

PROCEEDINGS  
OF THE  
WORKSHOP ON TRAINING OF SEVERELY RETARDED CHILDREN

Conducted by  
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Faribault State School and Hospital  
Faribault, Minnesota

#### Editor's Note

In the interest of conserving space, the proceedings of this workshop have been considerably condensed. Unfortunately, much of the "flavor" of the workshop—the humor, the anecdotes, the inimitable personality of Dr. Goldberg—has thereby been lost. It is hoped that the proceedings will nevertheless serve a useful purpose by indicating the range of topics and views encompassed in the workshop.

Since this is not a completely verbatim account, the remarks attributed to the various participants may not always convey what the speakers intended to convey, and I accept responsibility for any gross errors in interpreting their remarks.

Arnold A. Madow  
Editor

### Program

First Day	Clinic on Mental Retardation Characteristics and Special Needs of the Trainable Child
Second Day	Objectives and Goals of Training
Third Day	Curriculum for the Trainable Child Demonstration of Activities Carry-over of Activities Between School and Home
Fourth Day	Educational and Emotional Problems of Retarded Children
Fifth Day	Parents' Day The Mentally Retarded Child in the Home Problems Pertinent to Parents

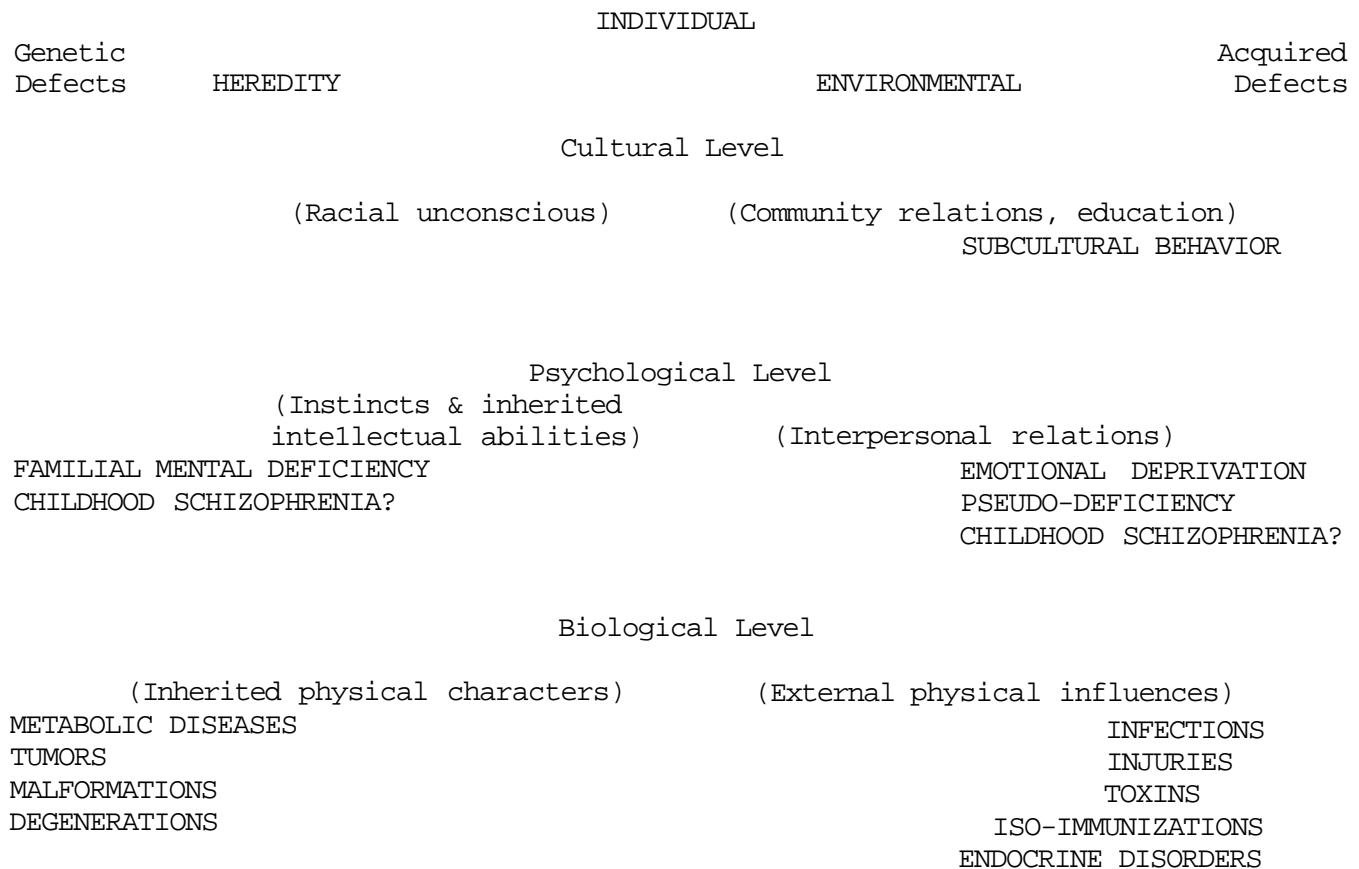
### Panel Members and Resource People

Dr. Harriet Blodgett, Program Director	Sheltering Arms, Minneapolis
Dr. H. H. Bruhl, Pediatrician II	Faribault State School and Hospital
Mrs. Jessie Driessen, Psychiatric Aide II	Faribault State School and Hospital
Dr. E. J. Engberg, Superintendent	Faribault State School and Hospital
Gordon Hoban, Psychiatric Aide II	Faribault State School and Hospital
Mrs. Olive Lynch, School Principal	Faribault State School and Hospital
Arnold A. Madow, Clinical Psychologist III	Faribault State School and Hospital
William H. Miller, Laundry Manager	Faribault State School and Hospital
Daniel Pepin, Cook III	Faribault State School and Hospital
Shirley Peterson, Social Worker I	Faribault State School and Hospital
Raymond C. Roach, Patient Program Supervisor	Faribault State School and Hospital
Ralph Rosenberger, Educational Director	St. Cloud Reformatory for Men and Annex for Defective Delinquents
Dr. Thorsten Smith, Clinical Director	Faribault State School and Hospital
Rev. Bert O. Streufert, Chaplain	Faribault State School and Hospital
Roy Welsandt, Patient Placement Agent	Faribault State School and Hospital

## FIRST DAY

Dr. Goldberg: To begin our workshop, Dr. Smith is going to show us examples of the various types, causes and degrees of mental retardation.

Dr. Smith: Before we see the patients, I want to explain this chart. In every individual there are two major sources for variation—heredity and environment. Each of these may exercise its influence on at least three different levels of integration—the biological, the psychological, and cultural. Mental retardation can originate at any of these levels of integration, and may arise through hereditary influences or through environmental influences. And, of course, the hereditary and environmental influences often combine, as in tumors and malformations.



(Editor's Note: Brief histories and descriptions of sixteen mentally retarded children were then given, and each child brought in for short periods of observation.)

Dr. Goldberg: Thank you, Dr. Smith. Every human being--normal, retarded, or handicapped--has three factors which affect his personality. One is the biological factor. Before we are even born, from the time we are conceived, certain factors are present which we cannot change. Sometimes something in this biological development goes wrong. Then there are the psychological and cultural factors which affect us very much. We have to remember that we are creatures that have to conform to the culture in which we are living. Let us remember that there are still cultures in this world where it is not necessary to eat with fork, knife and spoon. It is not necessary to know how to zip and unzip one's dress or trousers. It is not necessary to be toilet-trained at the ripe age of two. This is very important as far as retarded children are concerned, because mental retardation is shown through the culture in which we live. If some of the kids whom we just saw here were transferred to a tribe in Africa, where life is much more simple and primitive, probably the retardation which we see here in our civilization would not be seen so much. And let's remember, too, that our society, our culture, and our civilization are becoming more complex. Although we might not necessarily have more retarded children being born, the retardation will be shown more and more. As people who are engaged in the training and care of the children, we have to remember that some of the biological factors cannot be changed. But when it comes to the psychological and cultural factors which affect handicapped children, we can make quite a contribution. Very often we want to be "jacks-of-all-trade" when we have plenty of honest work to do without trying to be and do everything.

I've invited several people to come up to this table with me: Dr. Smith, Miss Peterson, Dr. Blodgett, and Mr. Madow. Let's define what we are talking about. Education is what we do for the child 24 hours a day. You people who are working here at Faribault are in a much better situation than some others of us, who see one set of values taught the child, at home, another set of values taught in school, and it is so difficult to bring the parents and teacher together. But here if something goes wrong it's all your fault, because there is nobody else to blame for it. The teacher and the aide are both parts of the total education of the child and have to work very closely together, have to understand each other, and have to have common goals and objectives.

Now we'll see how a group of people representing five disciplines can actually develop a common language and a common understanding as far as the care and training of the more severely retarded child are concerned. Let's consider this as a team which looks at the child from various angles but which is concerned with the care and training of the retarded child. Dr. Smith, how should we proceed from the recognition of the various causes and types of mental deficiency to the other factors, the psychological and cultural? And then, what can we do as far as the child is concerned?

Dr. Smith: Naturally, I would consider the biological point of view first, until the physician has satisfied himself that he has learned all he can from that aspect. The problem is then referred to the psychologist and the social worker. The psychologist must make his independent examinations to determine the abilities, the mental status, emotional status, and total personality development before we can begin to get the whole picture.

Dr. Goldberg: Let's suppose that we have a mongoloid child whom we're seeing for the first time. What is the psychologist looking for as a supplement to the diagnosis?

Mr. Madow: The psychologist will, first of all, get his information from two types of sources. One is a history of the interaction of the child with its environment, for which he relies on the social worker a great deal. For most children the environment that we are going to be primarily interested in is the family. Together with that information the psychologist is going to try to get a cross-sectional picture of the child in terms of a good many-things: his abilities--the things that he can do and the things that he can't do, his special interests, his attitudes toward other people and toward himself. In this cross-sectional approach we primarily use observations, interview, and various standardized as well as unstandardized tests. These are designed to give us an understanding of the child as he is now. The next stage, I think, is to relate the things that we find in the social history to the child as we see him today.

Dr. Goldberg: You do this without any bias because the child is a mongoloid, a spastic, or whatever else the cause of his mental retardation, is that right?

Mr. Madow: Yes, that's right. I haven't said anything about the type of retardation, though it may very well be that the biological background in a particular case may be the crucial factor. For example, supposing we had a spastic child and a family which has placed obstacles in the way of this child's functioning as efficiently as he can function. The child may now be upset and angry because he can't do the things that he wants to do. The biological factor or physical condition is then a contributing factor, as is the family situation.

Dr. Goldberg: If you have a kind of brain injury reported by the team you can then better understand the behavior of the child, but you generally approach the child as a child, not as a "case". This will be important for the aides and teachers later on.

Mr. Madow: The idea, then, is to try to describe the child as we see him today in all of these particular areas, relating these findings to what we know of the child's background, and perhaps making some guesses as to the future. The psychologist uses quite a number of instruments today, plus his own insight, experience, and clinical training in arriving at these guesses about the child's future.

Dr. Goldberg: What he puts down in a report is not a definite thing, but a guess that has to be tested to see whether or not other additional information is needed to come to a definite decision. Now as far as the tools themselves are concerned, we teachers and aides very often do not understand the magic of the numbers 71, 41, or 46. We accept it and very often do not read the entire psychological report. We look at the IQ number and from it form our own biases. Will you kindly tell us a little bit about the tools that you are actually using besides your own clinical insight and experience?

Mr. Madow: Let me just describe what goes into making up the intelligence test. An intelligence test is a series of questions and tasks graded in difficulty which are given to an individual to perform. The scoring depends on the test having been standardized on a large number of individuals so that you have some expectation of what an individual at a particular stage of maturity should be able to do. When a person is examined, you can compare his performance with that of the group on whom the test has been standardized. The ex-

pression "IQ" is a single index which summarizes the individual's status in the population in terms of his intelligence or brightness. While it summarizes, it also omits a great deal of information. It is entirely possible for two individuals with the same IQ to have completely different patterns on the test as far as what they have been able to do successfully and what they have not been able to do. The two people may be quite different and yet be represented by the same index number. The question can rightfully be raised as to what good is this index. Does it tell you anything about the individual? Experience indicates that it does, but it doesn't tell you everything. While intelligence tests have proven to be a very good indicator of school success, at least for a large group of people, they do not explain why a particular person does or does not do well in school.

Dr. Goldberg: I think that helps very much. Don't misunderstand me. I am not advocating that we throw IQ out the window, but we should also read some other things which the psychologist reports about the child. Let's hear now from the social worker.

Miss Peterson: We try to get a complete social history. There are many ways of obtaining a history and many things to look for. I think the best place to start is with the family. It's important to know before you collect the material just what the problem is. Why has the family come to the team for diagnosis or for service? Are there physical problems, social problems, or is it simply for study of an abnormal child? This type of information gives you clues to begin your investigation. I think we always look for information about the prenatal period and the child's period of development. We try to find out about special studies and, if he goes to school, obtain accurate reports of the type of work that has been attempted and the progress made. Many times there has been a very serious social situation and there are many factors that must be looked into there. I think the important thing is to obtain facts and not just subjective judgment, either on the part of the social worker, the family, or whoever else we are contacting. Once the material has been gathered, it is put in such form that it will be meaningful to the other members of the team.

Dr. Goldberg: This is the type of information that a social worker, through her particular training and experience, can bring together and present to medical people, psychologists, and others. This is a very skillful job. It is not so easy to gather this kind of information. These are people who are especially trained to try to find out as accurate information as possible about the history of the individual that will throw light on the medical diagnosis and help the psychologist so much. Again, let's not attempt to do things for which we are not prepared. We find so many teachers and aides doing so many other things besides the job which is so important--training and care of the children. It sounds easy, but it is a very difficult job to sit down with parents and, out of all this history that the parents have rationalized, to come up with the one clue that may disclose the whole story.

Dr. Blodgett, will you kindly supplement the other presentations so as to facilitate my presentation on the care and training of the child?

Dr. Blodgett: Having had the opportunity recently to work in a very special kind of school situation, I can describe a couple of things that we do that would perhaps throw a little light on it. For instance, I think more and more that one rule for the psychologist is to use the psychological study time not

only to measure ability but also to look for any physical symptoms that may have been missed if the child has not already had specialized medical study. He may have had ordinary medical attention as far as his general health is concerned without having had a thorough work-up of the type that we recommend when we are trying to reach a diagnosis. Such things as looking for evidences of petit mal seizures in the child whose attention seems to be variable, looking for evidences of hearing loss in children whose verbal ability seems to be out of keeping with other types of skills, looking for visual handicaps, looking for perceptual-motor difficulties by specialized tests and by observation, looking for things that might suggest that *one* or another kind of medical specialist ought to be brought in to add to our information. When you also have a school situation at your disposal, one of the things you can't help being concerned with is measurement of more areas of ability. We don't want just the IQ. We want other ability measures which may also yield IQ's, but they are different IQ's because they are based on different test content. The - fact that a child has a particular facility with puzzles may not matter as far as a long term life prediction is concerned, but may be very useful to know in planning his early school experience. Or the fact that he may be particularly angry when you ask him to look at pictures may tip you off that his parents have pushed him too hard in this area and it would be wise in planning his early schooling to avoid asking him to look at pictures. This I think is part of the psychologist's job and part of the educational planning for the child. I am also greatly interested in the problem of measurement in non-intellectual areas. We see these children and we know they are retarded—in this respect they have something in common—but increasingly as we watch them in group situations we are concerned with their differences, even at the same ability level. These differences have to do with motor skill, temperament, disposition, behavior control, and their attitudes towards other people. These are things that up to now we have observed and talked about more than we have been able to measure. I think we have to work more on this area, developing rating scales, perhaps, or situational type tests that the psychologist can use in his office but which will have meaning when transferred to the classroom. Then I think the psychologist has an important part to play in the area of parent interpretation and education. Many of the problems that we see in our retarded children are related to the life they lead at home. The attitudes the parents have towards them and the expectations show up in the responses of the children. The children come to you bringing their background and experience with them. The resistiveness, stubbornness, hostility, and aggressiveness that they show toward other children and adults are probably, if we can trace it back, very closely related to the ways in which they have been treated and the experiences they have had.

Dr. Goldberg: Dr. Smith, do you have anything to add to what the panel members have said?

Dr. Smith: I would like to make just one observation. The biological status of an individual is not static. There are many mechanisms here that are understood and that can be treated. We are not through with biology; it goes through all of the other areas.

Dr. Goldberg: Right of course, if this is not static, if they can change in the biological sphere, they change in the psychological, cultural, and so on. I'm sure that the whole concept of so many different aspects is disturbing to you. What has all this to do with the girl whom we want to work in the kitchen?



The dietitians and cooks are interested in how to get the maximum out of a helper, sometimes because of the shortage of personnel but mostly because it is a good training area. What has this to do with whether she will put two pounds of salt into the soup or one pound? It has a lot to do with the final product. It will make the boy or girl useful in the kitchen or will make him a not-too-useful human being. The medical man is supplemented by all the other members of the team. He does not go out himself and look for all these things. He depends very much on the information coming not only from these people here but from all of you. Very often his diagnosis may change on the basis of some observation that you might be making in the kitchen when you work with a boy or girl. From the psychological point of view, any clue will probably help quite a lot in testing the hypotheses or guesses made. The social worker may revise her opinion or seek additional information on the basis of all the clues which come to her. It's a constant, continuous, fluid teamwork. It is like a clock--take one little screw away and the whole clock stops.

Now, as far as educators are concerned--aides, teachers, nurses, all those concerned with the training of the child--what are we going to do with all this information that is summarized and to which we have access? Is it going to bias us against the child or are we going to use it for better understanding of the child? One school of thought believes that we are so biased by this information that we are prevented from helping him. On the other hand, an understanding person can help more by knowing this kind of background information. It is a very difficult thing not to be biased, and no college in the world can teach us how to detach ourselves from these problems. We bring to our work all our cultural background, our solid citizenship, and suddenly we face something with which we cannot cope. The best example is a child who uses obscene language. It bothers us and we cannot accept that child. We go into a shell when we hear swearing and cursing by young children. We are immediately biased by this and our relationship with the child is such that we cannot help him. We usually say in theory that we should take the child as he is. He is here because he uses obscene language and has certain disabilities. Accept the child as he is and when the relationship between you and the child, has developed to such a degree that you trust each other, then you can work on the obscene language. But as soon as you say something to the effect, "I will not like you", you cannot help him. This is part of his disability, perhaps one of the weapons he is using to get even with society. We have to treat it like a broken arm or bad eyesight and not penalize the child for it. Provided we do not become biased by it, this information can be very valuable in our work with children.

What then is the role of the teacher, the aide, the supervisor, and so on? We have the tremendous opportunity of observing the children for 24 hours a day, providing the information is noted and fed to the team. Not only the child that does something wrong but also the child who suddenly does something that he never did before. This doesn't have to be put into scientific language. Very often the psychologist and the medical man will derive more good from a statement like "On the 25th of February Wary hit Johnny over the head", than the statement, "Mary is an aggressive child". "Aggressive child" means one thing to you, something else to me, and another thing to somebody else. But it doesn't matter so much how you put it down as the fact that you do put it down, for this can be a tremendous help to the team to change things a little bit so as to help the child. The first job of educators is to have our eyes and ears open. We must take the child as he is, with all his faults--even liking his faults--and observe him. This may be more important to the child in the long run than teaching him reading and writing.

Now, when we get a child the question arises as to the degree of retardation. We know that if we group children according to some kind of criteria, we will have a better chance to give them good care, training, and education. In our field we have gone through all kinds of groupings. We started grouping according to IQ, putting all those in certain IQ ranges together. It didn't work too well because we discovered that aside from IQ's, people have to be grouped as to abilities and disabilities. So we started to consider the mental age of people as the basis for grouping. Here we also made a mistake because, though a fourteen-year-old and an eight-year-old might have a mental age of six, the chronological age and physical status of the children makes a big difference. So we went right back to chronological age and started to group children according to it, taking into account what we call the functional level of the child. The functional level is something which cannot easily be explained. It's a mixture of our notes or our insight more than anything that we can put on paper. I think those of you in the institution will agree that the best way of grouping the children here is according to physique and function. For the teacher the question of recognizing the different degrees of retardation is a very difficult thing, though it will much affect the techniques that we are going to use.

Let me try to explain it in schematic form. First of all, if we take into account the chronological age of the child, we assume that during the lifetime of the individual certain growth and development takes place. We see this even in the very lowest of the mentally retarded. Maybe not in the intellectual or social area, but we are sure that in the physical area some growth takes place. The infant grows up to be the very disabled and very much retarded adult. We must therefore subdivide our retarded population into chronological age groups. Traditionally we take the ages from birth to six and call it the pre-school stage. The second group will be people of ages six to twenty-one, which will be the school age. And then, of course, the third group will be people of ages twenty-one and over.

We also find that there are children with various levels of functioning growing up through these chronological age stages. The first level is the one that used to be called the idiot child, who, between the ages of zero and six, very early shows signs of very severe retardation. This is the child that very often shows the biological damage that Dr. Smith has spoken of. This is also the child who doesn't do the things that babies usually do at certain times; He doesn't walk, he doesn't talk, he doesn't hold his head up at the time that we expect him to. This is the one who, between the ages of zero and six, needs complete care and will die if that care is not given him. Sometimes this is referred to as the infirm case, the totally dependent, or total care case. In a home situation the care for this kind of child is very difficult. Given proper medical and nursing care, and the best therapy available, we can expect that when he grows up he might become a little less dependent, to a degree that maybe he will start to walk and be able to produce some type of sounds. The role of a teacher for these level-one children is still not too well defined. The role of a recreational worker is. In many institutions the recreational worker provides a lot of passive activity, like music. In this group we also have a lot of people who have an associated physical handicap. There is still controversy whether a physical therapist should work with these children or not, because it is thought that they will not respond to therapy. However, if we don't try, how will we know whether they will respond or not? We don't try it because it is too expensive to work with these very lowest patients. Whenever the question comes up whether to do something for these children or not, the answer is "Yes, let's do

it and let's prove that nothing can be done". So the work with the level-one child is left to the aides, nurses, and medical people, with very little participation by teachers or even recreation workers. We hope that the time will come when we will be able to prove that some improvement will take place while these patients grow up.

The level-two child is the one who used to be called imbecile and is now called the "trainable" child. Very early in life this child shows certain disabilities which are manifested in inability to learn to talk, to walk, and so on. The discovery of a trainable child can very often be made between the ages of zero and six. These children include a great many of the medical categories, such as mongoloids and cerebral palsy cases. Please remember that the medical diagnosis has nothing to do with the degrees of retardation that we are discussing now. What will happen with the trainable child? Between the ages of zero and six, if we bombard him with all the services at our disposal, we can very well prepare him for the next step when he becomes of school age. Around school age we can start socialization of the child and prepare him for as useful a life later on as possible. One thing is sure--this level-two child will require a certain amount of supervision throughout his life. Controversy at this point is whether the level-two child between the ages of six and twenty-one should attend public school classes, go to institutions, to private schools, or whatever. There can only be one answer, I think. It depends on the child, the family, the public schools and the institutions. Certainly many institutions in the United States are not ideal places, but they are developing very well and will soon be places where we can place children without fear. As far as the public schools are concerned, if there is too much opposition among the administrators to having programs for this type of child, I think it is better that they don't have them. The attitudes of the administrators will prevent them from helping the child. It is said that teachers of these children are simply doing a lot of baby sitting, but it depends upon the teacher. There are teachers who are doing baby sitting in high school. There are also teachers who are doing teaching. If we believe that the function of the public school teacher is to teach children the three "R's", there is no room for the trainable child. One thing we know for sure is that there is very little place in the education and training of the trainable child for reading, writing, and arithmetic, because this is not what he needs. If public schools are considered places which prepare children for life, depending on their level of development, then there is definitely room for the trainable child in the public school situation. Private schools such as parents are establishing all over the country are very good. They are needed for the children and they are very often needed for the parent as well. So it is not a matter of one kind of program or another; it will all depend on the situation.

The level-three child is definitely more functional than level-one or level-two, This is the so-called "educable" child. These children are usually not discovered between the ages of zero and six. Usually they are discovered when they go to school and it is found they cannot learn the usual curriculum. Many communities in the United States provide special classes for these children to give them the best education and training. These children will *one* day occupy the unskilled and semi-skilled jobs in our society, and will become very useful citizens, provided they get all the services they need,

Then we have another group, group four, which we term the slow-learner. He is really the forgotten one in our public school system. The slow-learner is usually the child who doesn't show too much retardation between the ages of zero and six, nor when he first comes to school, but he begins to lag behind when he comes to the second or third grade. Very often the teacher and parents call him a lazy child. Actually the level four child is not so retarded that, with an understanding teacher, he cannot very well be incorporated into the regular classroom activities.

We include level five just to indicate that this is the so-called normal child in our society, whatever that means.

One thing we must remember--our job is to help the child grow chronologically. Unfortunately, what we try to do is develop the child mentally. We take a level-one child and try to make him normal. We teach reading and writing to the level-two child in order to make him normal. But we can never do it--it's a waste of time. We have to help him to grow from childhood into adolescence, into adulthood, into old age. If a forty-year-old man in an institution comes running up to you, puts his arms around you, and says, "I am a good boy", we have not helped him. We have not explained to him at some point that he is not a boy any longer, but a man. Unfortunately, we are a little bit afraid to help them grow up. We are afraid of an adult who is retarded, and cannot cope with him.

I mention all of this for one purpose only: that when we discuss what we propose to do with the retarded child we know whether we are talking about a level-one, level-two, or level-three child and whether we are talking about the first stage of development, the school age, the adolescent, or the adult. When we talk about preparing a retarded child for an unskilled occupation like farming, whom are we preparing to be a farmer? Level two? When they grow up there will be no jobs in farming for them. A farmer's helper today needs a little more ability than we have in the level-two person. If we are talking about training janitors, we cannot be talking about the level-two child because they cannot make quick decisions and will not be able to work without supervision when they grow up. The program of education and training will start as soon as we discover that the child is different from normal and continue throughout his life. When we give the normal child fifteen or twenty years of schooling we can't expect the retarded child to start school at the age of eight and then at fourteen send him out to work. With the tremendous deficit he has, he requires much more training than just six years.

Question: In level three, can we assume that a person who has received training as a janitor can transfer this training so that he can work as a farmer?

Dr. Goldberg: We are training in particular skills, but our labor of today does not consist of manual work only. If we were preparing somebody merely to do manual work for forty hours a week we could train level-two people to do this. The problem is what are we going to do with this individual in his free time? This is when he gets into trouble. The problem then is to help him to take care of himself seven days a week. Teaching manual skills is the least of it.

We are now going to split up into several groups and I would like you to describe and discuss the characteristics of the trainable child. How is he different from the normal? We will then hear reports of these group discussions.

Descriptions of the trainable child reported from the discussion groups:

He is unable to learn to generalize.

Favorable response to routine situations.

The child shows a natural deceleration as he grows older.

The child becomes upset with anything that breaks the routine, so that it is necessary to have a set pattern for him.

Many of these children are able to learn to talk enough to express their wants and feelings though they cannot express abstract things.

Because of the variations in this group, some will not even be able to talk, but even these will be able to express themselves in some way to make themselves understood.

Many will be able to walk, though at a later date than the normal.

Most can be trained to feed themselves.

Most of them can learn to dress themselves but will always need a certain amount of help and supervision.

The child will require constant supervision whether in the home, the institution, or wherever he will be.

He can probably be taught to do simple household tasks.

The child can be trained through repetition in the use of his five senses.

Habit training is possible with the trainable child.

They can be socialized at perhaps a lower level than the normal.

They learn by imitation and by repetition.

They resist re-training after they have learned something. This implies that the original training should be very careful and that they be taught the correct things.

Like all children, they are very curious and therefore we should try to take them on tours as much as possible in order to satisfy their curiosity.

Difficulty in following directions.

Lack of initiative.

They are self-centered.

They are dependent upon others.

Dr. Goldberg: I don't think we have hit upon some of the most striking characteristics. To say that there are individual differences is fine, but we still treat a group of kids as a group. Very seldom do we have time to take into consideration their individual differences. What we are actually after in this discussion are some of the characteristics which are very common to this group of children whom we term "trainable" and which make them different from the level-one, level-three, or normal child. There are certain aspects which were mentioned. There is, of course, inability to learn to generalize, a very important thing to remember. In connection with this, we mentioned the learning of the concrete versus the abstract. Teaching a child that two and two are four will not help, though he may memorize it and be able to repeat it for us. If we want him to learn that two and two are four we have to teach him through concrete examples all the time. Another thing we know is that we cannot teach him one thing and hope that he will be able to generalize it to another thing. If you would just analyze the number of things we have to learn about as simple an activity as going to the toilet and leaving the place clean afterward, you will realize how many different things the child has to learn. With the trainable child, because of his inability to generalize, we have to spell out for him every activity and not leave the training to chance. You know the wooden shoes

we use for practice lacing and to develop dexterity and fine hand movements. If we are using the wooden shoe to teach the trainable child how to tie his laces, we are wasting our time and wasting the child's time. Have you ever tried to tie a necktie around someone else's neck? The transfer of training from tying our own tie to tying our neighbor's tie does not come naturally. If we teach a child to tie a shoe lace in an opposite direction and expect him to be able then to tie his own shoes, we will find that he will not be able to do it. The same way with learning to zip and unzip garments—let him learn to zip up the clothes on himself.

In connection with the question of tolerating stress, I think we should mention the short attention span, which has not been brought out here. We say that trainable children have short attention span, going from one activity to another. We find difficulty in keeping their interest. The question of routine seems to be very important; the more routine, the better we seem to be able to teach the child.

From all of these characteristics brought out by the people working with the children, we find that we are dealing with children, adolescents, and adults who are lacking in their development but who might be trained through very long, patient work. The question then is, "What are we training him for?"

#### SECOND DAY

Dr. Goldberg: Yesterday, you will remember Dr. Smith tried to convey to us that every human being has a personality that is influenced mainly by three factors—biological, psychological, and social. The biological factor is represented in the genes which we have inherited and which we cannot change. Very often some biological disability occurs and sometimes it results in mental retardation. Then the psychological factors—the interpersonal reactions or the psychological climate in which we grow up—also play a very important part. Today we know, for example, that even identical twins are different in personality, though they have the same biological endowment. The very fact that one twin influences the other and provides a different psychological climate for the other twin makes for difference between them. As for the cultural factors, we mentioned yesterday how much we as educators, medical people, social workers, and psychologists bring our own cultural background into our work. The cultural factor also enters in when we ask ourselves for what particular society we are training our child. If we put our child in a more primitive society we would not have to concentrate on such things as good table manners. All of the twentieth century-cultural modes that these children find so difficult and which require such fine coordination would be unnecessary in another society. Within our American society there are also variations in culture. We have to prepare our child for a sheltered society, whether it be an institution, or a sheltered private home or whatever. We actually must manipulate the society and culture for which we are preparing the child.

We then had a panel discussion, the members of which represented various disciplines that are concerned with diagnosis—medicine, psychology, and social work. Each of the representatives outlined for us what they look for and what they contribute to the total diagnostic picture. We then tried to discuss what the characteristics and special needs of the so-called trainable child are. I don't think we really found out. The main purpose of this workshop, of course, is to

find out how we can train the children in our care to become more useful citizens in whatever community they will find themselves. I'm sure that we all know many of the techniques to use--the gadgets and gimmicks--but we must first find out who these children are. We will need to know what the disabilities of these children are that set them apart from the educable group. Let's divide up into groups again as we did yesterday and let's get down to earth and describe these children. Have one person in each group describe a child with whom he is working, in a way that the people who don't know the child will get a good picture of him. The rest of you jot down every characteristic, every kind of description that is mentioned about the child. In this way we will come out with certain negative and positive characteristics.

Group 1: This child is 11 years old, has a mental age of three. He has a very nice appearance, is crippled, doesn't walk but goes around in a wheelchair. He has good table manners, tries to be helpful, and shows leadership in gathering other boys together to play. He uses words very well. He is very hyperactive and has a short attention span. He encourages other boys to be mischievous and likes to see them punished. In school he likes to play with blocks, puts plastic bricks together, and likes to construct things. He likes to color and to **put** simple puzzles together. He doesn't read or write.

Dr. Goldberg: According to the way you describe this boy--the leadership abilities, his helpfulness, his vocabulary--are we being fooled by the mental age of three and is this really an educable boy whom we should challenge much more? Are there any characteristics here that are common to the trainable child? The short attention span and the mental age of three perhaps are, but most of the other things seem to suggest that this is a boy who takes advantage of his physical disability to win sympathy from people and to escape his responsibilities. Most of the things seem to show that he is not in the trainable category, that given concentrated training we could prepare him for very useful work in a sheltered community, which would be needed because of his physical disability. Is this really then a trainable child?

Comment: Because of his physical disability he will always remain an infirmity patient, but he will be able to do chores in the building in which he lives.

Dr. Goldberg: That's a very good point. Although he might have a lot of other abilities, from our society's point of view he will probably always need the continuous partial care in some type of sheltered environment for the rest of his life. Can we prepare him for the life of a physically handicapped person in our society? After all, we do have a good many physically handicapped people who are operating pretty well in society. The paraplegic veteran, for example, drives his own car. Can you see this boy driving a car, even with special attachments? No? Can you visualize him going into a factory in his wheelchair, sitting down and doing some kind of manual work? Could he then go home and look after his own affairs within his disability and without others helping him all the time? No? Maybe then we should consider this to be a trainable child and prepare him for the most useful life within the institutional environment. The question is, "Are we giving him the best of our knowledge of today?" I believe a physical therapist might very well teach a boy like this to walk on crutches. Paralyzed people can learn to walk. In schools for physically handicapped, children with spina bifida are being taught to walk on crutches. It takes time, effort, and a lot of skill. Are we then going to give this boy the maximum?

With the maximum we can expect he will become a pretty useful worker and member of your society in the institution. I think this illustrates how we can be fooled by some things which appear to make this particular boy more educable than trainable, although I think we came to a pretty sound conclusion.

Mr. Madow: I would like to mention that these characteristics of leadership and so on are sometimes shown by these trainable children. In other words, they differentiate themselves in a social structure within their own group, whereas this boy, if he were put into a group of normal children, might show none of these characteristics.

Dr. Goldberg: We are using the yardstick of others who are less capable. I would like to point out that, if we spent time in training this boy, there is nothing to prevent us from assigning him to the kitchen to work someday. We are very much fooled by the inability to walk. It just takes a little imagination. A table could be put over his wheelchair and, if he can use his hands as described, he could make a very valuable and useful salad cutter. We waste a lot of human resources, regarding them as infirm patients and doing all the work for them ourselves. The point is to train the boy within his disabilities to become as much self-sufficient as possible. If you look around the industry of the United States you will be surprised to see who is working. Have you seen a double amputee operating a tremendous machine that has only been slightly adjusted to his disability? Have you seen blind people operating machinery that we would be afraid to touch?

Group 2: We took two cases. The first was a girl, 16 years old. She is quite large for her age and weighs 180 lbs. She is subject to epileptic seizures. She knows how to color in a book, but does not stay within the lines. She will write her first name on everything, although she is not able to write her last name. She often molests other patients. She is able to read a few words on some days, but is inconsistent. She is quite sloppy in her dress. The second case is that of a 26-year-old man who is unable to speak except for "yeah" and "no". He understands directions well, however. He has been trained to rake leaves and haul them away in a wheelbarrow, but will do so only when asked. Otherwise he is quite unkind to other patients and spits in their faces. His toilet habits are tidy but he is not very neat in his appearance. He has to be told before every meal to wash himself. He has learned to rake leaves since the time he came to our cottage about three years ago. We feel that the training period should not be limited to the first twenty-one years or to any other time limit. We also feel that the trainable would be able to learn one thing very well, but if you attempted to teach them more than one thing at a time, they would probably become confused and not be able to do even the one thing. About the male patient, although we found him to be trainable in the one area, we have been unable to do anything about his belligerency toward other patients and his spitting.

Dr. Goldberg: Of course, we very often get the patients too late. One would guess that if, in his childhood, we had persistently conditioned this man to be with others and not to spit in their faces, he would be fine. But he has probably been left alone for twenty years to do as he liked and at the age of 26 we find ourselves confronted with a very bad situation. With today's children we want to avoid such problems and start as early as we can, because if we leave them alone they will not know how to get along. Spitting in someone's face is a learned habit. It is not something that one inherits. If you learn it, you do



it. There are ways of teaching a youngster at an early age that, in this society, one doesn't spit at people. It is a long process, but it can be done. When we wait twenty-six years it's a little bit difficult to do it, because it is by then a well-established habit.

One thing that you said about the 16-year-old girl bothers me. A 16-year-old girl is not supposed to be coloring in coloring books. This is an insult to her and she should have more important things to do. About her being sloppy in dress, let us realize that many institutions only recently introduced flattering dresses for girls. There are still institutions in the country that are using denim uniforms as dresses. If we gave attractive clothing to every girl it would motivate them to look better. In connection with this, there arises the question of lipstick. Instead of having her coloring books, perhaps we should sit down with such a 16-year-old girl in front of a mirror and teach her how to use lipstick properly. Lipstick is here to stay in our society, whether we like it or not. Maybe the motivation for coloring within lines could be used to teach her to put lipstick on and make herself more attractive. This is definitely the role of a teacher or an aide.

The question of inability to talk that was described in connection with the man is one of the common disabilities of the severely retarded. Very often a speech therapist will be of no help, because the speech develops to a certain level and we cannot exceed it.

As far as working habits, a child has to be taught to work. It doesn't come with his mother's milk. Vocational training starts at the ripe age of three months, not at the magic age of twenty-one or twenty-six. It starts as soon as **we know** that the child is disabled in one way or another. His playing with others is preparation for vocational training. His playing with a toy or use of scissors is also preparation for vocational training. I don't know why we don't use hammers in our classrooms. We are afraid to give five-and six-year-old children hammers to use although we leave more murderous weapons around. A pencil is a very dangerous tool, capable of taking out an eye. We give them pencils and we also give them little chairs which they can lift up and use to hit some other child over the head. But when it comes to a hammer, we say no, because we think that they will kill each other. They will not kill each other. If they really wanted to, they have enough tools already to do it. Anyway, there is no magic cut-off age for ending training. We don't have somebody coloring books up to the age of fifteen and then send them to work in the kitchen. The people in the kitchen can't use anybody who only knows how to color books. They want somebody that is reliable and who knows how to follow directions, It is our job to prepare them for kitchen work and other kind of work.

Question: Is a pounding toy in the classroom the first step in learning to use a hammer?

Dr. Goldberg: Yes, that's fine, but personally I don't see any reason why it has to be a toy hammer. Why can't it be a small hammer, a real nail, and a real board, and let the child pound the nails into the board?

Mrs. Lynch: We have noticed that the children prefer the real thing rather than the pounding toy.

As for the 12-year-old mongol, the fact that he has poor speech is not unusual because many mongols do have. Short attention span such as he has is very often a sign of a child's retardation but is sometimes an indication of the type of activities that we are providing for him. About his difficulty in handling small objects, we have to remember that there is a law of human growth that the sequence of development goes from central to peripheral. Therefore, the development of fine, small muscle coordination cannot come before we develop large muscles. The normal child perhaps learns to hold a pencil at three years of age, tie his shoe laces at five or six, eat with fork and knife at a later age, and these things take training. Very often our trainable child will not even reach this stage of development. Therefore, trying to teach him to lace his shoes or to eat with a knife and fork is really a waste of time until he has developed the larger muscles. We forget that, although his chronological age may be advanced, his developmental level is much lower. We should give him a big ball before giving him a tiny one; give him a big toy rather than a small one; give him a tremendous brush to paint a picture as high as this wall before you give him a little piece of paper and pencil. These are the very last things that we give them. Give him the space in which to develop these large muscles until he is seven, eight, or nine years old. Very often we fail to train these large muscles and that is why he cannot do some of the more complicated things. The same is true of speech development. You know how important the jaw muscles are in speaking. How often have we seen six-and-seven-year-old severely retarded children being fed strained baby foods? This is so he won't make a mess when eating, but what does this do for his speech development. The parents will spend a lot of money on a speech therapist to teach the child to talk, instead of giving him a chicken bone to chew on for his muscle development. Speech also has sequences of development, from the first cry to various sounds, to single words, and finally to sentences. Our retarded child goes through the same stages of development as the normal. The only thing is that it takes a longer time and sometimes he will not reach some of the higher stages that the normal child does. When the eleven-year-old retarded child says "Me, me, me", we have to recognize that this is his stage of development and that there is nothing we can do about it. I am not talking about speech difficulties that can be corrected, but the normal development of a very retarded child. From all of this we must realize that our classroom procedures cannot be the same for the severely retarded child as for the normal child. To put him behind a small desk is wrong because his physical development is more advanced; to give him a small piece of paper and a small pencil is wrong. Surely there is a short attention span and inability to learn under those circumstances.

Question: Do you mean that we should not try to correct the child when he uses the wrong kind of expression?

Dr. Goldberg: You might try to correct him, but it may be that he is simply talking at his particular stage of development. Or it may be that he has received no speech stimulation. How many people talk to him? In *one* of the cottages I visited yesterday, people don't have time to talk to the patients, so the ladies just sit there and watch television. Of course, television is a very good tool for speech stimulation for the mentally retarded. What we did before television, I don't know. It should really be regarded as a teaching tool rather than as a time killer.

Group 4: We chose a 15-year-old mongoloid boy, who is only five feet tall and heavy-set. He has an enormous appetite. He does simple tasks, such as carrying out laundry and swishing a mop around, although he isn't too good at it and uses too much water. He likes music, dancing, and church—he likes to hold a hymn book—and seems to have a happy disposition. One of the things we discussed is that the parents very often spoil these children by doing everything for them and we are doing the same thing. We let the patient helpers help a child to dress instead of letting him dress himself.

Dr. Goldberg: Sometimes, from the aide's point of view—and I certainly recognize the tremendously difficult job you have—there is no time to let the kids do something. Look what it takes to dress seventy kids, or to get them ready in the morning for whatever it is they're going to do. We have to do it in a hurry, so, instead of letting the kids do it for themselves, we do it for them. It would be wonderful if we would let the children make their beds in the morning, but what would a large dormitory look like if we did that. It would be fine, of course, if we could relax on this "looking nice", but we would first have to educate the governor, the board of visitors, and others that we are training the children to do these things and that naturally it can't be expected to look perfect.

One of the things you mentioned—about his liking to hold a hymn book—is very important, because one of our aims is to make the child less and less conspicuous in our society. For instance, we advise teachers in public school to go through the morning exercise each day and not fear that they are spending too much time on it. I have seen a class where the children every morning had a ceremony in which they saluted the flag, recited the pledge of allegiance, stood at attention while a recording of the national anthem and the Lord's prayer were played and showed wonderful decorum. Anybody who didn't know that these were retarded children would have been completely fooled. When we discussed afterward what this program was all about, the things that were mentioned were "spiritual values" and "citizenship". Although some may disagree with me, from my point of view these prayers and ceremonies have nothing to do with spiritual values, because one of the disabilities of severely retarded children is the abstraction of spiritual values. Of course, everything that we do and all our teaching should demonstrate spiritual values and good citizenship. But there is a more primary value to such training. When the child goes to a baseball game with his father and the whole crowd stands up for the playing of the anthem, here the conditioning of the child comes to the fore and he also stands up. In this way he is part of the crowd; otherwise everyone would notice him and they would say, "He's mentally retarded, what can you expect?" It's the same way when the family goes to church. We are helping the children to conform to the social arrangements of our life. We ourselves have to live spiritual values and good citizenship all the time if we are going to train these children who imitate us so much.

Rev. Streufert: I am sure that there are some who are apprehensive whether it is of no value to have religious instruction for these children. I am sure Dr. Goldberg did not mean that. For the trainable we simply do not start at that level. We don't wait until the child is six years old before we teach him to fold his hands. Here at the institution it is our privilege to help these children learn to fold their hands at the table, to worship in the same faith they have at home, to attend services regularly, and to receive their denomina-

tional training on Monday evenings. I think this, too, is important for parents, that when a child is seriously ill, the first one who is notified is the Chaplain. One thing I can assure you is that when the child comes to the institution, he does not regress in his spirital life.

Group 5: This is a woman, 32 years old, IQ 46, of average size and appearance, but with very attractive curly hair. She is neat, has nice posture, and normal gait. For many years she was a behavior problem in the cottage. She did nothing, had no assigned tasks, and constantly molested the other children. When she came as an adult she was able to read and write a little. For the last two years she has received intensive training and now is able to dress others when reminded to do so. She works in the dining room, setting tables, washing dishes, and cleaning up. She has learned the entire routine and is able to complete the work. She enjoys all of the social activities, has a nice disposition, and is well-liked by the other children. She has developed good control when she is frustrated and no longer has temper tantrums.

Dr. Goldberg: Somebody obviously has done a good job training this woman. Even though she probably will have to spend the rest of her life in the institution, she will at least be useful.

Group 6: We discussed an 8-year-old deaf boy who is one of the best of his group as far as certain manipulative skills are involved. He puts puzzles together, strings beads, and can become absorbed for periods of time up to fifteen minutes. Otherwise he is quite inattentive, cruel to the other boys, slapping and hitting them and seeming to enjoy the annoyance he creates. He always seeks affection from others, and in other ways pushes himself forward to be first or to get attention.

Dr. Goldberg: I think we have had some pretty good descriptions of the characteristics of the various trainable children. Now we have a special treat for you. We are going to hear what the supervisors of the various work areas in the institution think should be the training of the so-called "trainable child" before they come to work. I will let Mr. Welsandt introduce the panel members.

Mr. Welsandt: I have here three supervisors of various work areas: Mr. Miller of the laundry, Mr. Pepin of the central kitchen, and Mrs. Driessen of Pine Building. We will take the patient care area first. The work there consists of bathing, feeding, toileting, dressing and undressing patients, and cleaning of dormitories, day rooms, and dining room. It also involves sorting clothes, putting the children to bed, getting them up in the morning, making beds, and providing recreation. We will have Mrs. Driessen tell us what she expects of a patient assigned to work in her area.

Mrs. Driessen: We expect that they can carry out the household duties. Of course, we have to teach them to be kind to our little boys, because some of them aren't naturally that way. We also try to make the girls feel that they are doing a big job along with us, that they aren't doing play stuff. We try to make them feel that they are a part of the building team. We like to have them neat and well-groomed.

Dr. Goldberg: Do you have any idea what kind of training teachers could give these girls so that they would be good workers for you?

Mrs. Driessen: We would like them to know how to take care of these little boys--dressing and undressing, housekeeping duties such as cleaning and making beds, setting tables, and feeding.

Dr. Goldberg: How much reading and writing do you require from your helpers?

Mrs. Driessen: Well, they don't need too much of that.

Mr. Welsandt: Now we'll talk about the kitchen, where approximately 100 boys and girls are employed. Boys work in the pan room, deliver food through the tunnels, clean the large steam kettles, coffee urns, and stoves, sweep and mop floors. In the bakery the boys' duties are to grease pans, roll out buns, take the bread from the hot ovens, clean the mixing machines, and also do the general clean-up work. In the butcher shop some of the boys trim meat, slaughter hogs, sharpen knives, and do the general cleaning of the shop. Mr. Pepin, will you kindly tell us what characteristics you want to see in the details assigned to you?

Mr. Pepin: Well, one of the most important things is that they are individually clean, and that they know to wash their hands after they've used the bathroom. We don't want anybody that has a bad temper. We also need boys who are pretty strong because we use large quantities of everything.

Dr. Goldberg: How many of us are teaching boys and girls how to lift things, or even know how to do it ourselves? You know there is a technique to proper lifting. The proper time to start training these techniques is when the child is still playing with blocks. We forget that many of these boys will be working on unskilled jobs as laborers and will have to lift heavy things. The same skills are needed in the patient care area where sometimes heavy patients have to be lifted. This has to be taught; it doesn't come automatically.

Mr. Welsandt: The next area is the laundry. Here the work consists of sorting dirty clothes and clean clothes, placing and removing clothes from washing machines, spin dryers, tumblers, etc. There is also the operation of the mangles, ironers, and presses. Now you tell us, Mr. Miller, what your ideal helper would consist of.

Mr. Miller: I do think that years ago we didn't have to have our patients trained as we do now. Now we have to get along with a much lower type of patient. If we get a patient who really gets along with the other patients, can be told what to do and will listen to you--even if they don't know how they are supposed to do something--if they don't cause any trouble, we just let them coast along and pretty soon they're in there--pitching with the rest of the boys. We have leaders among the patients--those who lead the work while the remainder just follow along. Our main problem is to get a patient who is agreeable and who can be trusted.

Dr. Goldberg: Then you would much prefer one who is agreeable and can follow directions than one who knows how to operate the machines but is nasty and bothersome?

Mr. Miller: We have some girls who have already learned how to operate presses before they came to us and this is a big help, but we can teach most of them these things. If we get a patient in we can fit him into one of the twenty jobs we have.

Mr. Madow: I think it is quite remarkable, the intellectual level of some of the patients working in the laundry, putting in an eight hour day. It shows that very little intelligence is needed to do some of these tasks, and yet they are important.

Mr. Miller: The reason for that is that they are agreeable, stay with us, and get used to it.

Dr. Goldberg: I am sure that there are a lot of things that we can do in the cottages and in the classrooms that we can begin very early and slowly develop into a work assignment. There has been quite a shift in institution populations; most of the higher grade patients are no longer coming to them. Institutions cannot exist without patients working and, on the other hand, it is a good vocational placement even for those who might be trained in the community. Since we are getting lower grade patients, we have to change our training procedures and train them for this kind of work in an institution. They can receive good food, fairly comfortable lodging (especially as we get more modern buildings), a little bit of pocket money—it is as good employment as anyone can imagine for people who have such a deficit in their capacities. The point is we have to train them for the jobs; not in the manual skills, but in the non-manual skills—working with others, following orders, and so on. If the work supervisor has someone who is well-motivated to do the work and who has good work tolerance, I am sure that, understanding that they are working with unskilled workers, quite a bit can be done in the way of vocational placement. One of the most crucial questions in this country today is not the training of the severely retarded, but what to do with them after they complete their schooling. While sheltered workshops provide a certain amount of work possibilities, we should not forget the institution as a placement opportunity.

Question: From my observations, I have discovered that conduct and getting along with people are very important. Is there any way of measuring this?

Dr. Goldberg: Of course, in the developmental scale that we have been talking about we will find the severely retarded to be very low in socialization as well as in other things. You know that there is a natural development in the area of socialization just as there is in motor abilities. For example, the normal two-year-old child is a very selfish person. He is very much enmeshed in himself, is virtually a tyrant in demanding things for himself or in guarding his toys. This may continue until he is three or four, and then comes the stage of development where he starts to play with other children. Then comes the stage where girls don't recognize boys and boys don't recognize girls—at the ages of six to ten. Try to figure out activities for both boys and girls at these ages. And then suddenly something happens and we can't separate them. These are the normal stages of development as far as socialization is concerned. In the mentally retarded there is a retardation in socialization. Therefore, very often our seven-year-old with a developmental age of three or lower may still be in the stage where he thinks that everything belongs to him, and we have to teach him gradually to share with others. The normal child soon learns that if he does not share he will not belong to a group; the retarded child has to be taught this. Because of the low level of socialization, it is better to have the severely retarded in small groups of two or three in the classroom rather than trying to teach the entire group together.

### THIRD DAY

Dr. Goldberg: Let me now tell you about the various facilities there are in the United States for the care and training of the severely retarded. First of all, there are the state training schools--sometimes called hospitals, school and hospital, or some other title. There are 97 residential training schools in this country at the present time. Nevada is the only state that does not have a public facility for the mentally retarded. Arkansas has just appropriated \$5,000,000 and is building a model school. There are about 200,000 patients resident in these 97 public institutions. Then we have private residential schools, of which more and more are being opened every day. Some of these are operated for profit, but more are non-profit. Some are operated by religious groups. Then we have special classes in our public schools, operated under the boards of education. More and more special classes for the mentally retarded are being opened in the United States, for educable as well as trainable children. Then we have private special classes, usually sponsored by parents' groups. We also have both public and private day-schools. These are the main facilities where we will find training being given the mentally retarded.

Question: Are there any other states besides Ohio where special classes for the severely retarded are operated under the department of welfare?

Dr. Goldberg: No, not as far as I know. We are watching the situation in Ohio very carefully because there is a controversy whether classes for the severely retarded should be under the welfare department or the responsibility of the public schools.

Question: Then how many states have public school classes for the severely retarded?

Dr. Goldberg: In one survey superintendents of public instruction in 32 states reported that they did not have such classes, while school superintendents in some of their larger cities reported that they did have. Either it's a case of the left hand not knowing what the right hand is doing or else there is some misunderstanding about the term "trainable". In California they don't use the terms "trainable" and "educable", but rather "point one classes" and "point two classes". In Ohio they talk about "slow-learners" and "mentally deficient" in place of our educable and trainable. In Arizona they talk about "accommodation classes for the trainable" and "training classes for the educable". We really have a problem of terminology.

Now the total number of mentally retarded in the United States is estimated at 3% of the total population, which would be something over 5 million mentally retarded. It is estimated that 2% of the total number of school children are mentally retarded. It is almost impossible to conduct a really accurate survey because whenever you ask how many retarded there are in the classrooms you get fantastic answers. One of the counties in New York tried to conduct a survey, asking that on a particular day the names of all the mentally retarded individuals in the county be referred to them. When they checked back they found a lot of gifted children on the list. Generally speaking, a special effort is being made in the United States today to provide training for those who are more severely retarded. Work with the educable level has been going on for the past fifty years in the public schools, but programs for the trainable are quite recent.

I would like to summarize for you from our discussions of yesterday what the goals and objectives of training the severely retarded should be. One objective is emotional health. This is, of course, an intangible thing that we don't teach as subject matter, but we have to work continuously toward the end that the person might accept himself as he is. In all our contacts with the child we should pay attention to this. We should also aim for him to develop confidence in his abilities and pride in his work. We also want him to develop an ability to accept responsibilities, which must be developed gradually. In this connection, we want him to develop good working habits. This may mean increasing the attention span, but this can be done over a period of time.

Another area is the physical health of the child. We have to help him carry out some of the basic health habits that our society requires. For instance, in our society we don't sneeze without covering our mouth. To a group like this we might give a lecture on the danger of spreading germs; with the trainable child we don't explain why we do it, but simply show him how to do something. Similarly, we teach them to put overcoats on when they go outside and to do other things for themselves where their own bodies are concerned. The development of self-help is a job for both parents or aides and teachers. This is a twenty-four hour a day process and we can't expect the teacher to accomplish it all in the limited time she has available. The child must be shown how to keep himself clean, how to groom himself, and how to take care of his things. This is all part of our curriculum.

Another goal is to help the child to develop imagination and self-expression. In this connection I might mention again the important role played by television which, despite its defects, stimulates the child's imagination. Then there is the whole field of communication, a very important asset to the individual. We reported yesterday that many of these children have speech difficulties. We must remember, however, that speech is not the only form of communication. Listening is a very important part of communication and we have to develop the ability to listen in our children. Although we don't consider it very polite to use hands in speaking, we should not avoid gesturing because very often this is an important supplement to communication that people who have speech difficulties can use.

Another area in which we need to work is that of helping them with their social development, teaching them to play and work with others. We also discussed the importance of motor development, an area in which we are not doing nearly enough. Finally, there is the question of intellectual development, which we should not discard. If a child shows a readiness for learning to read or write his own name, we should not discourage it. We may even try to teach them to read and write, not because this is our objective, but because it may help us to reach all of the other objectives. We don't teach them to write their names so that they will be able to sign checks some day. Let's be realistic--these people will not sign checks or have bank accounts. As long as he is a youngster it may be a means of obtaining recognition from others, although when the individual becomes an adult nobody cares whether he can write his name or not. As far as reading, we sometimes hear it said that reading would be useful if only to read the weather reports in the newspaper. Who reads weather reports? We switch on television and get a complete report, with maps and so on. Or it is said that they can keep up with the world news. First of all, we've got radio and television to tell us the world news. Secondly, we've already said that the trainable child will live in a sheltered environment, and this sheltered environment will let him know what's going on in the world.



This afternoon we will observe some activities and afterward we will discuss how the various goals are achieved through these activities.

(Editor's notes The first part of the afternoon was spent in visiting the auditorium, where the recreation department was conducting party games for severely retarded adults. There followed demonstrations of other activities by Dr. Goldberg and Mrs. Lynch.)

Dr. Goldberg: The activities you have been watching can be done with any type of children, even the hyperactive, as long as we don't think of conforming to the traditional schooling. All the children in a classroom need not be doing the same thing at the same time. This is a matter of classroom arrangement, and surely you cannot do these things if you clutter the room with desks. If you have primitive tables you can arrange them flexibly in any part of the room. Maybe one child will want to do something by himself and not join the group. Perhaps others will not participate at first, but gradually, almost like a miracle, one child after the other will participate. The teacher's role is very important. If she stands off in a corner and tells the children, "Now let's all sit down and be quiet", nothing will happen. Unfortunately, in our work we have to sit there with the kids and do the same things with them. If we play a circle game, the teacher has to be a part of it, and maybe will even be chosen by the kids to run around the circle. It is hard physical work. This is not a job for a supervisor, a person who will tell the kids what to do; we have to do it with them ourselves. Very often the teacher in an institution is accused of working only five or six hours a day instead of the required eight to ten hours, leading to a lot of dissatisfaction on the part of other employees. This five or six hours of teaching, however, is very intensive physical work. It is pretty difficult to explain to others, but if the teachers really work, they are putting in more than forty hours a week. Surely, if they are sitting behind a big desk and the children are crammed into little desks, this is easy work. But if the teacher is really doing her job, she has to be alert to the needs of every child in the room, changing activities constantly and participating with them.

Tomorrow we will spend more time on the deviate child—the hyperactive child—and we will ask some of the medical staff to help us figure out what we should do with them. Should we run after the child all the time and sacrifice nine other children, or should we exclude him from the classroom activities? Then, when we exclude him from the classroom, what is he going to do? This is a very-difficult problem. I am sure you were all thinking, during the activities, of Johnny, who might get up in the middle of everything and decide that this is a good time to tear up every curtain in the room. Then you get up, leaving the other children, and go after Johnny. Johnny decides to have a race with the teacher outside the building, the teacher runs after him, the rest of the children decide that they should have temper tantrums, and in the meantime the school principal or some guest decides that this is the time to visit your beautiful classroom. What do they see? The teacher running around, the children in a turmoil and, the more the teacher tries to cover everything up, the worse it gets. We have to relax, because this is our work.

Mrs. Lynch: We have practically a world of our own up here and lack almost none of the facilities of a big city. We have a laundry, a kitchen, a dairy, a pig-gery and many other facilities that we can use to take them out of the classrooms.

Many of our children have come from limited environments, such as boarding homes, and have not had many of the experiences that we accept as normal. Sometimes I wonder if we are making full use of the facilities that we do have.

Dr. Goldberg: Of course, the institution does provide wonderful facilities for this purpose, but the public or private school class does not exist entirely in a vacuum. There is no excuse for confining children to the four walls. They should get out once a day even if there is no playground immediately available. This business of having the kids walking hand in hand to teach them to follow directions is also very important. Unfortunately, we are victims of the tradition that school consists of four walls, a lot of pictures—usually painted by the teacher—a lot of furniture in the middle of the room and a lot of junk somewhere else. Then we complain about the short attention span, although it may be our fault for keeping the children confined for so long. My appeal is to break with the traditional type of schooling, which is not good for our kids. Show them the cow, the horse, the fire department, and the other things around us. It takes a little bit of ingenuity on the part of the teacher, but she will find that people in the community are very sympathetic to supply what she needs. Look around your community and see what it has to offer. If we really believe in what we are doing, there will be plenty of people to help us. After all, we are reclaiming human beings, and this is very valuable work.

Mrs. Lynch: I would like to point out that all of the activities that we have seen this afternoon can be carried over into the cottage areas.

Dr. Goldberg: How much carry-over is there from school and recreation to the cottages? Apparently it varies with the type of patient and with the different cottages. Of course, the time when it would be nice to carry over activities is the after-supper period, before the children go to bed. Unfortunately, the second shift of aides is probably so tired by this time that they haven't got the energy to jump around, but with normal people this is a kind of family time and a time when a lot of activities could take place in the cottages. The questions are how to do it, who's going to do it, when is it going to be done, and how to arrange for active activities and yet get the children off to bed properly. It is a difficult problem and both sides—teachers or recreation workers and aides—have to be very understanding. In institutions the worst time for recreational people to come into the cottages is between nine and ten o'clock in the morning. Who wants them there then? This is the time when the cottage has to be straightened up and cleaned. It has never occurred to many of us that we could spread the recreational work over fifteen hours a day as you do in Faribault. Incidentally, how do the aides feel about volunteers coming to help conduct activities?

Comment: Well, I feel that our recreation workers can do far more than people coming from outside, because they are not used to the patients and perhaps might be afraid of them.

Dr. Goldberg: In other words, instead of helping you, you would have to be with them all of the time in order to reassure them.

Dr. Engberg: I think I should explain that we feel that there would be a real place for volunteers here but that, unless we had a full-time person to supervise the program, it would not be successful. We have had volunteers coming to assist with the religious program for a number of years and it has been very successful. We are hoping that we can establish a position of volunteer coordinator.

Dr. Goldberg: I want to mention that the same situation occurs in private or public school classes. The teacher very often needs a helper to take children to the bathroom or help look after them. Sometimes mothers volunteer, and then teachers have the same problem that we have mentioned here. There is a lack of understanding. The teacher spends time not only with the ten children but also with the eleventh person--the volunteer. Therefore the volunteers have to be very well trained.

Mr. Madow: It seems to me the fact that a person has to be trained to do a job is no objection to having them there if they are going to be productive ultimately. The new person is always next-to-useless, but you have to devote the time to him so that he can become well-trained.

Dr. Engberg: I think that that is true, but still there must be someone to do the recruiting, screening, and general orientation before you dare to have the person start in to actually do any of the work.

Dr. Goldberg: This volunteer business is very interesting, because in working with retarded children it often becomes necessary for us to try to recruit volunteers. I agree that when we put some work into the volunteer program we get results, but the question is, how do we find the time to do this? You know colleges very often have classes in abnormal psychology, whom we should acquaint with the kind of work that we do in the institutions. Instead, the colleges call and say they have thirty students who would like to come the next day. "Will you show us three hydrocephalics with very big heads and two microcephalics with very small heads? Then we would like to see three mongoloids and, if you have someone who is very disturbed, we would like to see him too." Then the whole group comes, looks, exclaims over these people, and then leaves. We had that kind of an arrangement with the University, but one day we revolted. We said, "If you want to come, fine, but we will conduct the program." We got together a group of young men and women who were 20 to 25 years old, dressed them up to kill, brought them into our picnic area, and we mixed up a whole bunch of students with our patients and told them to go ahead and have a picnic together. I felt that it gave the students much better awareness of human relationships, less morbidity, and a much better understanding of abnormal psychology. Do you have any other thoughts about the activities that we viewed this afternoon?

Question: Is it as important for the trainable group to have both sexes taking part in activities together as it is in the group that might go out of the institution? Are we slipping up if we have groups and are not mixing the sexes?

Dr. Goldberg: Let me put it this way. In a state not very far from you, up to three years ago, the patient dances were held separately for boys and girls. This is a very abnormal situation.

Comment: I would think that for those who are expected to go out into the world they certainly should be mixed. But I wonder about the trainable level.

Comment: In this group it doesn't seem to make much difference--they seem to be quite happy one way or the other. With the brighter ones, however, I have seen the girls carry on after they have come to activities over here. I suppose it's quite normal, only they just can't seem to control themselves.

Dr. Goldberg: In other words, you had many more problems after they returned to the ward from activities. Let's have more discussion about this because there are two schools of thought, whether to train in a segregated situation or not.

Mr. Roach: It seems to me that not enough contact with the opposite sex is just as bad as too much. The situation is somewhat similar to something I've overheard, that in a ward for lower intelligence patients they remain disturbed following a period of active play. Does this mean that they are getting too much activity or does it mean that they are not getting enough activity?

Dr. Goldberg: How do we know that the girls are getting excited because of the mixing of the sexes rather than because of the excitement of the activities themselves?

Comment: We've said that we are trying to help them grow on their own level, and this helps them in their social growth.

Dr. Goldberg: In other words, one of the stages of social growth is the mixed activities. I will shake you a little bit. In Southbury Training School in Connecticut, boys and girls are living in the same cottage, with only the bedroom facilities separate. These are younger, middle-grade youngsters growing up together. Of course, this is possible only in a cottage which has a small number of patients and a large staff, but very little difficulty has been reported from this experiment.

Comment: One thing that concerns me is that for many of our patients the only sociability between the sexes is on the dance floor. When we put them out in the community we expect them then to take care of themselves and their social needs.

Dr. Goldberg: This is one of the abnormalities of the institutional situation. At least a boy who goes out to his community from Faribault and attends a community dance will not approach another boy to dance with him. I believe there will be more and more opportunities for socialization. Of course we do establish a wall between them because very few if any will marry and establish a family of their own.

Dr. Engberg: We have made some strides towards socialization in other activities, as in a few parties held in some of the buildings. As far as I know, we have had no difficulties arising from these,

Dr. Goldberg: Let me tell you what happened at our institution. We had a tremendous auditorium and when we had dances, the boys sat on one side and the girls on the other. Aides were present, of course, and the custom was that they sat at the doors. If a boy or girl had to go out to the bathroom, an aide would immediately get up and follow them out. We didn't like this prison-like situation. One evening some of us bright young newcomers got an idea: "Why don't we mix the boys and girls while they are sitting together after each dance?" The system had been in effect for about fifteen years, but we thought we would shake the old-timers and show them what we could do. What a mistake we made. We forgot that there was a psychological line developed for fifteen years in the patients against crossing the floor. Suddenly one wise guy got up and said, "Do you want to sit together? All right then, go ahead." Some of the boys thought they would be heroes and went up to the line. Then they turned and

went back to their side. They didn't sit down together that evening. Of course, everyone was duly shaken. Then we started to do it slowly and I think it worked when we discovered that you can't change things overnight. When we started to explain our idea and pointed out that nothing really harmful could occur, we made progress. Then came the problem, "Is it fair to do this? Is it fair to allow them this close contact and then separate them?" The question also came up about the patients being disturbed after this kind of dance. But the worst thing we did was to go back to the system of sitting separately; we almost had a riot on our hands when we did that.

Mr. Madow: We, too, have discussed this question of self-control—whether you are doing a service to the patient by placing him in situations which tax his control, knowing full well that these patients are defective in control as they are in many other areas. The situation here is that the main occasion for the sexes to come together is the dances. But dancing is not the most usual social situation in our society where the sexes are intermingled. Conversing, exchanging pleasantries, perhaps playing games together is a lot more common in our society and these activities are a lot less taxing of the self-control of these patients than is dancing. None of these are structured about the sex function as dancing is in our society. I don't feel that dancing should be done away with, but that we perhaps over-emphasize the contact between the sexes at dances and under-emphasize contact at many other kinds of functions. We have to progress toward the social evening type of get-together, where we talk about things that we have in common, perhaps have some party games, and enjoy refreshments.

Dr. Goldberg: I think that is an excellent point and could be done if we had the kind of buildings and facilities for this type of activity. In the type of cottages that they have at Southbury they can do this, with boys and girls dressing up and visiting each other's buildings. The question then arises, how much do you want to produce ladies and gentlemen? It reminds me of Pygmalion, the lady who could not find her place in society. We had a female teacher at our institution who worked with delinquent boys, most of whom towered over her. She made a bunch of gentlemen out of them. It was frightening to see how polite they were. She had lessons in shaving, washing clothes, darning socks—all accompanied by training in good manners. The question was: to what society would these boys return? A boy going back to his community would be regarded as so peculiar that people would think that, besides mental deficiency, he had contracted mental illness at the institution. This is one of the big issues about the high grade cottages at Southbury Training School, where it is important to know what society the patients are supposed to go back to.

Mr. Roach: For several years now we have had mixed parties in some of the buildings and have had no difficulty with any patients.

Mrs. Lynch: We've had mixed classrooms regularly.

Dr. Goldberg: From my point of view, for many purposes we should not separate the sexes, even those who will not go out of the institution. The problem is, of course, quite complicated when you have large numbers of people thrown together in close contact, with some of them expected to go back into their communities to lead normal lives while others are expected to remain here. We have to learn to distinguish the normal from the abnormal—what comes from mental retardation and what stems from the normal process of growing up.

#### FOURTH DAY

Dr. Goldberg: Today we will go into the problem of those who deviate from the so-called normal retarded child—with the hyperactive, the delinquent, and the emotionally disturbed child. We know that some of these behavior disturbances can very well come from the biological insult that some of the patients have suffered. But the distinction between a spoiled brat and a brain-injured child is sometimes very difficult to make. In order to be sure that we are not missing any of your problems, we will break you again into small groups, where you will not try to solve these problems but merely to tell what these problems are. Then we will have a panel discuss the various problems that you bring up.

(Editor's Note: Nine discussion groups were formed and reported the following to be problems:

Physical self-abuse	Assaultiveness	Complaining of imaginary illness
Hearing voices	Bullying	Refusing to cooperate
Having crushes	Hoarding	Attacking or abusing employees
Eating garbage	Masturbation	Never sorry for aggression
Suicidal tendencies	Homosexuality	Withdrawn, unpredictable behavior
Biting others	Selfishness	Refusing to eat or learn manners
Refusing to work	Delinquency	Feeling unappreciated
Obsession with sex	Destructiveness	Over-affectionateness
Keeping clothed	Perfectionism	Discouragement and self-pity
Religious fanaticism	Over-ambitiousness	

The panel then assembled to discuss the behavior problems consisted of Dr. Smith, Mrs. Lynch, Miss Peterson, Mr. Rosenberger, Mr. Hoban, and Mr. Madow.)

Dr. Smith: Almost all these complaints would be classified under what we call the primary behavior disorders. These disorders are not accompanied by extreme change in the emotions, but are usually reactions to lack of fulfillment of the individuals needs. The behavior disorders may go in two directions. They may be regressive, that is, going back to an earlier period of his life, and these constitute most of our habit disorders. Such things as enuresis and thumb-sucking would fall in this category, in addition to some of those already mentioned, such as hyperactivity, self-abuse, selfishness, and withdrawal. In the conduct disorders, the reasons are the same, but instead of the child taking it out on himself, he takes it out on the environment. The conduct disorders are aggressions. Here we would place assaultiveness, bullying, sex offenses, and the various attention-seeking mechanisms. None of these symptoms in themselves mean a thing; we have to have a constellation of symptoms in order to make a diagnosis. For instance, a boy rejected by his mother may react by enuresis, if he's that type of personality, or by delinquency, if he's that other type of personality. The symptom itself is not the diagnosis. We also see some of these symptoms in neurotics or in psychotics.

Dr. Goldberg: In other words, the child or the adult tries to show us something through his behavior.

Dr. Smith: That's right. Some other symptoms mentioned this morning are indications of psychopathy, where the person does not feel guilty about what he does and there is no anxiety. In the neurotic we have symptom formation due to anxiety. The anxiety may be displaced into a hysterical form where we may have

inability to speak, paralysis, blindness, or deafness. Or the anxiety may be transferred into compulsive activity or phobias. In psychosis we have irrational behavior in which the person does not realize that he is being irrational. In this category we would put hallucinations, delusions, suicidal ideas, and inappropriate emotion. Then we should mention, as another category, epilepsy, with various stages of loss of consciousness.

Dr. Goldberg: Would you say that running away could come under any of these headings as a symptom?

Dr. Smith: Any of these people could run away. Any of these people could have any of these symptoms. It's when you get a symptom complex, together with personality studies, that you can finally make a diagnosis.

Dr. Goldberg: I think Dr. Smith did a wonderful job of putting the symptoms you mentioned under certain headings. We've been talking about diagnosis, but we haven't yet begun to talk about treatment. Now panel, where do we go from here?

Mr. Madow: I'd like to add something to help focus attention on what we can look for. If we look at any particular kind of behavior we can think of it as the product of three different forces coming together to produce this behavior. One is motivation—what impels, pushes, or drives a person to act in a certain way. We all are born with certain very primitive motivations and, as we grow, certain other social motivations are produced in us. The person must also have the capacity or the ability to behave in a way that will satisfy his motives. For example, a spastic may want to express affection towards someone, but perhaps because of his motor incoordination, the only channel by which he can express this is by some overwhelming motion, since he lacks the finer coordination to produce a gentle hug. We might say that he was over-affectionate or aggressive, and we might place it under the category of a conduct disorder, but we realize that it is due to lack of capacity to produce a more socially acceptable affectionate response. The third variable I would like to introduce is the matter of control. Here we might include both self-control and control on the part of the environment. Given a particular motivation that requires expression, and the ability or knowledge to express this in a number of different ways, it will depend on the controls established within the individual or imposed by society which particular behavior finally emerges. In most of the habit disorders you can see very primitive kinds of motivation operating. Thumbsucking, for example, is closely related to the infant's sucking reflexes and the need for food. In masturbation we can see the expression of a very primitive sex need. Rocking expresses a primitive motor need. In many of the things that we label as behavior disorders, the individual either lacks the capacity to express his motivations in socially acceptable ways or lacks the control. In the conduct disorders we see that a lot of the problems deal with lack of control. They are primarily expressions of aggression, but the individual lacks the control to express his aggression in acceptable ways. Looking at these various behavior problems, I think you can frequently find that problems or disturbances of motivation, lack of capacity, or lack of control are the distinguishing features of the disorders.

Dr. Goldberg: Thank you. Will you, Mr. Rosenberger, tell us what you told me earlier?

Dr. Smith: I want to say something about the mechanics of tranquilizers. As you know, the sedatives, like the barbiturates, act on the cortex of the brain and the thinking processes, and in that way reduce anxiety; whereas the tranquilizers act on the lower centers of the brain and have a direct effect on anxiety. If they are not given in too high dosages, they do not affect thinking. It may produce a depression, however. Since it reduces anxiety without getting at the reasons for the anxiety it must be considered simply a measure for control

Dr. Goldberg: Thank you. Will you kindly tell us something about the team approach to the problems we have been talking about as part of their solution?

Dr. Bruhl: You have already heard about the team approach to diagnosis of mental deficiency and of behavior problems. A doctor, psychologist, educator, nurse, and aide come together to discuss how the patient behaves. We all pool our information about the patient in order to come to a clear concept. We have also formed a team of similar people in order to get clear what to do with the disturbed patient. We don't all have the same opportunities to observe each patient all the time, but by pooling our knowledge and our ideas we come out with some suggestions as to how to treat the problem.

Dr. Goldberg: This team approach is very important, I don't believe there is any discipline that can solve all problems, but by putting together our specialized skills, we can help the patient better. Mr. Rosenberger, could you make a few remarks about education and training?

Mr. Rosenberger: In the first place, I believe that any training program has got to be constant, and the objectives have to be understood by all. I also think that a training program should be expanding, starting on a limited basis with a single or a few opportunities for achievement and then expanded to include what we expect the individual to have. We must know whether we are expecting them to make an institutional adjustment, a work adjustment, a personality and behavior adjustment, or just what. There are two or three ways to develop a program like that\* A mental hygiene approach is essential. We feel that it is so essential that we make it compulsory for people to attend and learn what other people think about community adjustment. What are the principles that a community insists upon and that we must adjust to? In our "life adjustment" program we discuss such things as how to get along with other people, how to get and hold a job, how to live in a house and in a community, how to live with the police force, how to live with the social worker. These are things that our people need to understand. I don't think we can play guessing games with the mentally retarded person about what is expected of him. We should direct the program and tell them what to do. The only catch in such a program is that someone has to set himself up as an authority and decide what the requirements are, and that's the most difficult part of the program.

Dr. Goldberg: Of course, I don't think our trainable mentally retarded are capable of delinquency, and this is perhaps something that distinguishes them from the educable mentally retarded. They may have any of these problems that we've mentioned, but they probably do not have the initiative and understanding to be delinquent. Now, what can we—as teachers, aides, work supervisors—do as a practical approach to some of these problems that we face? When we have the immediate problem of an aggressive boy, what can we do?



Comment: Sometimes if I see a boy is getting restless or annoyed with something, it helps him to put him in a far corner of the room where he can be by himself and try to interest him in something. I think this is much better than locking him up in a room,

Dr. Goldberg: This is, by the way, the technique used with the so-called brain-injured, hyperactive child. Very often, removal of the child from all stimuli is extremely helpful.

Dr. Bruhl: I'd like to report on one of our buildings for very hyperactive, adolescent girls with a great many behavior problems. The building would not be recognized now as the wild menagerie of running, screaming, scratching girls it was two years ago. Besides the tranquilizing drugs helping, the charge aide has succeeded in organizing the patients into small groups which are occupied in activities by some of the more intelligent detail girls assigned to the building. One group may be playing ball; another might be scribbling or coloring on paper; a third group might sit and listen to a phonograph; and a fourth might be watching television. The patients are so fascinated with what they are doing that they forget their scratching, biting, or nausea. I would recommend this program to other groups where they have behavior problems.

Dr. Goldberg: Mrs. Lynch, are there any approaches that teachers use while the child is in school?

Mrs. Lynch: We have some children who have to work for a long time by themselves before they can join in the group activities. We have to find things that they are interested in, want to do, and can do, and get them gradually to work into the group situation. Many of our children are at an age when they can only engage in parallel play. We don't make every child participate in every activity that we have during the day.

Dr. Goldberg: Do you find a correlation between increased behavior problems and lack of interest in the activities?

Mrs. Lynch: Definitely. If the child is bored he might have an aggressive reaction or become quarrelsome. Many times I can trace the children's indifference or boredom directly to the activities I am presenting.

Dr. Goldberg: Now in closing our discussion here, it would surely be wonderful if you could sit down, give us your problems, and take down the appropriate recipes in your notebooks. We can't solve the problems of human behavior so simply, because the causes of behavior are so varied. Even after we find the cause it will not help us many times. One thing which is very important to remember is that this behavior is no reflection on our work. Unfortunately, we take the attitude that if a child runs away, or misbehaves, it is our fault. We can only do what we think is best, sharing the problems with the team and having as good a relationship with the patient as we can. We may not even be the right persons with whom the child will relate. The psychologist or psychiatrist who is doing play therapy may find that he cannot click with a child and, if he is honest, he will admit it and refer the child to somebody else. He will discontinue therapy because these two individuals simply don't see eye to eye. But teachers, aides, and other professions always seem to feel so guilty if they can't teach the child something. It is quite possible that we are not the right person to do

it for this particular child. It is our duty, however, to keep notes on the child and to inform the team what happens. The situation is the same in all of the institutions in the country. We are working under the most difficult conditions and were unprepared for the influx of patients that came when parents of the mentally retarded decided to share their problems with the rest of the people. You work by yourselves and think that the whole world knows the answers to these problems but you. There is a little bit of knowledge here and a little bit more there, but nobody really knows. There is a shortage of aides, nurses, teachers, doctors, psychiatrists, psychologists--and it takes a long time to train these people. It takes a long time for a new aide to get used to the situation and to understand these patients with difficulties. If you recall your first day in the institution you know that you grew a lot, the patients are growing, the problems are being solved here and there. Let's relax on this thing.

#### FIFTH DAY

Dr. Goldberg: Our goal in training the mentally retarded is to help them to become as useful citizens as possible in whatever society they will be. We believe that any human being can be useful, even though it may be only in a very small area. With the child who may have to spend his entire life in bed, if we can only train him to turn from side to side, he will be more useful than otherwise. Wherever the mentally retarded are, whether it be at home, in special classes, in institutions, or any other place, they are getting training. All of us are trainers and we can be training in positive directions or negative directions. Training is a continuous process. We can't dump a child someplace and say, "Here you take him and train him." We would have to say, "Re-train him", and re-training takes a lot more time than training. Now, nobody knows exactly how many mentally retarded there are in the United States, but one thing is certain--the problem of mental retardation will involve at least four times as many people as the number of retarded. It is a problem to the mother, the father, the brothers and sisters, the neighbor next door, the grandparents, and others. So the problem of mental retardation is tremendous. I am sure that no one in this room was prepared to have a mentally retarded child. I am sure that, when you took home-making or home economics courses, no one told you that you might have a handicapped child, that you might have to do things in one way rather than in another. We believe that it will not happen to us and therefore we are completely unprepared when it does happen. I say "we" because we teachers, we aides, we psychologists also took training without knowing that some day we would be working with those who deviate from the normal. All of us, if we want to work together--and we have to work together--have to understand this. We have to join forces in order to find out what is the best thing to do. All over the country the situation is the same. We are trying our best to do something with the child whom we have today and, if this is any consolation, we are preparing a much better life for these children for the future.

Now, we know that we are training the child for something, but there is often a mis-understanding in our minds about what we are training him for. Let us divide ourselves into groups and discuss two things which we will report back here. First, what problems do you have with the retarded children, and second, as parents, what kind of training do you expect your child to receive?

(Editor's Note: The following problems or points for discussion were reported out of the nine discussion groups which then met.)

How to handle behavior that is destructive or that is harmful to the child or others?

How to correct something that would be called misbehavior in a normal child?

When the child is in a residential school or institution, how is the problem handled when one child hurts another child?

As far as our expectations are concerned, our child is in the trainable group and we don't hope for any miracles. We understand that he will never learn to read and may not speak more than a few words. But we hope that he can be in a sheltered situation and will be happy just as our other child. We hope that he will always be able to do things that will keep him satisfied and happy. Right now play time is his happy time, but we hope that, as he grows, he will be given opportunities to do whatever he is capable of doing. I hope that he will receive good medical care and that he will be treated with kindness.

I think every parent hopes that his or her child will be loved by someone, because we aren't there to give that love and we know that they need it.

We realize that they become attached to their aides, and this is the way it should be, and we hope that you will love them.

After a parent has been notified that a new-born child is mentally retarded, should he keep the child at home or institutionalize him? If he is kept at home, for how long should it be?

What effect does the mentally retarded child have on other children in the home?

How can we condition the other children and the neighbors to accept the mentally retarded child?

What about the future plans for the child; for example, what will happen to the mentally retarded child when the other children leave home?

How can aides get parents to understand the limits of a mentally retarded child who is in the institution?

What can be done to establish a day school for children whose IQ's are under 50?

What can be done to help the normal children accept the retarded child?

We thought that the children should first be taught to feed themselves, then to dress themselves, then to get along with others.

We would like to have companionship for them.

We would like to have them learn simple tasks as helpers.

How can you prepare the other children in the family when you've made the decision to send the retarded person to an institution?

Why aren't there more facilities to keep some of the children in the institution busier?

Are parents too hasty in sending a trainable child to an institution when there might be special classes in the community?

How do you know how retarded a child is when he is only one or two years old?

How can you start planning for him, and how much training should you give him?

What kind of toys can you give to a young retarded child?

Should the problem of a retarded adult be passed on to brothers and sisters, or relatives, after the parents have passed away?

How can we get parents to understand the difficulties the institution may have and the institution to understand the problems of parents?

How can we be sure that a child who is well-trained and occupied in the home will be kept occupied and not permitted to lose her skills when she goes to the institution?

Does the age of institutionalization affect the person's adjustment there?

As far as the training desired, we would like to see the personal skills developed first, and then the child taught social skills that will be necessary and accepted in its environment.

Can the normal child in the home develop normal social relationships when there is some feeling of shame about the retarded child?

How can we get the retarded child to accept the fact that the normal brothers and sisters can do some things that he can't do?

Should a six-year-old child be kept in the same ward with children of sixteen to twenty, and what are the factors involved?

What should parents do with an educable child of twelve years who will be leaving the sixth grade? Should he be allowed to go into junior high school or should he be kept back?

How can you tell a child of twelve, who reads at a second grade level and understands that he isn't like the other children, the reason why he isn't like them?

Dr. Goldberg: This is a wonderful set of questions and we could really get into quite a discussion about them. These are the real problems that are in parents' minds, but we don't often get down to earth and deal with them. Some of these questions can be answered very quickly, and there are some which indicate that you parents can be very unrealistic. I will try to answer most of them myself.

The first thing we might take up is the question of destructiveness, doing harm to others, and all of the behavior problems mentioned. Mental retardation does not exclude all of these negative behaviors. Yesterday Dr. Smith told us how all of these things are symptoms of underlying causes in the child. The child is trying to show us something that is bothering him, and it may be everybody's fault or nobody's fault that he has to express these things. Many times it is a need for attention. Those who are quiet we don't have much time for and we say they are the good ones. Pretty soon the kids learn that if they are *noisy* they will get the attention. Not all parents are like you are; there are plenty that really do dump their children in an institution. There are many who never visit, never write, never send presents. What are we going to tell a child when he asks, "Why doesn't my mother write?" What can we do in a situation like that? Pretty soon the child runs off to try to find his parents; this is the most common reason for running away. Should we punish the child who runs away, who wants to go home? It's the parents who should be punished, but we can't do anything to them. And if you don't punish him you encourage other patients to run away. These behaviors are not inherited; they are learned. We learn that if we behave in a certain way we will get what we want. And the mentally retarded can very well manipulate their behavior to get attention or whatever else they want. Within the great limitations of our knowledge we are doing everything we can to deal with these problems.

Now the question of punishment for misbehavior. Of course, many times we call it misbehavior when it's only something that annoys us and we should be trying to figure out why it annoys us. Misbehavior depends on who identified it as such and what it is. To give you a prescription whether to punish misbehavior or not, we have to know what it is. Many brain-damaged kids are banging their heads against the wall, not from pleasure, but because they feel some pressure or irritation. If we are going to punish the child for banging his head because

it annoys us, when it may actually be giving him some relief, it is exactly like punishing a blind child because he cannot see or a deaf child because he cannot hear. We have to be very careful with our handicapped children not to punish them for their handicaps. If it is truly misbehavior, then we might tell him in a firm voice not to do it, and the parents should treat him alike. How often do we hear the mother say, "Stop it", and the father say, "Oh, leave him alone". A child brought up in this kind of situation is confused about what is good behavior and what is misbehavior. If we decide to be firm, then both parents must be firm. As far as other punishments are concerned, use your own judgement, but don't take out your frustrations on the child, particularly because he doesn't understand many things. Be strict with the child, but love him.

Now, very often we can help the child who is very hyperactive by isolating him from other people and from noise and confusion. This is not done as punishment, but as treatment, for many of these brain-injured, hyperactive children are confused by too much stimulation. Very often this isolation works. With a handicapped child one has to be a little bit careful—he must be able to understand why he is being punished. But a spanking from time to time to show the child that the mother means business will not disturb him particularly. Of course, we can't do this in institutions because people will say that this is corporal punishment. The aides are so handicapped sometimes that they really do not know what to do, especially when they have 120 or more children to look after.

The question of how long to keep a child at home and whether to institutionalize him is a very individual matter and nobody has the right to tell anyone what to do with the child. One thing I would like to say is that there are many people who are working long and hard to make the institutions for the mentally retarded in the United States places to which we would not be afraid to send our child. There are very few institutions which still look like a snake-pit. Why do we have to commit our children to the institution? The deaf child is not committed to the institution for the deaf; the blind child is not committed to the school for the blind. Why do we have to send the retarded child to the institution and forget about him? We should send him to the institution for training, work with the institution, and then see what we can do with him. The time will come when we will have smaller institutions, when we will be able to send a child for a year and then bring him home again. We will not have to separate from the child forever. On the other hand, many of us become so enmeshed in the care of our mentally retarded child that we ignore the other members of the family. It is not a question of the effect of the child on the siblings; it's the effect of the time taken by the mother to supervise the retarded child. So no one can tell you whether you should put your child in an institution or not.

The question of the effect of the retarded child on other children in the family depends a great deal on the particular family. I've seen families of six children where there was no effect, and I met parents who had not been out of the house for twenty-seven years because they had to care for a retarded child. Or another child is very hyperactive and pulls everything away from his older brother or sister. The question is, how long can we stand things like this? The effects can be negative or positive, depending upon the family situation.

I'm sure that we will not convince neighbors in our lifetime to be nice to the retarded child and to let their children play with him. I was told that in one institution a principal who was highly trained in special education of the mentally retarded had to leave after two months because his wife could not stand the place--believed that if she drank the water, she would catch mental retardation. If this could happen with an educator's wife, you can see that it will take a long time before the neighbors learn anything. We will have to educate our cousins and our mother-in-law and so on before we go to the neighbors and expect them to understand our problem. There are so many myths and misconceptions still existing about mental retardation. It will come in time, but please remember not to try to push this down anybody's throat. The worst thing we could say to our neighbors is, "This could happen to you." This is not the way to educate them.

"How can we explain to the parents the limitation of their children<sup>8</sup> is a question that the professional people ask. My answer is, "We cannot explain it." Let me tell you of one of my own experiences. I lost my arm during the war and was sent to a hospital in the Union of South Africa. We had a very good occupational therapist there who insisted that I develop my left hand, for which I bless her. But she made one mistake. She used to come to the ward where the amputees were and demonstrate things that she could do with one hand, holding the other hand behind her back. We would try to do the things she showed us, such as tying a tie, with the one hand, and we couldn't do it. It used to make me furious. I knew there was something wrong about the way she was teaching us, but I couldn't figure out what. Later on, when I started to study psychology, I learned what it was. It's the whole person who is doing the task, whether he has his arm in back of him or not. We don't teach a one-armed person by putting the other arm behind our back. We can't explain to parents the limitations of their retarded children because we are not parents of retarded children ourselves. We can only do it with "an arm behind our back." We can only work with parents slowly and carefully until they themselves understand the limitations.

How we can explain it to the normal children so that they will accept the retarded child, I do not know. We tried everything under the sun and we came to the conclusion that it's not the child, but the parents. We are not born with prejudices, we learn them. We don't explain that all people are brothers; we act it ourselves. We know that not everybody is the same, that one child is tall and another short, one heavy and one light, one clever and the other not so clever. When we take this attitude, there is no problem of special explanations. We act in a way that the child is part of the family unit. Then one day the child has to go for specialized training in a residential school, and we bring the other children to visit their brother in this school.

Now the question comes up why there are not more facilities in the institutions to keep patients busy. This is where I really feel like giving you a piece of my mind! First of all, where you have one child at home, there are 120. Then there's another thing. When we young administrators came in, we were standing on our heads to have, at seven o'clock in the morning, hiking; 7:25, Swedish gymnastics; at 7:30, breakfast; at 7:45 something else. Who wants to live like this? Do we want to have our lives regulated? Haven't we got the right to sit down and not do anything from time to time? Do we know whether they are busy or not? Sitting down and talking to somebody is also being busy. Why do their

hands have to be occupied? We have the old-fashioned idea that if the hands are not occupied, the person will get into trouble, It's true that there could be an increase in quite a lot of things if we had increased personnel, but that isn't easy either. The institutions today are completely different from the custodial places they were years ago, where patients were placed in order to keep them away from the community and where the more closed the institution was, the more satisfied the community. There was no radio, no television, no activities, no curtains on the wards. Today people are being kept busy, and you don't see many institutions that have curtains hanging in the wards as you see here in Faribault. It's a hard job that the employees have and parents have to understand this.

The question of how you know whether a two-year-old child is retarded is a difficult problem, but we have better diagnostic tools and facilities today than we used to have. Of course, if a pediatrician says that a two-year-old is retarded, there are probably many manifestations of the retardation and he probably knows what he is doing. But please don't play around with IQ--leave IQ to the psychologists. It really doesn't mean what we think it means. Let's leave IQ to the psychologists, let's leave the appendix to the physicians, let's leave the teaching of our children to the teachers, and let's use this team approach to things. As parents, let's not try to solve all the problems and know everything. This IQ business has brought more unhappiness to families than happiness. We sometimes hear parents say that, if they had only prepared their child for the psychological test, he would not have failed it. This shows that we don't know what it is all about. Then why play with it?

We also had the question of when to start training the small child. We sincerely hope that the time will come when somebody will come into the home of the retarded child and work with the parents. In New Jersey they have been doing this with blind children for the past twenty years. Since no one is prepared to have a retarded child, we need this kind of early help, and it will do a lot to prepare our children for later training in schools or institutions.

As far as providing appropriate toys, we will not make any mistakes if we provide them with big toys rather than small. And don't overcrowd him with toys. Provide him with a shelf and teach him to put his toys away.

Should six-year-old children be with others who are sixteen or twenty? Again try to understand that, while the object is to make as homogeneous groups as possible, it is sometimes not possible. A six-year-old can be so physically handicapped that the only place to put him in an institution like this is with other physically handicapped patients. The work has to be facilitated, and this is not just the one child, but 3200. Then, too, there are the parents who visit the institution and claim that their child is better than the others. For goodness sake, let's come down to earth. In one city where the public school system opened a special school for trainable and educable children, the parents of educable children refused to have trainable children in the same school. Let's remember that, in the total picture of the United States, mental retardation is a tiny problem, even though it may seem a big problem to us; and if we divide this tiny problem into still smaller problems, we will not get anywhere. How are you going to explain to your neighbor the difference between a brain-injured child, a cerebral-palsy child, and a mentally retarded child? Why divide ourselves? Why have the feeling that I am better off than Mrs. Jones if my child is level-two and hers is only level-one? You are both in the same boat, crossing the same ocean. Please try to understand this; it will make things much better.

Mr. Rosenberger: Up to now I can't see where any of you people got any help with your individual problems. I feel that behavior is a matter of degree. For instance, behavior which would constitute a serious problem at Faribault might not be any problem at all at my institution. Cursing might be a problem here, but, in many of the people that we see, cursing is almost the normal way of expressing themselves. If a patient curses, I think we should ask whether he learned it before he came, where it may very well have been the normal way of talking at home. Obscene language will disturb one aide where it would not bother another one at all. Running away from here constitutes a serious problem, but we have a twenty-foot wall and guards with machine guns to keep people from running away, so that it is not a problem for us. Stealing and wrecking a car might be a serious offense with one of your patients, but constitutes a comparatively minor one among our people. So when we get into the question of behavior problems, I think it is essential that we realize that behavior is a matter of degree and is relative to the environment. I also very definitely believe that for these degrees of behavior there must be limits established from which the individual cannot escape. There should be a definite understanding in the institution as to how much bad behavior or what kinds of behavior will not be tolerated. Then, when the individual has exceeded these limits, he should be reported to a clinical group, but within these limits we should be flexible,

Dr. Engberg: I think it is also important to realize that there are differences in the degrees of control that are necessary.

Dr. Goldberg: This question of control is very important for us to understand. The patients who come to us do so mainly because they either don't live up to society's standards, or they went overboard on those standards. None of us are trained to cope with all of the problems that can arise in our society. We bring to our work the solidness of good citizens. We come as good men and women, but suddenly we see in the work situation a mirror in which the patients show us the worst in ourselves. The controls can come from without or they can come from within the individual. If you can stand obscene language, please read Fritz Redl's book, "Children Who Hate". This is an account of the verbatim language of six-and-seven-year-old children who are disturbed or delinquent. We are probably dealing with children who hate. In our own up-bringing we were taught to love, and as soon as we meet people who hate, we become panicky. When we review the histories of these human footballs who have been kicked from one person to another, or from one institution to another, it is not surprising that they are disturbed. And as soon as we are biased by their crimes we cannot work with the individual. After all, our work does not consist of gimmicks and gadgets. These are only a means of attaining better interpersonal relationships with each other. We have to start looking at ourselves more and more and find out why we are annoyed by certain habits. Is it a symptom that we really have to report, or is it one that we could overlook and which will disappear when the patient finds that he cannot shake us too much? Will you kindly bring us down to earth a little bit now?

Mr. Hobans We found out that some *of* our problem patients did not have enough to do and, through exercise, music, games, we could cut down on some of these problems. We found that a lot of it was just bids for attention and, if you have them busy, they don't happen. With the aggressive patients, we worked with the doctors and some of them were put on reserpine or thorazine and they have given good results.



Dr. Goldberg: Dr. Bruhl, would you kindly give us your opinion on some of these behavior disorders?

Dr. Bruhl: I want to say that the cooperation of all of you with the doctors is most important to help in these various problems. We need to have reports from you about what is happening. A single symptom, like "running away", is not sufficient to help us understand what is going on with the patient. We have to see him as an individual, in terms of his background and his present environment. For example, running away may be a reaction to some immediate situation, but it may also occur in epileptics. In a state of clouded consciousness, they may have a rage attack or even run away. Once we have the understanding, and here the EEG helps us to diagnose epilepsy, we know better how to treat the individual and how to handle the problem.

Dr. Goldberg: Mrs. Lynch, do you have any comments you would like to make?

Mrs. Lynch: I would like to say that there are different overt manifestations of the same motivations. Tour over-affectionate child is just as apt to hate adults as the aggressive child. Very often we find that a child who is aggressive and who does not trust adults has been raised in boarding homes. And then we have children who also manifest serious symptoms coming from homes where the parents are wonderful people, but where the children may have been just as rejected as those raised in boarding homes. Children are not fooled. One of the hardest things we have to do is to give them the feeling that somebody accepts them.

Dr. Goldberg: In other words, that we trust them. The question has come up whether we should let them go by themselves. We don't know what will happen if they go back and forth by themselves until we try it. If we trust them and do let them go by themselves, this can very often be good therapy in itself. And if they do something, at least we know where we are.

Mr. Roach: I don't think we can emphasize enough the role of our own attitudes toward these problems. For example, telling the patient that he is bad all the time sets off motivations in the patient to be bad.

Dr. Goldberg: We must detach our own fears from the person whom we face.

Comment: In normal young children, the only way they have of defending themselves is by biting or thumb-sucking or some such behavior. Some of these things normal children will do in order to hurt their parents. Many of our 30-year-old children have never learned to defend themselves other than by these means.

Dr. Goldberg: Right. Many of them are constantly fighting society.

Mr. Rosenberger: Still, if we are not going to keep them in an institution for the rest of their lives, we are going to have to set up training limits. We used to call it discipline, but we are still going to have limits that they are going to have to adjust to.

Dr. Goldberg: Yes, that's the most important thing. Miss Peterson, do you have anything to add?

Miss Peterson: Very often, when we go back into the histories of these patients with abnormal behavior patterns, we can see so much that others have done to cause them to develop these patterns. We talk in terms of developing a sense of self and a sense of pride, and we teach them that they have to learn this and be able to do that in order to be accepted in the community. With our higher grade mentally deficient, there is enough self-awareness so that they want to be accepted, but so often we are teaching them to strive for much more than they are going to be able to accomplish. Eventually you see the development of these behavior patterns out of frustration, feelings of guilt, or aggression towards those who have made them feel this way. I think we are demanding too much without giving them realistic goals that they can attain.

Dr. Goldberg: If we put together what Miss Peterson said and what Mr. Rosenberger said, I think we've really got something. There is a pretty strict frame in our society which tells us that we are not supposed to behave in these various ways, and we have to accept this. We can have all this understanding of the causes of the behavior, but still our job is to conform the person to the frame of the society, narrow as it is. Then within the frame of society we have the still narrower frame of the institution in which we live--another set of rules and regulations which we cannot break. Our job is, first of all, to conform the individual to the frame of the institution, which requires consistent treatment where everyone knows what the requirements are. Even when we have gotten them to conform to the frame of the institution society, there may be discrepancies with the outside society. Those of us who live in the institutions very often become enmeshed in the limited society and forget what the society outside is like. As long as a person behaves in the ways that we have described, he is not only disturbing us, but is definitely not fit for outside society. The question is, knowing the constellation and background of the problems, what can we, as non-medical, untrained people, do to push them into the narrow frame of the institution society and the narrow frame of the outside society? Maybe we can't cope with this problem; perhaps we are limited only to understanding it. What about the people who keep saying, "I don't see why this patient has to be in an institution?" They forget what our society requires. In the sheltered environment of the institution we simply don't realize the number of decisions we have to make every minute of our lives. We have to be pretty well-adjusted to get along in this changing world.

I'm going to ask Dr. Engberg to tell us something about the tranquilizing drugs and how they help with these problems.

Dr. Engberg: We started using the tranquilizing drugs about two years ago. We felt that we would have to learn from our own experience what the use of these drugs might be. We decided to give it only where there was a clear-cut indication for its use with patients who were assaultive, injuring themselves, or tearing their clothes. Later, because of a shortage of funds, we divided them into three groups: those who, we felt, must get tranquilizing drugs, those where it was highly desirable that they get it, and those who might possibly benefit from it. Only the first group then was able to receive the tranquilizers. In a short time our accident rate about doubled. Fortunately, we received additional funds so we could include those for whom it was considered desirable. We have found the tranquilizers to be of tremendous value. We do not use the drugs until the individuals have been here for a period of time and their behavior has leveled off. If they are then assaultive or self-abusive, we put them on the tranquilizers. The drugs are supplementary to, not substitutes for, regular programming, and should not be used until all other measures have been tried.