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A study to explore the learning experiences available to a graduate nurse student in a nursery clinic for retarded children

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A STUDY TO EXPLORE THE LEARNING EXPERIENCES AVAILABLE
TO A GRADUATE NURSE STUDENT IN A NURSERY CLINIC
FOR RETARDED CHILDREN

By

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CHAPTER I

INTRODUCTION

The graduate nurse student in the Maternal and Child Health program at Boston University School of Nursing participates in field work in an area that pertains to her individual interests. The area is often within the agencies of inter-related disciplines that can provide experiences that motivate the nurse to explore with increased understanding, the process of growth and development, child welfare, unique contributions to family adjustment and appreciation of community resources. The nursery school, as a fieldwork experience, has long since been considered a human relations laboratory which students can use to great advantage to learn about people. Questioning adults, like questioning children are on the road to maturity and understanding. ". . . Teachers find that as they study children they themselves change. Thus we often gain insight and understanding, not only of the children but of ourselves as well."¹ During the last two years the School of Nursing has expanded the field experience to take advantage of placing the graduate student in certain nursery schools for retarded children.

The current study was undertaken because the writer

¹Millie Almy and Ruth Cunningham, Ways of Studying Children: A Manual for Teachers (New York: Bureau of Publication, Teachers College, Columbia University, 1959), p. 4.

has spent two semesters of field-work in a nursery clinic in Wakefield, Massachusetts, that is attended by retardates who are residents from there and from the surrounding towns. The experience has seemed to be one primarily of enrichment in learning about the process of growth and development, with emphasis on the development of social competency of the retardates, adequate enough to ensure adjustment that is optimum for them in the society in which they live.

The term "nursery clinic" rather than nursery school has been designated by the Massachusetts Department of Mental Health, that initiated the nursery-centered state programs for preschool retarded children from three to seven years of age. These programs are intended to be much more comprehensive than the usual nursery school.² If this is true the learning experiences that are available will vary in some ways from the traditional programs as they attempt to provide more adequate diagnostic and evaluative direction for the children. It should be expected that such an opportunity could afford deep, rich and unusually valuable experiences that would appreciably contribute to the understanding of human behaviors of the total family group.

²Arthur J. Bindman and Lewis B. Klebanoff, "A Nursery Center Program for Preschool Mentally Retarded Children," American Journal of Mental Deficiency, LXIV, No. 3(November 1959), 561-573.

Definition of the Problem

This is a study to explore what learning experiences are available to a graduate nurse student through a nursery clinic for retarded children, that might contribute to the knowledge and better understanding of maternal and child health problems.

Justification of the Problem

It is the opinion of this author that a nursery clinic program for the retarded preschool child can offer valuable learning experiences for the graduate nurse student that includes the broader aspects of social service, psychology, medicine and teaching, as they relate to the problems of a total family group in a community and show an interdependence at state levels.

Retarded children have a decreased but not an absence of their mental faculties. Their growth and developmental process is representative of normal children in many ways, and can be followed in considerable detail through play and other activities of daily living in the nursery situation.³ In addition to developing new and broader concepts of how the preschool child develops, adjusts and learns in a nursery school setting, it would seem that there is in this instance the opportunity to discover broad learning experiences that

³Ibid.

will increase the student's understanding of a comparatively new field of activity - increased education and socialization of the retarded child - that is directly related to her clinical specialty and her responsibility in maternal and child health nursing. During the last five years, the development of clinical programs for mentally retarded children has constituted the major extension of maternal and child health services in the Federal and State health programs.⁴

The hours a retarded child spends in the nursery clinic are so limited in relation to the total experiences of daily living, so dependent and interwoven with the family he has left, to come to the school and will return to, that this author found it a challenging situation to explore, and to further develop for scope and understandings and to examine the learning experiences that can evolve from activities of the graduate nurse student with the interdisciplinary team members, the retardate and the families for whom the service exists.

Scope and Limitations

This is a case study approach to better understanding of what the nursery clinic for retarded children can present as learning experiences to a graduate nurse student. It is focused primarily on the problems of a four to five year old

⁴Arthur J. Lesser, "Health Services - Accomplishments and Outlook," Children, VII, No. 4(July-August 1960), 142-149.

boy, who has attended the Wakefield state nursery clinic for a full year. It attempts to bring together and share the understanding of many of the aspects of a retarded child and the problems that concern him, rather than having any one discipline of the team dominate. It is felt by this writer that the quality and not the quantity of the cases contacted in such a setting is one of the determinants of the worth of the experience. Although the observations and the interactions with all of the children attending the nursery-clinic were valuable and contributed to the understandings of the student and to the peer relationships of the retardate chosen for individual study and evaluation, it became evident to this writer that a more complete and satisfying study with a focus on one child chosen for certain reasons, can be developed to demonstrate the breadth and detail of inter-disciplinary action that is necessary and representative of team members and related agencies in a single case, as they work to promote the optimum growth and development and to minimize the actual and potential handicapping of a child, as they counsel the parents.⁵

Limitations of this study are considered to be:

1. It is concerned with the opportunities for learning in one nursery-clinic for retarded children, in Wakefield, Massachusetts. The results therefore will point to the

⁵Edith U. Baker, "Diagnostic and Treatment Services for the Mentally Retarded Child," Child Welfare, XXXIX, No. 7 (September 1960), p. 8-13.

opportunities present in this agency and may not be indicative of similar opportunities in other nursery-clinics.

2. It is limited to the experiences of one graduate nurse student in the field, who was in the role of participant-observer for three or four mornings each week for two semesters.

3. It is primarily the case study of one family situation of which the nursery-clinic child is a member, and is in terms of the direct relationship of the child's problem of retardation to his family group.

Definition of Terms

Nursery-clinic has been described to be an adequate nursery school setting, with a well-prepared nursery school teacher, but is more comprehensive than the usual nursery school. The term clinic is used in that it goes beyond socialization and is a diagnostic center as well for the child and a center for counseling his parents.

Retarded as it is used in this study refers to a symptom complex and does not attempt to classify the degree except as it refers to that part of the case history of the child in relation to the results quoted from the psychometric testing.

Participant-Observer is used in reference to the graduate nurse student, whose role was participation in all of the activities in the nursery clinic, and used the observations made during participation for her records.

Maternal Deprivation is used in this study to refer to the withholding by the mother of sufficient loving-care for which the child had a need.

Retardate in this study refers to the child who has been diagnosed clinically to have the symptom complex responsible for retardation.

Preview of Methodology

The literature was reviewed relevant to the nursery school, its development and use as an educational factor today and to mental retardation, its causes, effects and ways of coping with some of the problems resulting from the condition.

One boy at the chronological age-level of four to five years, who is attending the nursery-clinic was chosen for detailed observations by the participant-observer in the nursery setting. After a detailed preliminary anecdotal record study, the observation guide was developed to apply to the child and the setting, and was used for a period of observation consisting of two semesters. The observation ran from September through December 1960, and from February through May 1961.

A family study of the retardate chosen for a focus was obtained through planned conferences with the case-worker in the health team, who reviewed the family records with the writer by interview and discussion.

The child's nursery school performance as reported by the teacher to the department of mental hygiene, was studied

for her evaluation of the child in the Teacher's Record submitted at stipulated times.

Sequence of Presentation

The remainder of the study is presented as follows: Chapter II contains a review of the literature in relation to the nursery school and mental retardation. Chapter III describes in detail the methods used in conducting the study. Chapter IV is a presentation and analysis of the data. Chapter V contains the summary, conclusions and recommendations.

CHAPTER II

REVIEW OF THE LITERATURE

A review of the literature in relation to this study falls into the two general categories: (a) The nursery school and its contribution to children of preschool age, and (b) The retarded preschool child and some of the present trends in his diagnosis, care and preventive aspects.

The Nursery School

It has been stated that:

If the available knowledge about children and about human relationships could be applied by all who are influencing the development of young children, much of the world's unhappiness would be averted. . . . Our knowledge about behavior comes from many fields and is the basis of many professions. The fields of psychiatry, health, welfare, and education have contributed, each in its own way, to this core of knowledge, and have drawn on each other's contributions. . . . The inter-relatedness of knowledge derived from research in these respective fields is increasingly evident. But their values are not fully integrated into community programs.¹

The present trend in our country to establish smaller homes, to live in more crowded urban communities, to build mobile units with such limited space that there is room for neither materials or activities that are needed for over-all optimum development of children has become a way of life, and

¹Winifred Allen and Doris Campbell, The Creative Nursery Center: A Unified Service to Children and Parents (New York: Family Service Association of America, 1948), p. 9.

not just a substitute for things to come. These and other reasons are why families have found nursery schools a satisfying way to meet the needs of their children. They are the places where young children learn to play with many materials and share the experiences of their peers and teachers. These human relations laboratories are used by adults and students from many disciplines for learning about people as they observe children and participate with them.²

A Brief Historical Resume of the Nursery School

More than two thousand years ago Plato stressed the benefits of education for the very young child. Since then care and guidance outside of the home has taken many forms and has been changed many times for diverse reasons.

In the early eighteenth century there were centers established for preschool children in England, where the stress was on religious and health protection. About one hundred years later there were "infant schools" founded in Italy and Germany. Considerably later in the nineteenth century, the kindergarten movement instituted by the educational leader, Friedrich Froebel, became popular in Germany. Some of his theories that were considered revolutionary have stood the test of time by their soundness proved by the

²Katherine H. Read, The Nursery School: A Human Relationships Laboratory (Philadelphia: W.B. Saunders Co., 1960), p. 3.

experiences of many. The object of his system was, "to give children employment in harmony with their nature, to strengthen their bodies, to exercise their senses and lead them up to the original ground of all life, to the idea of unity with themselves."³ This design to help children develop potentialities is considered the direct forerunner of the modern preschools, in that they were the first early education centers for children that did not emphasize religious and moral discipline.

The first "nursery school" which was so named, was British in origin and established in London in 1909 by the two sisters, Margaret and Rachel McMillan. Its purpose was largely custodial in nature and was based on health, cleanliness and the proper feeding of the neglected children of poor parents. The influence of the McMillan sisters was noted throughout America by the establishment of similar centers for similar reasons in the years that followed. This effort of the early twentieth century was paralleled somewhat by a woman physician in Italy, Dr. Maria Montessori, who was appalled at the neglect of tenement children whose mothers worked outside of the home, so she established schools where children were encouraged to use motor and mental skills. Her philosophy, that busy children are happy children has an

³Louise Langford, Guidance of The Young Child (New York: John Wiley & Sons, 1960), p. 16.

important bearing on child guidance concepts at the present time, as has another of her contributions, that mothers should have the opportunity to learn improved methods of child care while the children reap the benefits of the organized group schooling.⁴

The spread of nursery schools to other countries has become a popular trend, as they have continued to become appreciated more widely for the kinds of contributions they can make in helping to establish basic concepts in a number of fields at an early age. The nursery centers have continued to reach out to help fulfill the needs of young children in the many corners of the earth, as the various crises and the exploding populations continue to appear around the world.

Since World War II in all countries where there is a trend toward the establishment of nursery schools there has been considerable progress and a number of variations of purposes reported. Each country has had to develop its own aims and standards for preschools, based on its own recognized needs, resources and social philosophy, with their social aims far outweighing their educational aims. Australia has used her preschools to help in the care of neglected and underprivileged children living in industrial-residential areas that are substandard, but has also progressively set up laboratory nursery schools as part of a program to study human

⁴Ibid.

development. The Commonwealth government of Australia became so alarmed by the excessive number of physical and psychological rejects from military service in recent years that parent education and early education for the individual child is stressed, in hope that it will prove to be at least a partial answer to a better understanding and way of evaluating their total problem.⁵

Some countries like France, Denmark, Germany, Israel, Mexico and Norway have followed the trend of increasing the number of nursery schools in school systems and as private ventures, but most of them are established for socio-economic reasons of health and housing problems. Such movements as The New Kashmir Plan in India has allowed for a marked increase of preschool facilities to be established in selected rural areas where rich and poor alike live closely in school, homes and communities. Russia recognized the value of preschool centers as early as the first Five Year Plan in 1917, when she started with the nursery age group to implement the progress of the Communist regime. She has continued to find it a profitable place for the purpose of all-around development of her children, aged three to seven years while their mothers are pressured to participate in the government, cultural and socio-political life of the nation. Among the aims of Russia's nursery schools today are those that specify the organizations

⁵Jerome Leavitt E., Nursery-Kindergarten Education (New York: McGraw-Hill Book Co., 1958), p. 15.

are to work to develop special attitudes toward adults and other children, to stress respect for their elders, and to attempt to cultivate the love of the Soviet motherland, its people and leaders, the Soviet army, wealth and natural resources, and creative genius of the people.⁶

Development of Preschool Centers in America

Growth of the preschool centers in the United States has been so spontaneous that much of the accurate origin has been lost. The first day-nursery was opened in New York City in 1854 for the purpose of caring for groups of infants and children whose mothers worked, thus care was provided to fulfill an obvious and felt need in the community. By 1898 when the National Federation of Day Nurseries was formed there were at least 175 such centers in existence. Since that time, among the many and varied reasons that have provoked changes in purposes for the existence and the direction that the nursery schools have taken, are those for the convenience of working mothers where the people in charge have had no training in child development and guidance and have become group baby-sitting situations, to those highly structured centers developed beyond the children's development.⁷

Logan states that, "the nursery school in the United States is a cultural agency for supplementing and strengthening

⁶Ibid. p. 29.

⁷Langford, op. cit.

the normal functions of the normal home."⁸ Various factors, situations and needs helped to create a variety of types of nursery schools since those early pioneering need-fulfillment attempts to the present where the motivation in America is primarily that of education. In 1915 the University of Chicago faculty wives started a cooperative nursery school. In the 1920's there was an expansive movement continued throughout the years by a number of research centers and colleges. The Merrill-Palmer School in Detroit, Teachers College in Columbia University, Cornell, Iowa State, Ohio State, Yale with its Clinic Guidance Nursery under Dr. Gessell, Vassar, Smith and Antioch colleges were some of the many early ventures. University nursery schools were the pilot centers where leaders studied and demonstrated the kinds of learning experiences young children needed. The objective of the research centers was maximum development of children. From 1925 to the Second World War many efforts were made to study, guide and educate the young child, not merely to watch over him. The development of nursery centers have accompanied periods of National Crisis when forces have been mobilized to provide extra care for children so that their parents could become more fully and more safely involved in the labors that would help to meet the crises. The depression years of the early 1930's followed by

⁸Lillian M. Logan, Teaching the Young Child (Boston: Houghton Mifflin Co., 1960), p. 8.

the Works Progress Administration Family Life Educational Program, reported the administration of 1,500 nursery schools with an enrollment in the hundred thousands. The emergency years of World War II, when conditions similar to the industrial revolution existed, was another focus on the responsibility of society for adequate education for the youngest citizens and was responsible for a remarkable up-trend of nursery schools in the United States.⁹

The Nursery School Today

Today, the nursery schools in America besides being situated in research centers, are frequently part of the public school systems, while many more are private enterprises that range from little more than uniquely named private parking places for children to well organized effective schools of high standards. Cooperative nursery schools are available to the average family purse and are organized for good nursery education where worth-while group experiences are offered and may include a laboratory for parent education activities as well. Such organizations as churches, housing developments, junior colleges, neighborhood centers and boards of education sponsor them, and well-qualified teachers and directors staff them.

Nursery schools for the handicapped child with an

⁹Ibid.

orthopedic, neurological, speech or vision problem are supplied in many communities, and are sources of a supply of rich first-hand experiences for children with the special needs that the average nursery school is not equipped to handle. Neighborhood play groups, though informal in nature are organized by parents trying to meet the needs of neighborhoods on an individual basis.¹⁰

Specific Contributions of the Nursery School

According to the authors already quoted and others, the "good" nursery school is one which serves the needs of the two-, three-, and four-year old child by providing experiences adapted to what is now known about the growth needs at these ages. It supplements and enriches the basic experiences a good home offers as children are encouraged to broaden their horizons, develop new interests and to experience the stimulating and satisfying opportunities to explore, manipulate and create. Though nursery school is not a "must" for every child, it can present a number of ways a child can make discoveries about himself, his peers, the adults in his life and the world about him. It is a place where a climate is provided for the young "doer" and "goer" to develop a beginning ability to communicate in all ways with the people and the world around him. Stuart and Prugh have summed up the criteria for a good nursery school as follows:

¹⁰Ibid.

A place where the young child finds:

- 1 That he can be himself and still receive appreciation, respect, and a warm acceptance.
- 2 That the world has an order and a routine that he can understand and cope with at his own level of development.
- 3 That getting along with other people in a friendly way becomes increasingly easier because he is helped, in shared activities, to understand his own rights and feelings as well as those of others.
- 4 That there is interest and challenge for his growing powers, but no pushing of them.
- 5 That his physical health and well-being are promoted and protected throughout the day.¹¹

Mental Retardation

What is meant by mental retardation? The literature states that this question is asked by people of every nation around the world in one form or another, depending on their cultures, as the physicians, educators, sociologists, psychologists, geneticists and layman tries to evolve a concept of his own to define it as he sees it or as he affects, or is effected by the problem. This symptom complex has always been in existence, and has had various labels such as the Greek term "idiot". Education for the mentally defective began as long ago as 1800 when it was carried on by physicians rather than educators. Itard's contribution of his report on *The Wild Boy of Aveyron*, and the work of his student, Sequin, who was publically commended for his work with the education of Idiots and Other Backward Children, gave impetus to others to work

¹¹Harold Stuart and Dane G. Prugh (ed.) The Healthy Child: His Physical, Psychological, and Social Development (Cambridge: Harvard University Press, 1960), p. 390.

with mental defectives and demonstrated they can be helped to some degree.¹²

Sequin is also given the credit for considerable influence of early recognition and handling of the problems of retardates in America, where he migrated and became superintendent of the Pennsylvania Training School for Idiots. Though his methods were more empirical than scientific, they were similar to those still used in the education of the retarded. He emphasized the education of the whole child, the individualization of instruction, the importance of rapport between teacher and pupil, the physical comfort of the child during the learning period and the importance of beginning with what the child needs, wants and desires before progressing to areas that are unknown.¹³

Montessori of Italy, who had contributed to the nursery school for normal children worked extensively with the retarded child and perhaps made her greatest contribution through emphasis of scientific education. Other well known contributors like Decroly of Belgium and Binet of France are credited with others as being new achievers due to the changing social philosophy of the times following the French Revolution.¹⁴

¹²Samuel Kirk and G. Orville Johnson, Educating the Retarded Child (Boston: Houghton Mifflin Co., 1951), p. 69.

¹³Ibid. p. 70-78.

¹⁴Ibid.

Terminology and Classification

Terminology and classification of mental retardation has followed a very wide range of definitions and attempts to answer the question of what it is. "Mental retardation" has been used to denote the child with potentialities for social and occupational adequacy as distinguished from those who have not. "Mentally handicapped" has come into use by some to indicate a deviation from the normal and to indicate it is a different kind of handicapping.¹⁵ "Severely retarded" has been introduced to indicate an intelligence level. "Educable" puts the emphasis on a degree of intellectual potential for accepted school subjects, and the term "trainable" identifies the level of those who will not achieve beyond rudimentary symbols of the culture but can learn self-care, some social habits and routine skills for life in a sheltered environment.¹⁶ "Mental deficiency" according to Zietz¹⁷ should be used to refer to social inadequacy that results from intellectual limitations resulting from incurable pathology of the Central nervous system, and points out that regardless of the origin of the condition, heredity - congenital or developed at or

¹⁵Christine Ingram, Education of the Slow Learning Child (New York: The Ronald Press Co. 1960), p. 242.

¹⁶Ibid. p. 8-10.

¹⁷Dorothy Zietz, Child Welfare: Principles and Methods (New York: John Wiley & Sons, 1959), p. 242.

soon after birth, it imposes a dependency status upon the individual which limits social and vocational adequacy.

Cause and Scope

The underlying etiologic factors of mental retardation are of a wide variety and seem to increase or to be defined more clearly, as research discovers new information and develops new concepts of existing problems. Among the causes of mental retardation are those due to cerebral birth trauma, cerebral infections, maldevelopment of the fetus, prenatal maternal infections, mongolism, phenylketonuria, epilepsy, kernicterus, thyroid deficiency, neuronal degeneration, familial causes, psychogenic causes, such as institutionalization and maternal deprivation, cranial abnormalities and unknown causes. Some of these are specifically preventable with chemotherapy, such as the infectious origins; some by dietary management as phenylketonuria; some by endocrine replacement therapy as in cretinism; another is preventable by replacement transfusion if the presence of the Rh factor is discovered in time; some by improved obstetrical care as in birth trauma and still others by enrichment and control of the environment as in familial and psychogenic causes.¹⁸

Diagnosis of mental retardation is never based on one

¹⁸Leon Eisenberg (ed.) "Mentally Retarded Children Can be Helped in Every Case", Feelings: and Their Medical Significance, II, No. 4 (Columbus, Ohio: Ross Laboratories, April 1960), p. 1.

factor or determined by one discipline, but needs the combined efforts of a team so the physical examination, detailed medical history, certain laboratory tests, social appraisal of the family, and clinical evaluation of symptoms with psychologic testing can be correlated. The scientific factors are important but the psych-social adjustment and feelings of the family are professional obligations too. The family needs time to think and to plan and to recognize that they have considerable support available for weighing and discussing every angle and degree of retardation at the local, community and state levels.¹⁹

The prognosis of mental retardation is quite variable and depends upon the management and effectiveness of the therapy where it is indicated, but regardless of the eventual outcome there is always some degree of help for the existing circumstances of the child and his family.

Mental retardation is a major Health and Welfare problem in American today that affects one out of every sixteen members of our population. About one percent or 1,600,000 are severely retarded, and another two percent or 3,200,000 are less severely retarded, but seriously handicapped in life. This estimate does not include many borderline cases.²⁰ The problems of subnormality are by no means confined to our continent.

¹⁹ibid.

²⁰Walter Jacob, New Hope for the Retarded Child (New York: Public Affairs Pamphlet #210, 1954), p. 3.

Accurate figures are not available as prevalence rates, because of the many different factors concerned with society and with the socio-economic conditions. Surveys carried out in various countries have not provided statistics to show whether mental subnormality is rising or falling, but considerable research is going on.

Hormuth²¹ refers to a study that pointed out that mental retardation is not a stable category to deal with because there is a large group who move in and out of the diagnostic category at different times in their lives. A breakdown by age helps to show where the peaks and valleys are by pointing out that in newborn population there are two out of every 1000 who are retarded; between one and two years the number doubles to four out of every 1000 and by three to four years the number rises to six in every 1000. The steady rise is due to illness, injuries, deficiencies and others, with a decided increase in the school-age group and a maximum number in early adolescence.

In spite of the growing number and scope of services available, there has been a remarkable lag by professional and lay people, of organized interest in the retarded child. He has been called the "forgotten child" that communities failed to prepare for in a habilitative way. Too many have

²¹Rudolph Hormuth, The Public Health Nurse in Community Planning for the Mentally Retarded (Washington: U.S. Department of Health, Education and Welfare, 1957), p. 3.

terminated life in institutions without the benefit of organized planning at any level that considered his personality and need for human relationships within his family and in the community. The awakening of the public to action in behalf of the retarded child was brought about directly by bands of parents of the retardates with common problems, who formed a national organization and thus aroused the public conscience.

Initially the plan was to establish a clinic facility from which case finding, diagnosis, treatment and follow-up services could be directed. The result in 1955 was the establishment of The Clinic for Mentally Retarded Children, by the Bureau of Maternal and Child Health, in Washington, D.C., Department of Public Health. Emphasis was placed on the pre-school child. The consultant psychiatrist pointed out that the crucial period was the first five years of life. If the retarded child was helped to develop a healthy personality and to function as normally as possible within the limits of his capabilities, he would be able to get along within a family and in the community with less difficulty. His academic expectations would be an individual consideration.²²

Early legislation establishing centers for the care of these children provided "nursery clinics" for retarded children of preschool age. The term "clinic" has been used because the

²² Arthur Bindman, Lewis Klebanoff, "New Programming for the Mentally Retarded School Child in Massachusetts", American Journal of Mental Deficiency (March 1960), p. 875-880.

program was intended to be much more comprehensive than a nursery school per se. A nursery school setting for the pre-school retarded child was established where trained nursery school teachers could provide and supervise some basic training and socialization in preparation for "special" classes in the public school systems. This has been an ongoing program within many states. Massachusetts can count some positive effects within its program of fourteen "nursery clinics" for retarded children. The organized efforts of the Massachusetts Association for Retarded Children has as an objective the coordination of services for the retarded in order to improve the care of all retardates in local and state schools. They (M.A.R.C.) direct their efforts toward information for parents, and help to provide knowledge that they are not alone, but that their problems are shared.²³

There is no "typical" retarded child. Their intelligence has a wide range from below normal to very low normal, but they are individuals just as normal children are. Part of the diagnostic procedure to determine mental retardation puts great emphasis on the Social Quotient as well as the I.Q., because it is indicative of how well the child is able to use that intelligence he has in caring for himself, how well he is growing toward his ultimate maturity. In spite of the great

²³Special Report: Massachusetts Needs in Mental Health and the Care of the Retarded, Commonwealth of Massachusetts, (July 1958), p. 97.

importance of new methods of teaching, educational research and other research, a most important development is the new attitude of the educators toward mental retardation, changing the outlook from one of discouragement to one of hope, with the emphasis on rehabilitation and the return of the mentally retarded to society, depending on his potentiality for development.²⁴

Socialization is one of the most desirable aims that professionals working with retardates attempts to foster in many ways. It is expected their first steps in this direction will be taken within the family circle, because success in early childhood socialization depends upon the parent's relationship with each other and their feelings toward the child. The nursery school that has been well organized and has been directed toward the recognition that good personal adjustment at all levels, but particularly in the early years of life is especially important in laying personality foundations for later years, has considerable to offer to the development of the retarded child.²⁵ Nursery school clinics described elsewhere in this study, are in an excellent position to contribute initially to child-centered planning, with their emphasis on the individual child rather than on retarded children in general, and on evaluation and preparation of

²⁴Edward French and Clifford Scott, Child in the Shadows (New York: J. B. Lippincott, 1960), p. 30.

²⁵Allen and Campbell, op.cit., p. 39.

the retarded child for further training and special classes.

French²⁶ states it has been shown the learning pattern of many mentally retarded children is strikingly different from the normal child's, in that he tends to see things differently and to confuse foreground and background, does not make obvious generalizations and relationships or draw concepts from facts. Emphasis must be on the practical instead of the theoretical, and on affection, respect and approval of each child, in order to help him build values made available to him.

The nursery school can make many individual contributions to the normal preschool child, because of the climate made up of a well-appointed setting for the child's interests and needs and a wholesome attitude of well-prepared, experienced nursery school teachers toward children and family needs. Such an environment plus the teacher's special guidance by team associates, in understanding the causes, significance and potentialities of mentally retarded children of a community, can do much toward opening up a life for the unfortunate children that is a contrasting revelation in relation to the guidance and care in former years.

²⁶French, op. cit., p. 138.

CHAPTER III

SELECTION AND DESCRIPTION OF THE SAMPLE

The Setting

The nursery-clinic for retarded preschool children selected for this study is in a town north of Boston. It is situated in a large church near the center of the town, which makes it quite accessible to families, and provides adequate facilities indoors and out for child pleasure and development throughout the year. Children who come here from Wakefield and the surrounding towns have been selected to take advantage of the program under the division of Mental Hygiene of the Massachusetts Department of Mental Health. The children are from families who are a cross section of nationalities, religions and socio-economic standing, but who have been bonded by a common problem--that of a mentally retarded child. The children in this nursery-clinic are representative of such centers throughout the state, set up for diagnosis and evaluation of the individual child's symptoms and his ability to develop his potentialities in preparation for special classes, and for the counseling of the parents.¹ The program also has as one of its broad and progressive aims, "to encourage the learning of professional workers . . . in an effort to include discussion of

¹Bindman, op. cit.

mental retardation in their programs."²

The Child

The initial group of children observed by the writer were nine in number - four boys and five girls between the ages of four to six with varying causes of mental deficiency and their range of attendance in the school from beginners, to children entering for the third year. After a six weeks study of the group in relation to play activities, responses to adults and other children and a limited association with the families, it was decided that one of the children, a four year old boy, who had come to the school at about the same time the writer did, would be representative of some of the learning experiences available in the agency that the observer could take part in or view closely. All of Bobby's adjustments to this group of children and the setting were expected to be in terms of first experiences, so conditioning by familiarity would be lessened.

Bobby is a handsome four and a half year old child without defects that would suggest handicapping of any kind. He is an excessively active child of young parents of the apparent economic means to give him considerable help. This child and his family keenly interested the writer to look at families with retarded children more closely, and this family in particular for as many of the phases as could be explored

²Special Report, op. cit. p. 97.

of family life and the child's developmental history, in an effort to discover if possible what there was to learn about one total child that could be applied to the understanding of the problems of growth and development and socialization, and how mental retardation can affect, or be effected by family interaction. In the six weeks period of observation Bobby began to show in this observer's estimation, signs of adjustment and simple accomplishments that contribute to social competency and seemed measurable to some degree.

Tools Used for Collection of Data

There were three tools used for the collection of the data in this study: (1) The Observation Guide used by the participant-observer, (2) Planned conferences between the case worker of the professional team directing the agency and the graduate nurse student and (3) The Teacher's Record.

The Observation Guide

An observation guide was devised to facilitate the recording of the activities of one child over a period of nine months. It was the outgrowth of rather bulky, hard-to-follow anecdotal notes, kept on all of the children in the nursery-clinic during the first six weeks by the participant observer. The author in assuming this role was unable to make on-the-spot recordings of behavior, so arranged the activities into six broad categories to be sub-headed by descriptive terms denoting activities and influences found to be present or

anticipated through the observation of the many activities of all the children. This guide became the observer's frame of reference for all of the behavior observed and recorded over the months that followed. The categories represent free and guided play, singular and group activities and peer and adult interaction. Specifically the six broad categories are:

(1) Attitudes (General), (2) Activities (General), (3) Use of Play Materials, (4) Habits of daily living, (5) Socialization: (a)Peers, (b)Adults, (6)Speech.

The observation guide has been supplied with many sub-categories, in an effort to record for more detail and accuracy the childhood activities of the subject for their occurrence, absence and change in character. An X has been placed in the check squares on the graph-guide to symbolize an all or none category recording, which in each instance indicates behavior observed as described on the left, and recorded as soon as possible after the observation. In some instances activities may be accumulative of not more than two consecutive days of observation in each instance. The periods are approximately two weeks apart, and are bi-monthly records, for the periods from September through December and from February through May of two semesters.

Planned Conferences

Planned conferences were arranged to take place between the caseworker and the author to discuss the family situation as well as the child who was chosen for the study. The

intensity of studying any individual child makes it necessary to obtain sufficient information to demonstrate and explain the features of the case that are unique and have common elements with other cases. The comparatively extensive examination of the immediate situations of play and related activities in the nursery clinic, that the author was able to observe were quite incomplete and lacked sufficient meaning without the facts of Bobby's life history that were contributing to his activities in so many ways. A detailed social history is an essential part of the study of any child. "The family is the unit-structure of our society. Its strength is dependent on the bonds of love and understanding which bind its members together. Such bonds have their roots in deep, shared, emotional experiences."³ The conferences helped to relate Bobby to his immediate family influences and to contributing ones that are generally so obvious in a child's response. "We see the mental retardation of a child not as a mother's problem or a father's problem, but as a family problem requiring joint decision and action. . . . Their child's needs is complicated by such problems as serious emotional difficulties, marital conflict, excessive guilt reactions, or need to overprotect or reject their retarded child."⁴ Conferences with the caseworker provided data on the family status, inter-family relationships

³Ernestine Wiedenbach, Family-Centered Maternity Nursing, (New York: G.P. Putnam's Sons 1958), p. 1.

⁴Baker, op. cit., p. 11.

needed for a better understanding of Bobby's problems, his hospital evaluations and others that are quoted in this study.

The Teacher's Record

The Department of Mental Hygiene requires the teacher in the nursery-clinic to keep a record on each of the retarded children attending the center, describing her impressions of his progress and development during the weeks of work and observation with him. For this report a summary of the reports of the tenth and twenty-fifth week are included with a summary of an overall report on the Behavior, Interests and Activities of Bobby while attending the nursery school clinic. These are all under the one category, Teacher's Record and are contributed as one tool.

CHAPTER IV

FINDINGS

Presentation and Discussion of Data

This study, to explore the learning experiences in the agency described in this paper, has been approached through the detailed investigation of the present situation and the life history, as far as it could be examined, of the retardate and his family, through their records and interactions in the total nursery clinic setting, in direct relation to the participant-observer's approach chosen by the writer, and the usual roles of the caseworker and nursery-school teacher. The choice of the sample previously described in Chapter III, that had seemed to grow naturally out of the preliminary study as a focus for some of the possible experiences in the agency, continued to represent a desirable choice in this writer's opinion, in that there was a continual flow of new situations introduced, that were insight-stimulating into the better understanding of mental retardation, the process of change in the retardate and his family and the importance of the socio-psychological characteristics of their development.

The writer observed in the early weeks of this experience, that though the number of pupils in the class was only nine initially, or three-fourths of the number of pupil population for this nursery clinic, they were quite represen-

tative of some of the causes and responses in mental retardation. Four children were mongoloids who had attended the clinic for two years, and five were partially diagnosed as brain damage - cause unknown and diagnosis incomplete. Observation and participation in activities with all of the children was carried for the first six weeks in detailed anecdotal notes, in respect to their general behavior, their responses to the kinds and frequency of play activities, acceptance and rejection of peers, feelings and acceptance of the teachers, acceptance and associations with the writer, daily living habits and parent interaction to a very limited extent. After the preliminary period each child was evaluated by the author to decide which small pupils would contribute most fully to the graduate student nurse's objectives, and would be eligible for continued recording of observations and which ones would continue to be generally observed for group appreciation. The four mongoloid children had been at the school for about two years, and seemed quite sophisticated in relation to the newcomers and to have reached a level of response in many ways that seemed learned and often quite predictable, so were eliminated as being too advanced for an untrained participant-observer to fully appreciate for new learning and adjustment. The other five children were again separated and evaluated for their possible contributions to the study. A six year old girl was eliminated on the basis of three years of attendance with limited response, while a five

year old girl who had attended the nursery clinic the previous year and was doing very well in most ways, was found to be receptive of the author to the point of seeming to seek repeated dependence activities with her in many situations of dressing and play, that made interaction with the child too subjective to evaluate well. There were in the school population, three boys who were newcomers to the clinic at about the same time the author joined the group. All of them came from home situations that were quite dissimilar in most ways, all were markedly retarded and had behavior manifestations that were interesting and challenging to keep up with. Two of these boys were also eliminated because of minimal progress, and because arrangements for long term care was a possibility for both. These children who were eliminated were very important individuals to measure the chosen child with, and without them Bobby's activities as recorded would have had less or possibly a different meaning. The elimination process left one boy, the youngest of the children, who had not had his fifth birthday, was emotionally disturbed, had not yet learned to speak, was hyperactive, and showed behavior deviations that could be followed with detailed study. Bobby was the one child in the total group that the author felt demonstrated the greatest possibility of change in many ways that could be measured to some extent. The family situation though quite incomplete at the time, bore earmarks that indicated to this

writer some essence of mother deprivation.

Case History of the Family

Bobby is a good-looking, blue-eyed blond boy who was four years and ten months when he entered the nursery clinic for retarded children in Wakefield in September 1960. This alert-appearing youngster who seems of slight build for his age, has no physical signs of handicapping that would label him abnormal in any way. It is the second time he has attended a nursery clinic for retardates, having spent several months in another nursery clinic in the spring of 1960 where his mother had enrolled him without referral or psychological testing by the clinic program. The venture had been unsuccessful as far as showing progress in socialization.

Bobby had shown signs of retardation and personality disturbance since the age of about one year, and had been a patient in Massachusetts General Hospital in January 1958 and again in January 1960 where his parents had taken him for mental and psychological evaluation. In January 1960 Bobby, then four years and one month old, was not toilet-trained, had not learned to talk, had had episodes when his mother questioned his hearing, was hyperactive, spent hours at a time crying, did not conform to home routines and was often uncontrollable. During his stay at the hospital he was completely examined and evaluated. His hearing was reported to be normal, his electro-encephlogram was reported poor and distracted because of inability to cooperate. The Merrill Palmer Scale for

psychological testing was reported at a two year level of mental development, or fifty percent retarded for his chronological age of four years, but it was not entirely satisfactory and retesting was recommended. Bobby was discharged with the diagnosis, "Speech and Personality Disturbance - all inclusive with moderate retardation superimposed by his personality."¹

In May 1960 when Bobby was four years and six months and a pupil in another nursery school, he had a psychometric test by a psychologist from Children's Medical Center. The test was reported: Child understands little, is silent, had a minimal response, was bewildered and resistive. His mother was confused and a recommendation for retesting was made. Bobby's mental age level was reported by Cattell's scale at two years - consistent with a variety of ties.

In June 1960 Bobby was referred to James Jackson Putnam summer session in the out-patient department clinic, where he was seen weekly for two months and had examinations and testing by a health team consisting of a psychologist, neurologist and a pediatrician. Bobby's E.E.G. at that time was reported to show a mild disturbance not indicative of anything. His diagnosis was -"Primarily retarded with severe separation anxiety shown by crisis clutching, with a Low Normal mentality."²

¹Personal interview with Caseworker, May, 1961.

²Caseworker, Ibid.

Bobby, who is now five years old, the third and youngest child in the family, was born in Connecticut on November 30, 1955, of Irish-German parents. The other two children are girls aged eight and thirteen years, who are well and apparently normal in every way. It is a family with a middle class status. Mr. X, a college graduate with a degree of M.S. in Research Engineering, and now employed at a missile base in New England, is thirty seven and earns an income in five figures per year, which affords him his own home, a car and other comforts of living that contribute to a good standing for his family in his community. Mr. X is the only child of parents who are still living and are well, with no history of chronic family illness.

Mrs. X, now thirty-four years of age was born in New England also, where she is one of a middle class family with three children, all of whom have high school educations. Mrs. X's brother and sister and mother are living, well and have no history of family illness. Mrs. X's father died suddenly when she was fifteen years old, and she has stated she was quite attached to him, so his death has left her angry because he left her at such a young age. She has been evaluated as an immature person, who has felt her mother preferred her sister to Mrs. X. This is a catholic family of which the father, Mr. X, is the more devout. Mrs. X makes frequent contacts with the church dignitaries of her parish, invites them to dinner and seeks advice, but is said not to be very

attentive to her religion.

History of Pregnancy

Any illness during pregnancy or trauma to the infant at birth are possibilities to be considered as causes of mental retardation in the child. Mrs. X's medical history was investigated for anything that might contribute to the better understanding of the family and the child's history. Mrs. X was reported to have had a difficult time prior to Bobby's birth. She vomited for nine months, but had no symptoms of toxemia or other physical problems. She was tense during the time she was carrying Bobby and had trouble with people in that she felt they disliked her and used her. She was insecure with a great need to be liked. She was referred to a psychiatrist at the time, where she went for ten interviews, but it was not judged long enough for any appreciable help. Mrs. X had had two different periods of miscarriages, three of which were prior to the birth of her second child, which was terminated by Caesarian section after a long labor. Bobby's birth was also Caesarian section.

Bobby's Early History

Certain illnesses and accidents during infancy and childhood reportedly are causes of organic changes that may result in the mental retardation of children. The infant's conformity and any deviation from, or shift in the normal growth patterns, are considered important to record and to be

noted by those who work with children. Bobby's developmental history is far from complete but does include some of the highlights in his early development, that are important indications of his direction and capabilities during the first months of life.

Bobby's record states that he weighed eight pounds and eleven ounces at birth and except for a period of vomiting and being gassy during the time he was in the hospital after birth, there were no untoward problems. His condition was good at the time of birth with no periods of anoxia or convulsions. Bobby was fed by bottle and showed a good gain in weight and physical development. These facts were substantiated by Mrs. X with the help of her records in a Baby Book. She revealed that Bobby noticed his hands at four months, sat up at five months, had his first tooth at five months, reached for objects at five months, held objects at six months and weighed eighteen pounds at six months. At that time the mother thought the baby was slow, a nervous baby and was crying somewhat more than normal. He was sitting at nine months. Mrs. X stated that Mr. X had a very close tie with his son during the first eight months of Bobby's life that she described as too close and she considered not good. A note in the Baby Book said, "Your father thinks you are O.K."

About this time Mr. X had to spend several days at a time away from home, over a period of about three months, while he was making a change in his plans and place of work.

Mrs. X was alone with the children at their home in Connecticut during these periods and was unhappy about it. Bobby was nine months old when the family made the move to a town north of Boston. Mrs. X said that the baby was crying a good deal at the time and that she felt his father over-indulged him and was too close to him. Mr. X she said, spent a lot of time with the baby which she thought was not necessary and was in fact harmful. When Mr. X was not around Bobby's mother described his crying as hysterical in nature and increased.

In January 1958 the parents took Bobby - twenty five months old - to Massachusetts General Hospital where he stayed for nine days for observation and evaluation. His diagnosis on admission was for: Failure to gain any weight for about one year. Mrs. X described Bobby as drawing his legs up to his chin and crying for hours. She again gave a history of Bobby's father being too close to the boy. The total marriage problems were many at that time. The hospital saw the mother as acting out the baby's problems. She said she thought the baby was normal at first, but less so as time went on. During the year of no weight gain Bobby had eating problems and continued to scream. The eating problems were described as eating none or poorly. The family had had a doctor see the baby at one time and thought he seemed a little better afterwards with the medication prescribed. (Trophite - Vitamin B concentrate)

Things were not comfortable or happy for Bobby during

the next two years. He continued to have hysterical crying periods until he was placed in the nursery clinic in the spring of 1960. Bobby's nutrition improved, he learned to walk and run but Mrs. X was not able to toilet-train him, and though he became very active and developed excellent coordination, he did not attempt to speak. He played with small cars and toys, slept poorly, pinched and constantly wanted to be near his mother. Bobby uttered many sounds in play and developed a shrill call and other tones but did not make an attempt to speak. When the maternal grandmother visited the family Bobby became very upset and cried.

Psychiatric help has been recommended for Mrs. X because of her repeated and constant crisis episodes which show in the child. She has admittedly had many periods of anger that are not temporary but are deep and lasting. The caseworker had many conferences with Mrs. X in an attempt to talk out her problems so that she in turn would understand herself better and could establish a more satisfactory relationship with Bobby. The case worker states she occasionally found Mrs. X responding, but feels it is a case for more extensive help. Mrs. X has stated she feels everyone dislikes her and that she has felt strong and deep feelings against the boy and herself. She feels other mothers with retarded children dislike her and was overwhelmed by the attention they gave her during a recent hospitalization. The cards, visits and offers to help her and her family were quite

beyond her expectancies and understanding. "Mrs. X has been diagnosed as a Borderline Personality with Paranoid components. Bobby has been diagnosed as a Typical case of Separation Anxiety with Maternal Deprivation."³ How much is emotional and how much is retardation for Bobby, and what the relation of the retardation has to the continual emotional upheavals remains to be worked out. One psychological testing estimated that Bobby may turn out to be of low normal intelligence. Mr. X is resistive to having Mrs. X visit a psychiatrist because of the expense involved, and failure of enough help when Mrs. X was in therapy before Bobby's birth.

Some Evaluation of Mother and Child

Since Bobby's entrance into the nursery clinic he has shown many ways that he is able to make adjustments to people, peers and routines. After the first week he was fully toilet-trained for school where he had not previously been able to discard the diapers, but while he is in the home situation he is still having trouble with wetting. There have been no crying episodes since the beginning of his nursery experiences, and he has some episodes of independence at home as well as in the nursery-clinic. The poor sleeping habits that had previously been reported have improved considerably. The family is aware that his hearing is all right and that he does hear

³Caseworker, Ibid.

them speak to him, which does lead to the possibility that the inattention may be a mechanism he has found helpful in gaining the attention he can't get in some other way. He has continued to make sounds of play at home but Mrs. X says Bobby does not make attempts to talk to the family.

Mrs. X could be said to be doing less well than had been hoped for with the guidance of the health team. She has been advised as part of the therapy (hers and Bobby's) to spend an hour or two with the boy during the afternoons after nursery school, when he and she can play together and plan some simple activity that he has chosen as an individual expression of his interests, or perhaps take a walk to some place or to see something that can be planned for him alone, with a focus as simple as an ice cream cone, where there is a decision to make as to a color or flavor of the cream. Mrs. X reported that she did this on several occasions and the play trips were apparently enjoyed by the child, but that she found she could not keep them up and bring herself to repeatedly enter into these relationships with Bobby, so now after nursery school she gives him his lunch and usually puts him in his own room for two hours with the door closed.

Mrs. X recognizes the marked improvement in Bobby since he has entered the Wakefield nursery clinic, but still does not have insight enough to recognize the problem as being one in which she is so fundamentally involved. She stated that if any influence outside of the home like the clinic

shows it can do so much for a child, then putting him into some place full-time would be better for him, so she does not want to try to keep him at home, but does instead continually try to justify Bobby's retardation by talking about his inadequacies and placing the emphasis on the negative rather than the positive factors. Mrs. X has initiated the idea and has made application for Bobby to enter a home in another part of the state in the fall when he is between six and seven years old, and to remain until he is in his teen years. The agency administered by the Catholic church is rather expensive and individual in approach to a child's needs, in that it can assign a nun to a child to act as an individual figure to him during his stay there. This solution for this particular case is seen by team members to be a possibility for helping Bobby to gain some stability and to catch up if possible in some of his developmental tasks. During the year that Bobby must wait for admission to the catholic home he will probably continue to attend the nursery-clinic for retarded children in Wakefield, where he can continue to receive therapy with a fairly stable group and where his mother can continue to have counseling with the clinic caseworker.

Caseworker's Summary

The objectives of the caseworker have been to:

1. Support and strengthen the client, (Mrs. X.)
2. Develop ability of client to manage her family,
3. Develop client's ability to gain satisfaction out

of life for herself,

4. Encourage reality testing,
5. Build defenses (against falling apart),
6. Build on her own self-esteem - realistically,
7. Give support in limiting community activity,
8. Support feminine identity through personal body and clothing attention and pleasurable activities with her family,
9. Recommend a final goal. (Catholic family service for regular counseling)⁴

The observation guide that was set up and is included in this study to show the actual product for evaluation, with the all or none recording has much to be desired, but was the totally individual tool that was built around this boy and the activities described with the children in his group. (Page 48)

There were days when the author was associated with Bobby that his activity indicated tensions, desire to communicate, considerable attention-seeking activity, worry, non-verbal communication beyond casual interpretation, insecurity and other behavior symptoms that seemed to indicate situations beyond the immediate horizons of the understandings of the observer, and theorized by the writer that the answers might be found in the family relationships of the child, if the total family picture could be shared for professional

⁴Caseworker, Ibid.

MONTHLY RECORDINGS OF OBSERVED BEHAVIORS

I Attitudes (General)

- Cheerful (smiling-receptive of adults)
- Sullen
- Excitable-easily and frequently active
- Solemn
- Withdrawn & Searching (partly)

Break with home

- Brings own toys daily
- Clutches own toys continuously
- Can release " sometimes
- Can " " continually
- Can leave " at home
- Forced to come to school
- Comes willingly (apparently)

Attitude toward going home

- Eager to join parent and leave
- Holds back

	1960							1961							
	Sept	Oct	Oct	Nov	Nov	Dec	Dec	Feb	Feb	Mar	Mar	Apr	Apr	May	May
Cheerful (smiling-receptive of adults)					x	x	x			x	x	x	x	x	
Sullen															
Excitable-easily and frequently active	x	x		x		x	x	x		x	x	x			x
Solemn	x	x	x	x				x							x
Withdrawn & Searching (partly)		x	x	x											x
<u>Break with home</u>															
Brings own toys daily	x	x	x	x			x		x		x				
Clutches own toys continuously	x	x	x	x			x		x		x				
Can release " sometimes						x	x	x							x
Can " " continually								x	x	x					x
Can leave " at home								x		x		x	x	x	x
Forced to come to school															
Comes willingly (apparently)	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
<u>Attitude toward going home</u>															
Eager to join parent and leave		x	x	x	x	x	x	x	x	x	x	x	x	x	x
Holds back															

II Activities (General)

- Dashes and Darts
- Controlled with command
- Excessive (continuous)
- Pinching
- Relaxed (part of the time)
- Unable to relax
- Scratches
- Snatches(toys, etc. - no cause)
- Clutches toys continuously
- Shrill cries of excitement
- Attempts all activities - none finished

Takes direction (in play or activity)

- Never
- Occasionally
- Increasing understanding of direction

Dashes and Darts	x	x	x	x	x	x	x	x		x	x				
Controlled with command								x	x			x	x	x	x
Excessive (continuous)	x	x	x	x	x	x	x		x	x	x	x			x
Pinching	x	x	x	x	x	x	x	x		x				x	x
Relaxed (part of the time)								x						x	x
Unable to relax	x	x	x	x	x	x	x	x		x	x			x	
Scratches	x	x	x		x	x	x	x		x				x	x
Snatches(toys, etc. - no cause)	x	x	x	x		x	x				x	x			x
Clutches toys continuously	x	x	x	x			x		x		x				x
Shrill cries of excitement	x	x				x	x	x		x					
Attempts all activities - none finished	x	x	x	x	x	x	x	x		x	x			x	x
<u>Takes direction (in play or activity)</u>															
Never	x	x	x	x	x										
Occasionally							x	x		x	x	x	x	x	x
Increasing understanding of direction								x	x	x	x	x	x	x	x

III Use of Play Materials

Free Play (moving toys)

- Dolly stool
- Rocking horse
- " boat
- Trucks
- Tricycle

Dolly stool					x	x	x	x	x		x				x	x
Rocking horse	x	x					x	x				x				
" boat		x		x					x		x					
Trucks	x	x					x				x	x		x	x	x
Tricycle								x	x							x

x indicates the activity described, was observed.

Imaginative (makes believe)Other MaterialsBlocks

Played well with adult

Throws

Builds and top les

Destroys others efforts

Bench

Hammers nails

Joins blocks (with help)

Enjoys individual attention

Rejects other children

Shares with other children

Combative with other children

Peg board - arranges pegs (partly)

Form board puzzles

Finger Paints

Free movement

Unrelaxed

Play - out of doors

Excited

Shares with others

Sandbox

Digs & repetitive pail filling

Throws sand at others

Fights for equipment

Short, repeated sand play

Swings

Shares

Possessive (excessively)

Enjoys

Large ball

With other children

With adults

TricycleWagon

Shares

Possessive (fights for)

Slide

Enjoys

Mild interest

	1960						1961							
	Sept	Oct	Oct	Nov	Nov	Dec	Feb	Feb	Mar	Mar	Apr	Apr	May	May
<u>Imaginative</u> (makes believe)											x	x	x	x
<u>Other Materials</u>														
<u>Blocks</u>														
Played well with adult											x	x	x	x
Throws		x	x			x x	x							x
Builds and top les			x			x x		x			x			
Destroys others efforts	x	x	x			x x	x		x	x		x	x	
<u>Bench</u>														
Hammers nails							x	x	x	x	x	x		
Joins blocks (with help)											x		x	
Enjoys individual attention							x	x			x	x	x	
Rejects other children						x x x	x	x	x		x	x		
Shares with other children											x		x	
Combative with other children						x x x x								
<u>Peg board</u> - arranges pegs (partly)							x	x			x	x	x	
Form board puzzles								x			x			
<u>Finger Paints</u>														
Free movement											x			
Unrelaxed														
<u>Play - out of doors</u>														
Excited	x	x								/	x			x
Shares with others												x	x	x
<u>Sandbox</u>	x	x	x									x	x	x
Digs & repetitive pail filling			x									x	x	x
Throws sand at others	x	x	x											
Fights for equipment	x		x										x	
Short, repeated sand play	x	x	x										x	x
<u>Swings</u>														
Shares													x	x
Possessive (excessively)						x								
Enjoys						x							x	x
<u>Large ball</u>	x	y	y			x							x	x
With other children													x	x
With adults	x	x	x			x							x	x
<u>Tricycle</u>						x							x	
<u>Wagon</u>						x							x	x
Shares														
Possessive (fights for)						x							x	x
<u>Slide</u>														
Enjoys													x	x
Mild interest														

IV Habits of Daily LivingJuice time (juice and crackers)

Eager to join group

Molests others

Orderly (average)

Neat

Untidy

Says "grace" (partially)

Says "please"

Says "thank you"

Ired and solemn

Ate well

Toileting

Diapers

Training pants

Needs help in toilet

Self help

Modest

Exhibitionistic

Tension - grabs clothes

No sex awareness

Wets

Resting

Accepts opportunity

Dawdles

Resists (completely)

Restless

Rolls

Crawls

Noisy

Special attention

Teacher sits with

Takes out of room

Dressing

Removes & hangs up coat, hat, etc.

Puts on coat, hat, etc.

Partly independent

Indifferent - dependent

Requests help

	1960							1961						
	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	
Eager to join group		X							X	X			X	X
Molests others	X	X		X	X	X	X		X				X	
Orderly (average)		X							X	X	X	X	X	X
Neat		X								X	X	X	X	X
Untidy			X	X		X	X							
Says "grace" (partially)									X	X	X	X	X	X
Says "please"									X	X	X	X	X	X
Says "thank you"									X	X	X	X	X	X
Ired and solemn	X	X		X	X	X								
Ate well		X		X	X	X	X		X	X	X	X	X	X
Diapers		X												
Training pants		X	X	X	X	X	X		X	X	X	X	X	X
Needs help in toilet		X	X	X	X	X	X		X	X				
Self help										X	X	X	X	X
Modest		X	X	X	X	X	X		X	X	X	X	X	X
Exhibitionistic														
Tension - grabs clothes	X	X	X		X	X	X		X	X			X	
No sex awareness	X	X	X	X	X	X	X		X	X	X	X	X	X
Wets														
Accepts opportunity										X		X	X	
Dawdles	X	X	X	X	X	X			X	X				X
Resists (completely)														X
Restless	X	X	X	X	X	X	X		X	X	X	X	X	X
Rolls	X	X	X	X		X	X		X		X	X	X	X
Crawls	X					X	X		X	X	X	X	X	X
Noisy			X	X	X	X	X		X	X				X
Special attention														
Teacher sits with	X	X	X		X	X	X		X	X	X	X	X	X
Takes out of room		X	X		X	X			X	X			X	
Removes & hangs up coat, hat, etc.							X	X	X	X	X	X	X	X
Puts on coat, hat, etc.					X	X			X	X	X	X	X	X
Partly independent									X	X	X	X	X	X
Indifferent - dependent	X	X	X	X	X									
Requests help									X	X	X	X	X	X

reasons with the people working directly with Bobby. Frustrations of workers that arise from incomplete understanding can lessen the child's opportunity for the right care at the right moment, and could be somewhat overcome if orientation in the broad sense for the participants engaged in the care of the children was supplied. Cohen has said in relation to interpretation of behavior:

The next question we ask of his behavior is WHY? Why does he do as he does? Is it because he "spoiled"? Is it because of a loving or rejecting mother, brother, or sister? Is it because he feels inadequate, overconfident? . . . We work with the child, and do things for and with him. It is impossible not to form conclusions as to the causes of his behavior.

Whether we are right or wrong can make all the difference in the world to a child's growth and happiness. It is dangerous to interpret incorrectly. Any interpretation at all not only must be tentative and subject to change if new facts emerge, but must relate to a background of information which is indispensable. . . . The same behavior can mean different things in different children. Children hit out of anger, fear, resentment, jealousy, panic, and defiance. They can withdraw into silence out of anger, fear, resentment, jealousy, panic and defiance.⁵

After Bobby's behavior was recorded on the observation guide for several months there was evidence of a general up-trend in some areas and no appreciable change in others. Some activities that were observed in the early months were completely lacking later, while others that were not present

⁵Dorothy H. Cohen and Virginia Stern, Observing and Recording the Behavior of Young Children (New York: Bureau of Publication, Columbia University, 1958), p. 82-83.

at first made their appearance and became a part of the record each time an entry was made. Inconsistent appearance and disappearance of some activities seemed to bear out the ideas of Smith⁶, that characteristics that are developed and those that are suppressed depend in a large part on the social and cultural group into which the individual is born. Behavior is molded by adjustive response to the external, internal and social environment, and the person he develops into - his pattern of adjustment, his personality - is partly a product of society, but in order to give a name to an emotional pattern of a young child, it is important to see the whole situation that stimulated it. The graph showed recordings on some days where there were an accumulation of more negative reactions than previously, and responses that had not shown strongly for several weeks were evident again. The observer felt that to understand and to adequately cope with the child's depth of feelings the home would have to be explored more thoroughly.

When Bobby had not pinched or scratched his peers and adults for four to six weeks, and then began again, when at the same time tenseness, clutching and grabbing of toys were increased, and there was an increase in aimless activity, when shrill cries and rejection by other children occurred and was maintained for several days at a time, there was apt to be

⁶Karl U. Smith and William Smith, The Behavior of Man (New York: Henry Holt & Co., 1958), p. 52.

covert reasons of a serious nature, that are never to be considered as "naughty boy" activities of usual play, but expected at the preschool age to be the result of a mother-child origin. The Observation Guide helped to show that certain behavior occurred, but there is no way to show or measure the dimensions of feelings and understandings and interpersonal relationships on a graph that are part of the adjustment of the four to five year old, whether he is retarded or not.

Conferences with the caseworker provided a wealth of answers and suggested others. This author took five areas from the Observation Guide that to her seemed to be indicative of more activity and tension and less control for Bobby. The caseworker was asked to evaluate these episodes in terms of family relations at the time the tensions occurred. The collection of five observations and their interpretations are grouped and follow here.

October, 1960

Observed Behavior - Bobby's behavior was excessive activity, pinching of adults and peers, repeatedly and hurtfully, hitting peers, hiding, obvious tension and a searching attitude.

Caseworker's Interpretation - Some of this attitude was brought from home and was part of the reason why Bobby is considered mentally retarded and in need of the nursery-clinic guidance and further evaluation. Some of the activity was breaking-with-home and getting used to the new people and

situations and of course showed this more severely in that he is mentally much younger and emotionally not fully evaluated.

December 1960

Observed Behavior - At this time Bobby demonstrated behavior very similar to the previous episode by hitting other children more and often with an attitude of defiance, hiding, playing harder at everything, anxiety clutching of any toy he could take from or keep from some other child, and was less cooperative in many ways.

Caseworker's Interpretation - Bobby's mother had sought interviews at that time to discuss things that were bothering her. She was emotionally upset and disturbed about her status, her housing, her semi-devout religious attitude that was making conflicts in her family and in the church, and she felt she was having more to stand from Bobby. All of these feelings were obviously being reflected in her boy because she had felt tense enough about him to fear she would harm him bodily.

February 1961 (early)

Observed Behavior - Bobby was apparently carrying over some of his same confused behavior from the previous months. He was easily excited and noisy, active but aimless, and cooperating poorly. There were some very positive signs of saying more words, play with the peg boards, self-help attempts in dressing, acceptance of a reprimand. He seemed to be

trying very hard but lacked the quality of relaxation, and seemed to be in conflict.

Caseworker's Interpretation - Bobby's mother had sought a conference to discuss her unhappiness about her physical condition, tensions in the home, paranoid feelings about people. The general attitude was showing up in the child apparently.

March 1961 (late)

Observed Behavior - Easily excited, shrill and noisy just for the sake of attention apparently, scratching peers and adults again, aimless dashing and darting, interrupts others play, tumbles blocks, aggressive, hostile at times, bringing own toys to school again for several days. Bobby has maintained positive signs including more words and attempts to communicate more often, with verbal and nonverbal efforts combined.

Caseworker's Interpretation - Bobby's mother had sought a conference with the caseworker at this time. She was emotionally unstable, her problems were many, she feared she was pregnant. Bobby was again stimulated by his mother's problems and the immaturity with which she was handling them, and increased rejection of the boy while she thought of herself.

May 1961

Observed Behavior - Pinching after absence of this act

for a month, unrelaxed, snatching toys and any article another child wants, anxiety clutching of toys again until he hampers other activities, hitting, increased excitement and tension in all activities. Still maintains many positives, including play alone for short periods, and cooperative play with others for short periods. More new words added - children's names.

Caseworker's Interpretation - Bobby's mother had again been in conference by request. Her home had been less stable, she had many paranoid expressions, many tensions and anticipated an operation. She entered the hospital for major gynecological surgery. The father cared for Bobby during the mother's absence. The Child's world is completely disrupted by this and yet he is still unable to express himself and to talk things out with anyone, and they probably don't credit him with the ability to understand enough to try, or to explain to him what is happening.

The observer concluded from this general interpretation that the repeated crises that Bobby's mother creates and uses are more than enough to keep the boy emotionally unstable. This is one of the kinds of mother deprivation described by Bowlby⁷ and others, where the parent is in the home and yet willfully withholds the love and attention the child needs.

⁷John Bowlby, Child Care and the Growth of Love, (New York: Penguin Books 1953), p. 30.

Benedek⁸ has stated that the family is a closely knit organism, that thrives best when emotional currents are in dynamic equilibrium, which is not shown in any contacts observed with Bobby's family this year. Our society assumes that all parents accept their children through love and to hate your child, or not to want him, is inhuman. Mother rejection therefore is apt to be disguised as in Bobby's case to the average person who observes he is well dressed, is physically cared for, and his mother is seen with him frequently when she is taking him to and from school, but that she is denying him wholehearted acceptance and affection would be hard to believe.⁹

Bobby is apparently finding a positive influence in the school that may stay with him if he is but given a chance for some carryover and an opportunity to practice it. The child always comes to school willingly, he is showing a slow but what seems to be a definite progress toward socialization that he can maintain even in times of stress and emotional upheavals in the home.

The family case history included in this study was examined for clues to Bobby's behavior and for the deep-seated causes of his emotional disturbance including his inability to

⁸Therese Benedek, "Psychological Aspects of Pregnancy and Parent-Child Relationships," Emotional Problems of Childhood, ed. Samuel Liebman, (Philadelphia: J.B. Lippincott 1958)

⁹William Martin and Cella Burns Stendler, Child Behavior and Development, (New York: Harcourt, Brace and Co, 1959), p. 321.

speaking, which seemed to be one of the biggest obstacles in the way of Bobby's socialization. Since December as evidenced on the graph, Bobby had begun to actually say single words as "car" - "no" - "come" - "stop" - "Hi" and most of the children's names. At juice time "thank you" and "please" were learned without too much effort, and with the repeated reward of "Good Boy" and of course the cup of cool juice and a cookie. This at five years was the beginning expectancy of language for about one and a half to two years old. It has been said that speaking is the most personal thing we can do, in that it reveals feelings of acceptance and rejection, of personal worth, adequacy and inadequacy, security and emotional states. Speech does not usually take place in isolation, so the failure to speak could be partly due to deep psychosocial character problems.⁶ This author asks; Has Bobby been rejected to the point that he cannot bring himself to speak? What leads a mother to reject her child and what effect does maternal deprivation have on the child, and how can the difficulties that have resulted from rejection be remedied?

Bobby's mother admits rejection of him to a rather marked degree starting before he was born, when she vomited for nine months and was under psychiatric treatment. Before Bobby was a year old she was rejecting him and his father's

⁶Margaret Hall Powers, "Management of Speech Disorders and Resultant Learning Difficulties", Emotional Problems of Childhood, ed. Samuel Liebman, (Philadelphia: J. B. Lippincott 1958), p. 35-51.

efforts and his close attachment to the baby and interpreted the father's attention as harmful to the baby. She allowed Bobby to cry for excessively long periods until he was hysterical. He failed to eat well or gain weight for more than a year during the time he was allowed to cry and eventually had to have a hospital admission at two years of age for evaluation of the situation. Mrs. X was not able to toilet-train her child later or to help him to establish a sleep routine. These have both been accomplished fairly satisfactorily since attending the nursery clinic. Mrs. X was not able to induce her child to speak previous to the attendance at the clinic which leads one to ask, was this due to mental retardation or is the boy mentally retarded due to emotional disturbances that have been caused by mother deprivation and open rejection in many ways and day after day for years?

Mrs. X has been advised to follow the nursery clinic activities, where the stage has been set for Bobby for acceptance at some levels, with play trips each afternoon and complete focus of activities with him, with possibly holding him and making every effort to establish a relationship for him alone. After some effort Mrs. X stated to the caseworker that she could not continue, but does instead put him in his own room alone for two hours with the door closed, and has rejected him to the point of allowing herself thoughts of harm to Bobby and herself. Mrs. X asks for further help to complete her rejection of her boy by buying his way into a rather

expensive institution in another area where she anticipates several years of care that she will not have to cope with. This last example of rejection has been made since the apparent improvement and development in some ways has been evidenced through the help of the nursery-clinic. Bobby's hospital diagnosis within this year is: "Speech and Personality disturbance - all inclusive with moderate retardation, superimposed by his personality."¹¹

What leads a mother to reject a child to this point? What are Mrs. X's problems that they need to be continual influencing factors on the boy's life to this extent? Mrs. X has been diagnosed as immature, a borderline personality with paranoid components and as acting out the child's problems. She had psychotherapy before Bobby's birth and it is advised again. The other two siblings, who are girls have never had any history of rejection by the mother and in fact seem to have plans and direction of care that are most satisfactory. Mrs. X stated she was angry when her own father rejected her when she was fifteen years old, by suddenly dying at an early age. She has also stated she felt her mother rejected her and preferred Mrs. X's sister. She seems to lack insight into the problems of her husband, her son and herself.

The last part of the complex question asked by the writer of this case study is, how can the difficulties

¹¹Caseworker, op. cit.

resulting from rejection be remedied? Bobby's immediate problem of mother deprivation still exists, and the team approach of working with the child through his clinic attendance and frequent reevaluation by the team members, while his mother receives counseling, is but a beginning problem-solving approach. If Bobby is correctly evaluated, can he be salvaged now so he will have the opportunity of really reaching Low Normal level of development anticipated at this time? If Bobby develops to the educable level will he be successfully supported to develop enough emotional stability and maturity, and any or enough insight, to carry him through a productive manhood?

Allen¹² has said there are an increasing number of clinical reports of these cases that illustrate the seriousness of the barriers of emotional connections experienced between mother and child, while they are members of the same family setting. He calls it diluted motherhood and describes symptoms almost identical to Bobby's with the suggestion that although efforts are made for substitution of mothering and emotional nourishment, it is part of a vicious circle that might not fulfill a need but could cause the child to withdraw further to prevent more of the same — traumatic rejection.

¹²Frederick H. Allen, "Mother-Child Separation - Process or Event", Emotional Problems of Early Childhood, ed. Gerald Caplan, (New York: Basic Books Inc. 1958), p. 328-329.

Above and beyond an individual case, Bowlby¹³ has said that the proper care of children, who are maternally deprived, is essential or they will grow up to reproduce themselves, because they are a source of social infection. He sees the two problems of neglectful parents and deprived children as problems considered inevitable by the public with one of the main causes, a lack of the understanding of psychiatric factors that consequently are not managed. He states that social agencies and the public in general do not recognize that mother-love in infancy and childhood is as important for mental health as protein and vitamin supplements are for physical health. He urges the recognition of the relation of mental health to maternal care, by men and women all over the world.

The Teacher's Record

The last tool used for gathering data is the Teacher's Record. (See Appendix) There are three parts to it, one in the form of a ten week record that gives initial information about Bobby. The actual facts were very similar to the student's observations, which supported the student although all records were developed and followed separately. The additional information gathered directly from the mother was concerned with the types of toys Bobby played with at home, his responses to his

¹³Bowlby, op. cit., p. 181-182.

mother and her bid for team members to believe she was affectionate to the child. The nursery school teacher implies that she does not believe in Mrs. X, but evaluates Bobby's problem as one of retardation and emotional components. The second report at twenty-five weeks followed in very much the same vein as the author's observations, by recognizing changes in behavior in positive and negative ways. It relates that activities were changed by the team in the month of January, to give Bobby more relation to individual opportunity and personal contacts with one person.

The nursery school clinic has become a mother and home substitute for Bobby in a limited way, as it attempts to supply a receptive climate for his activities, internal, external and social. The setting designed around objects, activities and attitudes that provides the child with, and accepts him for, what he is, what he does and what he wants at the moment, is meeting more than diagnostic needs for evaluative techniques and direction. This laboratory school is providing a therapeutic field, where Bobby can come from days or weeks of frustrating rejection in his home, and find companions of his own age with similar limitations, to test himself against and grow with, and adult mother-substitutes (teachers) to replace momentarily for his mother, and who through their studied approach, invites - loves- teaches - limits - releases and readmits into a climate he can accept and hopefully provides the nucleus of feeling, acting and

thinking that will help him to form new and lasting patterns of childhood, be they ever so meager in relation to what he should have.

CHAPTER V

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Summary

The purpose of this study has been to explore what learning experiences are available to the graduate nurse student through a nursery clinic for retarded children, that might contribute to the knowledge and better understanding of Maternal and Child Health problems.

The role of participant-observer was assumed by the graduate nurse student in the nursery clinic setting, with eight retarded boys and girls between the ages of four to six years old that soon increased to nine in number. The characteristics of the setting and its routines for the preschool child, the diagnoses, abilities and some of the needs of the children, a partial look at the mothers of the group, the evaluation and contributions of the teachers and a self-evaluation of the graduate nurse student in the setting occupied the hours from nine to twelve for four mornings a week for the first six weeks. At the end of that time the writer made the choice of one child for detailed study, by the evaluation of all of the children, as to their length of stay in the school, the kinds of responses of which they seemed capable, the graduate nurse's opportunity for interaction with the children and their response to her, the

anticipated direction of the children, and the writer's evaluation of the child's potentiality to show a measurable change in the preliminary period.

Anecdotal notes that were kept the first weeks on all children were evaluated and reorganized to form the categories and subheadings that described the activities that the child was to be observed for, at bimonthly periods for the months ahead, which included the periods from September through December and February through May.

The patterns of Bobby's behavior that were recorded on the inanimate graph were interesting and were found to be helpful to the memory of the author, but the instrument was cold and non-predicting and lacked the properties for recording the dimensions of feeling, interacting and reflecting that the student was experiencing with the child. This pointed to the need of a human element - discussion - through conferences with a key team member - the case worker - who could bridge the gap between the participant-observer and a closer look and understanding of the child's family and their many needs, that a nurse becomes so vitally aware of in so many ways as she participates in the various functions in the fields of nursing. Conferences were arranged on an experienced professional level, that became dynamic sources of help and understanding for the graduate nursing student. A case history was obtained of the child and his family that was being explored, and many insightful understandings evolved through the direct and realistic approach of sharing a psycho-sociologic study by the author with the actual factors of the case under discussion.

which led the author to considerable reformulation and redirection, which further emphasized the broad contributions and deeper understandings that go to make up an interesting total experience in the study of human behavior.

Conclusions

The results of the total data that was evaluated and the concepts that grew out of the study were many, and some of the understanding ones are recorded here.

1. The nursery clinic for retarded children is a valuable human relations laboratory for a graduate nurse student's field experience.

2. The role of participant-observer is an excellent position for the graduate nurse student to take in working through problems of adjustment and evaluation, in that it can provide a close proximity to the actual and possible problems of the pupils, their families and the team members.

3. The pre-school child of three to six years is a valuable element of the community's population, to work with for increased knowledge and a better understanding of the causes of behavior at any age.

4. The retarded child of pre-school age can be observed as he gains in adjustment and socialization for better family and community living that identifies the process as a continuous one with each succeeding phase dependant for its success on the mastery of the previous one.

5. The evaluation and counseling of the retardate and

his family needs the purposeful understanding of team members of several disciplines that can play their roles to a fully developed capacity with the unique contribution of each part of the unified contribution of all, in their services to the families and the communities.

6. The true, detailed understanding of a child whether he is normal or not depends on identifying him with the family from which he comes, and not as an entity within himself.

7. There is a great need for the public and professions to have an increased understanding of the causes and effects of mental retardation so that prevention can be studied and practiced to a greater degree.

8. The case-study method is a very close and realistic way to study the total experiences in an agency for a problem like mental retardation. Only through the opportunity to study and appreciate all of the possible contacts of the lives of these families can the impact of feelings, empathy, studied compassion and need for guidance by various disciplines be appreciated.

Recommendations

The following recommendations are made in the light of the possibilities for enriching the learning experiences in a long term field placement such as that available in the nursery clinic for retarded preschool children.

It is recommended that:

1. The graduate nurse students continue to have long

term field placement in an agency which provides services for preschool retarded children.

2. Experiences be broadened to include planned contacts with related agencies during the semesters, to provide opportunities to gain a better appreciation of the inter-relatedness of work with other organizations, for evaluation, referral, research and follow-up needs in the care of the retarded.

3. Opportunities be studied for ways to share with the student the total appreciation of the direct impact of mental retardation on the family and the community, through the many natural contacts, organized team and/or parent meetings and individual family contacts in some instances.

4. The graduate nurse student be included as a team member on a professional basis with the opportunity to attend meetings and share experiences that evaluate the total setting and individual clinic cases.

5. The graduate nurse student, as a team member, be given opportunities from the first for planned individual conferences with the caseworker, in order to explore her questions and interests that may arise from work with children and families and the team.

6. The nursery school teacher arrange for planned conferences with the graduate student to interpret nursery school practices and anticipations and to explore mutually a total health understanding of the children and their families as it evolves through this specialized nursery clinic setting.

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APPENDIX

TEACHER'S RECORD
(Summary)

Initial Adjustment (10th week)

Bobby

Born 11/30/56

Entered 9/21/60

A. Physical Characteristics

Well proportioned, blue-eyed blond. Head seems a little large. Quick motions. Coordination.

B. Relationship to People

Sits close to adult at table or in morning circle. Stayed away from assistant at first, better now. Little attention to other parents. Does not relate to any child. Runs around by self.

C. Relationship to Materials

Loves activity dollie. Seldom selects another toy unless to take something from one of other children. Brings in bag of little cars and trucks which he guards zealously not wanting to share. Mother says he has many little cars he plays with. Knocks down towers of blocks built by others.

D. Reaction to Routine

Accepted fairly well. Occasionally runs from circle but will return. First week wore diapers. Second week training pants, cares for self in toilet. Manages juice glass. Moves around on mat during rest, not noisy.

E. Behavioral Patterns

Runs from one group to another. Takes toys from children not to play with but because someone else has them. If crossed by another child he pinches, pulls hair. Makes noises to attract attention. Anyone takes his toys he is frantic. When he is excited he makes sounds as though he is trying very hard to talk. When he is given something at the table he will stay there long after finishing until told to get up.

F. Parent Attitude

First day Bobby started to cry when mother left but was quickly over it. Very happy now when he comes in. Mother tells of going for walks with him and of how affectionate he is in giving the impression that she cares a great deal, but she sends

him to school in badly worn underwear or underwear which his sister has outgrown.

G. Comments

Bobby is emotionally disturbed as well as retarded which makes it difficult in the group. His mother says he has no speech but when we have looked at pictures, talked of animal sounds or during singing we have heard him say a few words.

TEACHER'S RECORD
(Summary)

Progress (25th week)

April 1, 1960

Bobby

5 years

A. Physical Ability

Same as initial report.

B. Mental Ability

Difficult to judge mental ability. Curious about everything another child has until he has taken it from them, and then it is just something to be carried around. No concentration at times. Other times plays with pegs, puzzles, for a long time. Shows no imagination. Learned some songs, a little speech which shows throughout activities. Talks with assistant in single words she can understand.

C. Use of Materials

Does not want to sit still long or listen to story. Enjoys records but jumps up and runs across room. Loves activity dolly and Ride 'em Horse. Excellent hand and eye control with hammer at work bench.

D. Social Responses

At first slapped, pulled hair, pinched, taking toys from others. Very disturbing. Many days played by himself with assistant in small room. Still, small room play alone, for short time. Able to stay with group all morning. Still takes toys but usually just to hold in hand as he rides dollie. No pinching, slapping for sometime. Frantic if child takes something from him.

E. Behavior Patterns

Angry if child takes something. Shows happiness by facial expression. Often noisy in morning circle. Will sit still for one or two songs and then start to yell. Days when he yells most of the time. Not anger or fear, just noise. Question of attention getting because he usually is taken out of the room. Activity alone is continuance of previous but he is then very quiet. Lots of noise lately due to conditions at home probably. First, mother away in hospital, father away on business, father and mother away for weekend.

Comments

Bobby is emotionally disturbed as well as retarded.

THE TEACHER'S RECORD (3)Behaviors, Interests and Activities (Summary)

The following summarization was made by this writer, of the record contributed by the Nursery Clinic teacher to the Division of Mental Hygiene, on the recent form designed like a check list with items of lengthy and accumulative suggestions.

Bobby X _____ Sex M Age: 5 yrs. 6 mo.

Entered September, 1960.

Attendance Regular

Previous nursery school Yes

<u>Appearance</u>	Normal, no grimaces, never drools
<u>Clothing</u>	Good outer wear Worn, soiled, old underwear
<u>Movements</u>	Well coordinated, right handed
<u>Toileting</u>	Rare accidents, able to help self
<u>Manners</u>	Acceptable
<u>Speech</u>	Simple, single words, no stuttering, no echoing or mirrored speech
<u>Attention</u>	Takes simple directions
<u>Interest in Play materials</u>	Certain ones are used alone after suggestion. Lone and group play sustained with simple materials, self initiated. Does not attempt pegboard, puzzles or formboards.
<u>Interest in Toys and Activities</u>	Enthusiastic and curious, tackles various activities at variable levels

and gives impression of not fulfilling his capacities in some areas.

Friendly and variable, relates to some children.

Takes part in some activities, but is rather independent of others. Invites attacks, looks out for interests and defends playthings. Copes with minor stress without breakdown. Some concern of self.

Negativistic behavior, contrary, wants to do opposite things.

Hyperactive, showing noisy, destructive and often aimless behavior. He moves around the room, moving from one activity to the next after a few seconds, and may interrupt other children's play.

No tears, parts easily from mother to join group, not affectionate, makes no repetitive gestures, is not shy and clinging.

Behavior at school similar to that at home as far as is known, except a toilet problem at home.

Appears happy and joyful most of the time. "Good" and "bad" days, or usually shows little emotion.

Compared with other members of this nursery group, this child has shown the following:

<u>Motor skills</u>	little progress
<u>Self help</u>	good progress
<u>Speech</u>	little progress
<u>Sociability</u>	Little progress
<u>Individual play</u>	good progress
<u>Concentration in the circle</u>	little progress

Ability of child outstanding for him

Skill with certain types of material (work bench)

Performance especially incompetent

Fluent-connected speech

What type of nursery school do you think child should go to after nursery school?

Trainable or sub-special class

Educable or Special class

Class of Emotionally disturbed.