching not for relief of guilt or grief — because such is not their need — but simply for the kind of professional attention and counsel which will help them know and better understand the nature of their problem.

GUILT OR GRIEF

The nature of many ills and medical problems is unknowable. Thus the sense of personal guilt, and of transferred guilt, is easy to come by. Parents may blame themselves for creating a defective child. They also may blame the physician. Therefore, in the course of interview and consultation, when it is justifiable to do so, parents should be properly reassured about themselves and their physicians. We can bring guilt-like feelings out into dialogue and dispel them with medical facts. We can also point out the natural-

ness of guilt feelings, and emphasize that such feelings often reflect not guilt but continued anguish and grief. But at times the question of guilt, associated or not with the child's problem, may continue and be more complex: past efforts either to prevent conceptions or to bring about miscarriage in early pregnancies; and the performance of a sterilizing operation after the child's birth. In such instances, without opportunity to confide the foregoing to physicians and to work out in conscience their feelings with confessors and clergy, there is apt to be endless confusion and invalid protests and disillusionment not only toward the child but toward those about them.

Children are genetic heirs to the best as well as the worst. But genetic predictability of mental defectiveness may be misunderstood by laymen and professional persons alike. It may be over-rated or misused, and not based on exact genetic data. This happens even when evidence for genetic transmission of a defect is lacking. Inheritance of a mutant gene, and thus cases of mental defect, occurs, but in either a single or successive generations there are few transmitted according to a predictable genetic pattern. It is extraordinarily important to emphasize this point, because more often than not, the rare but negative genetic risk is emphasized. Thus, unjustifiable fear. There is no widespread reason to forsake the positive aspects of general inheritance data. Statistics is a two-way street. For instance, is a 40-year-old couple more apt to have a child with mon-

golsism (the oft-quoted statistical risk is 29:1000 pregnancies),⁴ or more apt not to have a child with mongolism if the chances are 971:1000 pregnancies?

TEMPORAL OR SPIRITUAL

We human beings want children as nearly perfect as possible. But if perfection is not attainable we want them to be at least of normal intelligence. We tend to hold intelligence in awe and respect, and to have almost a reverend attitude toward it — not always for what intellect is but for what a defect in intelligence may mean to our own personal pride. For a child without full intellectual capacity, however slight or profound, will fail to measure up to our ideal; and there will be attached to him and also to his family stigma of a derogative, primitive sort.

But however difficult to accept, neither intellect nor intellectual achievement, although immensely respectful and useful in personal welfare and temporal distinction, indicate the final real worth and importance of a person. Neither can be equated with specific happiness and health. Neither may wear a halo, nor make secure a person's spiritual eternity. Yet this is not the viewpoint of society. For that matter it often is not the viewpoint of society toward those who are intellectually normal and superior. Thus, the sense of faith and spirit we professional people

impart in our temporal responsibilities serves in the long run to explain the nature of viewpoints and attitudes we hold toward human beings with blighted intellect and intellectual capacity. But without a sense of faith and spirit amidst innumerable secular pressures, feelings of self-pity and tormenting anxiety and behavior of a retributive kind are apt to prevail aimlessly and unresponsibly and all the while stifle efforts to create a course of positive and adaptive action.

Parents often harbor the notion and thought that a retarded child is a source of shame and embarrassment, and of fear. This is understandable, and should be brought up in the course of interview and counsel. But it takes parents time to abandon certain notions and thoughts and this cannot be accomplished in a one-stop, even all-inclusive interview, because virtually all laymen have different concepts of retarded persons and of their behavior and appearance. There are conjured up images of a backward child: one of total invalidism, or of terrifying activity, insane behavior, and grotesque disfigurement. In most instances this is not the case. Therefore the positive values of a child need to be brought out and highlighted in full discussion, not minimizing, however, the probable extent of his limitations, capabilities and capacities. And, what should also be made clear in talking with parents is that everyone invariably does best by a handicapped child — and he does best by everyone else — when persons

finally think of him, feel toward him and care for him not as a retarded child but as a person who happens to be handicapped.

PLACEMENT OR NOT

Upon diagnosing a child as retarded innumerable physicians urge his immediate placement in a nursing home or institution. This counsel may be well intended: to spare a family hardship or to make it easier for other children in the family. It may even be amply indicated in a few instances (approximately four per cent of retarded children), and thus be justified. But there must be a realization of what is involved in the parents' feelings on this score. In addition, there should be clear evidence that both hardship and detrimental effect on the family exist, and that the ideas and feelings, as well as the sense of responsibility, of both parents have really been consulted. The answer of placement and age of placement is neither pat nor simple; it must be based on a sympathetic but pertinent appraisal of individual specific needs and of a variety of complex factors. Some factors are obscure; and some are ever-changing and shifting. Thus there is no place in all this for the physician who always is the rigid exponent of the same solution — the immediate separation of the child from its family, or, for that matter, even the very opposite.

First of all, parents are in a turmoil. They are preoccupied with how and why it happened, and who is at fault. This is understandable and should be respected. They also are plagued with

thoughts of what a backward child holds for them and what they face in the future. Thus, at this stage parents need not extreme advice and abrupt mandates, but kindly counsel and time to think — time to release their hopes and plans for a normal child and time to reconcile these hopes and plans with a child of whom they as parents also are a part.

But innumerable families live with a sense of stormy wrongdoing after having been literally pushed into putting their children away. Unfortunately some physicians are so strong in their personal feelings of rejection of the defective that they advise parents not only to place a newborn infant in an institution or nursing home but also to tell their children and friends the baby died at birth — merely because it's better that way. This sort of mandate — the denial of a child's existence — we think, is inexcusable.

Nevertheless, the reason most parents give for placement in the newborn period — and there's no reason in our experience to think that parents distort this kind of advice — is that the doctor advised it: "It's better that way; it would be impossible to do later, for you will become too attached!" Glory to the Patron of little children! Normal parents are supposed to become attached to children, normal or not. Attachment is affection, devotion and a sense of fidelity. Indeed, it is for this very reason (affection and devotion) that parents will work out their child's care, education and training, regardless of his age and

⁴ Benda, C. E.: *The Child with Mongolism*. Grune and Stratton, 1960.

intellectual capacity. Lack of attachment, on the other hand, results in neglect of home, family and self and in compulsive, non-constructive attentiveness to a single person, normal or not. But this is a separate problem and must be coped with on its own score, for it often has no direct relationship to the presence in the home of a retarded child. Nonetheless, we admit, however rightfully intended and directed the physician's efforts to guide and assist a family, that his efforts may be doomed if the family's own level of adjustment, capacity and maturity is inadequate.

Of this, however, we are convinced: the presence of a child without major and uncontrollable problems in behavior and social relationships usually is not a source of continued shame, embarrassment and hardship for other children in the family. More often indeed, the child's presence may become a source of creative and positive values. For it may serve to create in siblings not a sense of rejection but a sense of fidelity and responsibility. Yet children tend to follow their parents' lead. Social and cultural pressures may make home care difficult, but fear and selfishness and a sense of blameless guilt are what may finally make it impossible.

Decision for residential placement should always remain the prerogative, the privilege, the right and the choice of parents. That they need time to face their problems, undertake a solution, and make a responsible choice has al-

ready been emphasized. For on their own they need time to prepare to accept the action of their decision. We may counsel and advise; but we should make no attempt to hasten their decision, nor to impose our own personal feelings and emotions on those of the family in order to press for premature action. Equally good, we think, is for a family to agree to a physician's recommendation for placement care but for the physician to place on parents the whole load of seeking a facility for placement, all the while knowing that neither facility in the community or state nor adequate money in the family for placement care exists. In most instances this is grossly unfair, and serves only to create unjustifiable anger in parents because they are unable to carry out measures advised by a professional person.

Furthermore, there simply are not, nor will there ever be, adequate facilities to handle all handicapped infants and children. Most public institutions do not have provisions for infants and young children. Indeed their waiting list, even for children of older eligible ages, often is not a matter of months but of years. Also most parents can bear neither the thought nor the actuality of an accumulative financial burden (from \$100 to \$600 a month) for care in private homes and institutions. In the first few years of life this purchases nothing more than synthetic mothering⁵ and at-

⁵ Schipper, M. T.: The Child with Mongolism IN THE HOME. *Pediatrics*, 24: 132 (July) 1959.

tention to mere physical needs. For anyone to insist that parents carry out professional recommendations of this sort is senseless and not without culpability.

INDIVIDUAL NEED

Each case, however, is different. Each should be handled on the basis of individual need, ability and capacity. If parents cannot accept or love a child for what he is, if a home and community can not cope with, or provide for, a child's changing but increasing difficulties in management and care, then home care is not the best. The nature of a child's social and behavioral conduct, and his physical size, make an obvious difference: amenable conduct, regardless of a child's age and size, makes home management far easier than conduct that is uncontrollable and untamable. The latter is pure torture for a family. Sooner or later they have right to reprieve from a child whose behavior is the mere puppetry of a wholly deranged brain-function. That a child's progress is better when he is loved and accepted for what he is, not for what everyone wants him to be, is largely true. But however great parents' love and acceptance, a child with aimless and unmanageable behavior in all ways will generally continue to show profound and deranged action and behavior.

Infants kept in the home until early school-age tend to show better physical welfare and higher levels of social and motor attainment than those placed in institu-

tions and nursing homes in early infancy. But no one set of rules may be counted on to apply to all infants and children and to all families, nor for that matter, to all institutions and nursing homes. A child may attain lower developmental levels in one institutional program, but merely because he receives there less personal attention and social stimulation. Yet in another institution or nursery home the very opposite may be noted. But this identical difference also is noted among home-care cases.

The capacities of retarded children may be few, but they have the right for them to be developed to the hilt in accord with the right and worth of any human being. Retarded children can be helped. This is true. But our kind of help is neither magic nor miraculous. It is the kind of help that is reflected in our attitude and feelings, and in our philosophy of concern. But it can also be realistic and practical, representing neither unachievable lofty dreams nor reflecting despair and hopelessness. Spiritually, for example, a retarded child, like any child, is capable of having his innocence strengthened with sacramental grace. For he too, whenever possible, has the right to reception of the sacraments and to religious lessons adapted to his age of comprehension and understanding. And medically, a retarded child has right to the identical kind of professional consideration ordinarily extended to any other child. But even more importantly — and this cannot be over-stressed — he also

needs opportunity for regularly scheduled consultations to review not merely any continuing problems but new ones as well. For parents constantly face new problems and need follow-up counsel of a constructive nature.

Parents must, however, agree to counseling. Fathers especially may be resistive, resenting suggestion and assistance, particularly when the retarded child is a boy. A retarded child affects parents, sometimes in shattering ways. Parents are human beings. They have the same burdens, the same troubles, and the same capacities as anyone else. But parents with a retarded child have a greater problem and a greater sorrow. Each may blame the other, as well as the child's grandparents. Separations and divorces are not uncommon. Yet in all this a physician, extending beyond his technical capacities and working with either social worker or nurse, or with another family of a retarded child, may do wondrous good for a child and his family, and perhaps bring parents closer together than ever before.

In this regard a child's program should largely be under the supervision of one physician, one who responsibly arranges all diagnostic tests and studies of a psychological, neurological and behavioral nature. If this is not done, both child and family are apt to get lost in a jungle of separate diagnostic clinics and specialty consultants. The result is not a coordinated program which can be useful and constructive but a chaos of overlapping test-results, suggestions and treatments. This is particular-

ly pertinent for a family whose child has multiple handicaps. For they need one professional captain, one physician who coordinates and centralizes all test and study data, as well as all prescriptions and treatment information. And too, the physician can forewarn and protect parents in their periodic temptations to engage in near fraudulent programs that aim to raise the intellectual abilities of retarded persons by a variety of hormones or medication, both old and new. Unfortunately some of these staggering claims are made not by nonprofessional people but by doctors of medicine.

As a child grows older the use of available community resources becomes increasingly important; and it is well for the physician to become acquainted with what they provide. This also pertains to education and training programs, public and private, in his community. In most major cities across the country there are associations of parents of retarded children. These have grown at a phenomenal rate. They usually are affiliated with the National Association for Retarded Children and carry out extensive programs, however incomplete, in guidance, pre-school education and habilitation for a useful vocation in society. Here in their own community parents, even parents of infants and young children, have a mutual way of finding that they are not alone, communicating individually with each other, sharing accumulated experiences, and learning further ways of coping with the numerous problems —

personal, social, and economic — which arise in the day-to-day care of a retarded child. Training programs in home-care methods, together with background suggestions of a practical nature, often are a realistic help to parents of a retarded child. Here too, ways and methods of establishing wills and trusts, in order to provide later continuing care for a child, may be learned. Parents may also obtain information about the group life insurance plans of the National Association for Retarded Children and knowledge about Social Security benefits, which may accrue to some. Hence, parents can learn about retarded children, not merely as they go along but from one another in a trusteeship of service and experience. Indeed parents bolster one another, not only growing in fortitude and confidence but working out useful ways of handling their own emotional strains and attitudes. But above all, parents' groups are a unified way of speaking up for retarded children, of spreading knowledge of the needs of retarded children to the public and community, and of calling for a vigorous program to prevent and treat mental retardation.

CONCLUSION

In this regard we professional people — it would seem to us — are endowed with a duty: a duty to soul-search our own philosophy of concern for children with mental retardation, and in addition, to provide for them the same opportunity for full spiritual, social and vocational development that is the right of every child. Mere sympathy is inadequate because it will never master the problem of mental retardation. Instead there is need for the kind of comprehensive and coordinated plan to combat and treat mental retardation advocated by President Kennedy:⁶

Both wisdom and humanity dictate a deep interest in the physically handicapped, the mentally ill, and the mentally retarded. Yet . . . we as a nation have for too long postponed an intensive search for solutions to the problems of the mentally retarded. That failure should be corrected. Our goal should be to prevent retardation.

. . . A successful attack on a complex problem like mental retardation (however) . . . requires a host of prior achievements, trained scientific personnel, tools and techniques, profound understanding of the behavioral sciences, a spirit of devotion to the underprivileged, and a free, democratic atmosphere of inquiry. Fortunately, ours is a country in which these ingredients abound.

⁶ A National Plan to Combat Mental Retardation. President's Panel on Mental Retardation. U. S. Government Printing Office, 1962.