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The Importance of Family Interactions with Institutionalized Disabled Individuals

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In this paper I tried to prove the importance of family interaction with institutionalized profound retarded individual. Not only for the institutionalized person but also to his family.

The purpose behind this paper is that I'm planning to work with families who have retarded children in my country - Saudia Arabia - because I feel that they are really in need of someone to help them to cope with their situation. And I would love to be that person.

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I. Introduction

There are several models or types of family organizations.

1. The nuclear family which consists of a mother, a father, and children.
2. The extended family, which consists of the mother, father, children, grandparents, uncles, aunts and so on.
3. The blended family which consists of the husband, wife, and children from previous marriages of the wives, or the husbands, or both.
4. The common law family which consists of men, women and possibly children living together as a family, although the former two have not gone through formal legal marriage ceremony.
5. The single-parent family which consists of a household led by one parent (man or woman) possibly due to divorce, death, desertion or to never having married.
6. The commune family which consists of men, women, and children living together, sharing rights and responsibilities, and collectively owning and/or using property, sometimes abandoning traditional monogamous marriages.

7. The serial family which consists of a man or woman who has a succession of marriages, thus acquiring several spouses and different families over a lifetime but one nuclear family at a time.
8. The composite family which consists of a form of polygamous marriage in which two or more nuclear families share a common husband (polygyny) or wife (polyandry), the former being more prevalent.
9. The cohabitation which consists of a more or less permanent relationship between two unmarried persons of the opposite sex who share a nonlegally binding living arrangement.

The traditional family type in America was the nuclear family. Nowadays, we can't find as many nuclear families as there were in the past. There are two basic reasons for this change: (1) The low rates of birth, (2) parenting without marriage, however, the major reason for changing family types is divorce (Golednberg, 1980). Blended families have become common because divorced people remarry, and the children from the previous marriages of each are blended into one family. Also stepparenting has escalated. The occurrance of extended families, made up of ex-husbands or ex-wives, new husbands or new wives and assorted grandparents, etc.

The traditional family type in Saudia Arabia and in the Middle East in general is the extended family. Also, because of many reasons such as education, travel, and western influence, one can find a lot of nuclear families.

The nuclear unit imposes on family life certain disadvantages and special burdens. For example, in the isolated nuclear family the personality of the parents are more crucial than in the extended family, this is true because each parent must function as a model for the child of the same sex. In extended family systems, alternate models and sometimes more wholesome ones than more those of the progenitors are readily and continuously available to offspring. Industrialization, together with child labor laws, have rendered offspring and grandparents economic liabilities, in contrast to earlier generations when both were more likely assets, especially on the farm. (Erikson, 1972)

There are two important and basic divisions governing family structure and dynamics that must be understood. First, the generation boundary which divides the group into parents who nurture, lead, direct, and teach and offspring who are dependent and follow and learn. Second, is that of the two sexes, the family being the environment where son learns to be boy and man, and daughters learn to

be girls and women. Of course behavior is influenced from outside the family, especially by peers in adolescence. According to Fleck, Erikson (1972), maintaining these two boundaries is the most important task of family life, a task accomplished more by example and nonverbal cues than explicitly.

II. The study of the family

1. Parental Coalition; there are two functions that are very important in parental coalition. First, mutual reinforcements; the wife and the husband represent respectively, culture determination, masculinity and femininity, not only as individuals but also through their support of each other. Second, the conjugal role divisions and reciprocities the wife and the husband establish for themselves.

The coalition must serve the establishment of triangular relationship when children are born. Those triangulars must be flexible. A child first must be very close to the mother and take a great deal of her attention and energy. When another child comes, the older child must give up this primary closeness with his mother and learn to tolerate his replacement by a younger sibling. Not only the family must change when a new born comes to the life but they also must change with the age of the family group. The family as a whole influences and affects their number individually and each member influence can affect the whole family.

2. Nurturant tasks; The mother can perform adequately only if supported tangibly and emotionally by her husband. Even if he is facing absence or death, the knowledge of his approval of the mother and her mothering behavior is

important. I remember that when my aunt's husband died, she lived on her own with her four sons, working days and nights to have money to send them to good respectable schools because she knew that would have been what her husband would have desired for his children. Because she did what she did, today her children are doctors and one is an engineer.

Nurturance encompasses more importance than food especially the establishment of basic trust.

According to Fleck (Erikson, 1972) the early nurturance of the child includes helping him learn how to manage and control his body, providing him with appropriate experiences and learning opportunities. There are many things that are part of nurturance such as social adjustment, education capacities and weaning. If the child is separated from his mother or sometimes the father without losing faith and trust in the continuity of the relationship and in the ultimate restoration of good feeling and a sense of security, he will through the separation experience learn and grow; and he becomes more able to avoid being far from others emotionally.

> "This mastery must be facilitated by the opportunity to observe, imitate, and eventually internalize how other family members cope with frustration and this kind of separation anxiety." (Erikson, 1977) P. 107)

3. Enculturation of the younger generation; any clear line between nurturant and enculturation task is absolute because according to Erikson:

> "these family functions are continuous and overlap, but the passage of the oedipal phase may be considered the turning from predominantly nurturant issues to enculturating ones." (Erikson, 1972, p. 107)

Now in this point the child should have acquired communicative competence and accepted the incest taboo in the sense of feeling comfortable in his de-eroticized relationship to each parent. Then the child begins to learn and increase his investment into peer relationships. Giving the child the opportunity to experience the world by himself as much as he can is very important. They must allow him to get the social skills that he needs by examples rather than explicitly. For example, they don't ask him to be friendly with other people and they are not friendly with their neighbors. The younger generation's formal education and emotional development depend on insturmentally and relationally valid verbal and nonverbal communication.

4. Emancipation of offspring from the family is an evolutionary task in a nuclear family system and culture. Emancipation must occur physically, geographically, psychologically and socially. This final separation cannot be sudden. There are many steps that each child should

pass through. Among such steps are school entrance, camp or other living-away from home experiences. Everyone needs to be independent but at the same time to be guided by others in certain ways.

5. Family crisis; coping with crisis is an important standard of family and individual mental health. The important thing here is does the family accept the situation and cope with it and how they face it as a group and as individuals.

Family disturbances:

1. Inborn defects in a child, whether inherited or not, have serious implications for the entire family which may distort structure and dynamics to a pathological degree. Family life may become centered around the parents guilt or shame and other maladaptive mechanisms. A shamed defect can dominate family life.

2. Understanding the deviant parental personalities is especially germane to the approach of family pathology which does not exclude organic defects or illness in a parent, but they comprise also the entire range of neurotic, psychotic, or psychopathic abnormalities. However, their impact on family life and family task performance is not determined by the intrapersonal abnormality itself. Schizophrenic mothers can have children whose personalities

and adjustment may fall within range, and psychopathic alcoholic fathers need not produce offspring with like abnormalities. Symptoms and behavior are copied and incorporated by offspring, but until now nobody knows how frequently. (Erikson, 1972)

> "The neurotic and psychopathic traits, especially conversion mechanisms, are transmitted more frequently than psychotic processes but investigations of trait - specific and mechanism - specific intrafamilial transmission are very much needed.....Young psychopaths often act overt and covert wishes of parents who themselves may not misbehave grossly." (Erikson, 1972. p. 111)

There was also found a high incidence of occupation of public relations type among the fathers of a small series of young upper class delinquents.

Parental personality patterns determine the character of the parental coalition or lack thereof. In schismatic family, a family with a parent of young schizophrenics, especially the mother, the children have to join one of the parents. The coalition here is a negative one. One of the major problems for the children in such a family is that each of the parents tries hard to devalue the other, making it difficult for the child to want to be like either of them or to appreciate the parent of the opposite sex as the prototype of a desirable love object. Of course that

will interfere with the development of a clear sexual identity and maturation toward heterosexual orientation. Besides homosexual proclivities and incestuous problems.

Another form of defective coalition occurs when one or both spouses remain attached to and involved with their families of origin which means that any decision will be made outside the primary family. This situation can compound a schismatic marriage but is also occurs apart from it.

Another distortion of the parental coalition has been described as skewed. This condition is rooted in severe psychopathology of at least one spouse, but the other who is usually aware of the severe abnormalities of his or her partner gives in and plays a negative role to preserve the marriage. Only a passive person could tolerate such a mode of adjustment.

All these coalition deviations and other difficulties can result in divorce or desertion.

3. Nurturance which can be defective because the husband either fails to support or actively interferes with the mother's tending to the infant. Some mothers of schizophrenics were found to have been too anxious and obsessively indecisive to function as normal mothers.

Pathology on the level of parental personality can of

course, have serious consequences in itself, and because parents with deviant personalities are apt to effect family patterns, the nurturant disfunction rarely stands out as a single pathologic or pathogenic item.

4. Parental expectations of offspring with respect to enculturation may be overly severe, stringent, and even unrealistic. Depression also plays a causative role in family malfunction especially in the form of unresolved mourning. Learning how to mourn is a family task, although it is more common today that a family may have no death to mourn before the children reach the ages of their emancipation from their family of origin; yet the evolutionary crisis such as separations or sicknesses or accidents do occur, and the family modes of dealing with these may help to strengthen or to weaken family functioning or promote or hinder emotional growth in the individual members.

Normal or abnormal familial interaction depends on the parental personalities and the parental coalition, the children learn through this interaction or fail to learn how to interact with their environment at crucial stages of their development. There is ample evidence that if the parental interaction is starkly atypical of the culture of subculture surrounding them, the entire family suffers estrangement and children will be handicapped in their inter-

actions outside the family and can develop serious intra-personal conflicts of neurotic or psychotic proportions." (Erikson, 1972. p. 115)

III. Communications in the family

The most important learning instrument is communication. Verbal communication must fit the nonverbal interaction. Abnormal intrafamilial communication is not only promise to yield to further analysis and classification of family pathology either in itself or as an indication of thought disorders in individual family members.

Also cultural deviations between the generations may be an important factor to children's separation from parents and the parental home.

A human being is capable of communicating in two different styles, or languages. One, when a person communicates in a logical way. The other, when he expresses himself in the language of metaphor. When he is being logical his behavior can be described in a logical, scientific language. According to Haley (1976) there is one way to characterize the two different modes of human communication; it is in terms of digital and analogic communication.

> "Digital communication consists of that class of messages where each statement has a specific referent and only that referent. Something happens or it does not happen; there is one stimulus and one response. It is possible to make a computer classification of such communication because each message fits into a specific category. In this mode, behavior appears to be as logical as the object linguists would like it to be." (Haley, 1976. P. 83)

The other term Haley used is analogic communication.

> "Analogic communication appears when the message has multiple referent, in that it deals with the resemblances of one thing to another. It is a language in which each message refers to a context of other messages. .... There is no single message and single response but multiple stimuli and multiple responses, some of them fictional ... Analogic communication includes the "as if" categories; each message frames, or is about, other messages. The analog can be expressed in verbal statement as in a simile or verbal metaphor. It can also be expressed in action. A message in this style cannot be categorized without taking into account the context of other messages in which the message occurs." (Haley, 1976. P. 85)

> "Communication is generally understood to refer to nonverbal as well as verbal behavior within a social context. This communication can mean 'interaction' or 'transaction'; also includes all those symbols and clues used by persons in giving and receiving meaning" (Satir, 1964. p. 63)

Communication is a social interaction between two or more people in a specific social context. One of them must be the sender and the other or others is or are the receiver. The sender wants to influence the receiver by sending a message.

This communication between people must be clear if they want to get and give the information they want to know and what others want from them. Communication is very important to find out what is going on, what people are thinking of, also its important because it gives us a general idea about the nature of relationships between

people, and what kind of behavior will please or displease them, etc.

In general, we get the information we want by asking for verbal responses, or by observing nonverbal behavior. But we must be careful when we hear any word or use any word because the same word may have different meanings. Also we must notice that there are many experiences that cannot be described by words. According to Satir, there are four patterns of communication: placating, blaming, computing, and distracting. First, placating. The placator always talks in an ingratiating way, trying to please, apologizing, always agreeing no matter what. He will say yes to everything, no matter what he feels or thinks. He thinks of himself as being worth nothing. He is always wrong; and he will agree with any criticism made about him. His voice is whiny and squeaky because he keeps his body in a lowered position that he does not have enough air to keep a rich, full voice. Second, the blamer. The blamer is a boss, he acts superior and he almost disagrees with everything; and he blames others for everything that goes wrong. A blamer holds his breath altogether, because his throat muscles are so tight. Third, the computer. The computer is very correct, very reasonable with no resemblance of any feelings showing. He is calm,

cool, and collected. His voice is a dry monotone, and the words are likely to be abstract. He uses the longest words possible, even if he is not sure of their meanings. He will sound intelligent. He uses his hands a lot when he is talking. Finally, the distracting. The distracter, whatever he says or does is irrelevant to what anyone else is saying or doing. He never makes a response to the point. His voice goes up and down without reason because it is focused nowhere.

According to Dixon (1979) there are several factors that affect the communication between people. First, the specific life experience of the individual. Each human being's life is a continuity of experiences, and individual methods of communication reflect those experiences. Each word contains all the associations accumulated to data. So individuals from different cultures, subcultures, and even different neighborhoods will have different frames of reference and therefore different communication patterns.

A second factor is the social context in which the communication interaction takes place. Most people communicate differently in a formal setting than in an informal setting. For example, you use different language to express your anger in your house than in your office.

A third factor is the roles of those people who you

communicate with. For example, students generally communicate differently with their professors than with each other.

This factor leads to the fourth one, which is self-concept which means how the individuals see themselves and their own identities. It involves perception, real and imagined, personality, abilities and weaknesses. Most individuals communicate most of the time in ways that are consistent with their self-concepts. Self-concept influences a perception of others as well. The basis for perceiving others is directly related to how people perceive themselves.

A fifth factor is education. This factor can be very important when people who have different amounts or kinds of education are communicating, especially when the person with the greater education does not take this difference into consideration.

Finally, the previous experience with the same person. People who communicate frequently learn each other's habitual patterns, feelings, and preferences. When people are familiar with each other they can take shortcuts, and they can make assumptions about the responses of others. For example, if a student has a vast knowledge of his teacher's likes and dislikes, also his manners and per-

sonality, he may predict the style of questions the teacher is likely to ask.

Communication between members of family is very important. If each one is clear and knows what to say, and understands what is being said, trouble is avoided.

IV. Measurement of family dynamics

According to the concept of family homeostasis the family acts in a certain way to achieve a balance in relationships. Each member helps to maintain this balance overtly and covertly. But when their attempts are not really noticed they try harder to reach it.

Family therapists deal with family emotional pain. When one person in a family has pain, this pain is communicated to other family members. Many studies have shown that the family behave as if it were a single unit. Jackson in 1954 introduced the term (family "homeostasis") to refer to this behavior (Satir, 1964). In therapy with families it's important to include every member of the family. Many therapists wonder how to introduce children into family therapy because of many reasons: children have limited attention, interest, and patience. But if the therapist believes in the idea of including the child or the children in therapy, he will figure the way to deal with it.

"A growing body of clinical observation has pointed to the conclusion that family therapy must be oriented to the family as a whole", (Saire, 1964). Those observations led many individual-oriented psychiatrists and researchers to re-evaluate and question certain assumptions

such as:

A. They noted that when the patient was seen as the victim of his family, it was easy to overprotect him, overlooking the fact that

--patients are equally adept at victimizing other family members in return

--patients help to perpetuate their role as the sick, different or blamed one

B. They noted how heavily transference was relied on in order to produce change.

--Yet perhaps much of the patient's so-called transference was really an appropriate reaction to the therapists behavior in the unreal, noninteractive, therapeutic situation.

--In addition, there was a greater chance that the therapeutic situation would perpetuate pathology, instead of presenting a new state of affairs which would introduce doubts about the old perceptions.

--If some of the patient's behavior did represent transference, why shouldn't the therapist help the patient deal with the family more directly, by seeing both the patient and his family together?

C. They noted that the therapist tended to be more interested in the patient's fantasy life than in his real

life. But even if they were interested in the patient's real life, as long as they saw just the patient in therapy, they had to rely on his version of that life or try and guess what was going on in it.

D. They noted that in trying to change one family member's way of operating they were, in effect trying to change the whole family's way of operating.

To understand individual personality development, one must include the whole family as a major unit of study.

Riskin and Faunce did a research they called "Evaluation of Family Interaction Scales" to develop and evaluate the validity and reliability of a method for investigating significant aspects of whole family interaction.

According to them, there are six categories of family interaction scales:

1. Clarity: Whether the family members speak clearly to each other.
2. The topic continuity: Whether family members stay on the same topic with each other and how they shift topics.
3. Commitment: Whether the family members take direct stands on issues and feelings with one another.
4. Agreement and disagreement: Whether the family

members explicitly agree or disagree with one another.

5. The effective intensity: Whether family members show variations in affect as they communicate with one another.

6. The quality of relationships: Whether family members are friendly or attacking one another.

Also, the researchers looked at the patterns of who speaks-to-whom and who-interrupts-whom.

There were 44 families. All of them were required to meet the following criteria: white, suburban middle and upper-middle class; at least second generation American; biological family intact; at least 3 children none younger than 6 or older than 21; and all members living at home. The interviewer put the whole family together in a sitting and asked them to plan something together then he left the room. The family had been observed from outside.

The researchers have suggested a way of classifying families other than by the application of traditional psychiatric individual nomenclature. In their system, they emphasized the effectiveness of the family interaction, and characterized families by their predominant atmosphere.

The study of interactive patterns in small groups crosses several disciplines: sociology, psychology, an-

thropology, ethology, and others. Researchers in all of these fields are developing a common interest in the technology of observation. This technology is designed to replace or augment videotape as a medium for recording the complex sequences of interaction that occurs in various kinds of social groups. The most widely used instrument is the Datamyte (Conger and Mcleod,1977; Syker, 1977). The SSR system is becoming popular (Stephenson and Roberts, 1977), and other instruments also exist, for example, EIOG by Fitzpatrick, 1977, and the inexpensive device by Magyas and Fitzsimmons, 1979).

A system called VIPER which is a flexible and inexpensive system. The machine was simply a moving paper chart on which verbal acts were coded in pencil. It consists of a 12 button keyboard, plus any standard cassette tape recorder with stereo capability. The keyboard encodes information into frequencies that are recorded in real-time standard cassette tapes. Decoding of the information is done by "turning the keyboard around" and connecting it to a minicomputer for analog to digital conversion.

The encoding system is portable, and intermediate storage is on cassettes, which are cheap, reusable, and relatively permanent. The unique aspect of the system is the use of both tracks of the stereo recorder, which per-

mits up to 36 distinct codes to be recorded in real time, or up to 12 codes plus a complete audio record.

An important feature of the keyboard is that it is a hands-on design requiring a minimum of movement for coding. An untrained observer can learn to code who-to-whom interaction pattern in a matter of minutes, because the left hand is associated with the speaker, the right hand is associated with the target, and there are only six keys for each hand.

The reliability of untrained observers using this keyboard system is quite high. Five observers coded the same videotape of a four-person group on two successive occasions. Test reliabilities averaged .74, and the mean introbserver reliability was .77, which appears to be higher than typical reliabilities for this type of data. (Baker 1981)

The term diagnosis is derived from the Greek, and means, thorough understanding. Diagnosis entails certain essential steps or operations. These consist of observation, designation, a delineation of causation or ethology, classification, prediction or prognosis, and control modification or treatment plan. p. 109

The distinction between mentally healthy and mentally sick families is relative rather than absolute. A sick

family is a family who progressively fails to carry out their essential family function. The depth and malignancy of failure of family adaptation can be seen by a family's level of dealing with its problems. (Ackerman, 1958)

The family tries to achieve a realistic solution of its problems, but when the family fails to achieve that it can control the potentially noxious effects of the problem. And at the same time give itself a long period of time to find a solution. When the family member fails to find an effective solution or to contain the destructive effects of conflict, the family responds to the tension of failure with an "acting out" such as ill-judged and harmful behavior. Sometimes the family as a group seeks a scapegoat, either from the family or outside it. But as the family keeps failing to solve its problems or to adjust to them, it will show increasing signs of emotional disintegration which in some circumstances may culminate in disorganization of family ties.

To meet the challenge of family disturbance, one must obtain sufficient and dependable data to enable him to make correct diagnosis, and to plan a successful treatment.

The process of collection data takes many forms; the usual initial exploratory interviews, the history-taking from the primary patient and other family members, direct

observation of family interaction during office interviews and home visits.

One person cannot collect enough information about the whole family, that is important to have more than one, which can be called a team. The mental health team who collects the information for the family diagnosis is contained of small groups of professionals collaborators. The team may be made up of a psychiatrist, a psychologist, and a social worker. But it is possible to vary the memberships in all sorts of ways, either from necessity or in order to meet particular interests and goals. For example, the family physician or a nurse is a helpful teammate.

The exploratory interview is a very important way to get all the information that the therapist needs to know about the family besides it gives him the opportunity to discover what is going on between the family members such as their feelings toward each other and what kinds of ideas they are having toward each other.

During the interview the therapist tries to evaluate each member. He begins with signs and symptoms. He listens to each one complain and at the same time he notices the effects of each one talking and behavior to other members.

The success of initial interview depends on the

therapists knowledge of what he must find out from the patient and of how he can find it out.

A history-taking from the primary patient and other family members will help the therapist to have a good idea about what is going on. When the therapist collects the information, he will have an idea about the people he is going to work with and most of all the reasons behind what they are suffering from now. Also he will be aware of the patients psychological strengths and assets.

Direct observations of family interactions during the office interviews reveals not only information about the immediate situation but also produces illuminating insights and material of inestimable value. The therapist must notice all family members behavior, when it changes, how, and in what direction. Voice, appearance, looking all these are important to give the therapist a clear idea about what is going on.

Home visits are an important way to explore the mental health problems of family life, with the goal of relating the behavior of the family as a group to the behavior of a family member.

Because of the special applicability of the home visit to the diagnosis and treatment of the family as a group, Ackerman, 1958 talked in detail about the techniques that

he had found most useful.

> "The home visit is unstructured, informal and without notetaking. The primary focus must be on family interaction patterns, and family role adaptation ..... the visit must be arranged when all or most members of family are at home." (Ackerman, 1958) P. 129)

If the visit began before the father gets home, the behavior of family members before and after he enters provides valuable clues to family group organization, attitudes, and feelings. A visit may last two to three hours. Then it is usually written up in detail, including the family's activities and the emotional interaction of family members.

According to Ackerman, 1958, the written report should be divided into five parts:

1. A summary of chronological events of the visit;
2. The family as a group, which covers the visitor's impression of interactional patterns and role behavior;
3. A short description of each member of the household;
4. The physical and community environment;
5. Miscellaneous information.

The most frequent concern about home visits is that the family may not behave normally, they may be in their

best behavior. But we should bear in mind that the family behavior during the visit differs only in degree not in quality. The earlier the visit is made with the family, the more value it has for diagnosis and for treatment plans. It may also be used during the course of treatment to evaluate family functioning:

a. to measure therapeutic progress

b. to check perceptions and reports of the family

c. to assess special problem situations that arise.

As a means of follow up, the home visit is indispensable. It is only a means of evaluation of the family and must be integrated with other findings.

V. Diagnostics in family therapy

The evaluative procedures used in child diagnosis takes many steps; it begins with the initial referral of a child patient, later phone calls, etc. This information might be right or wrong but it serves as the initial orientation in many ways:

1. It may reveal something about the child himself or his family environment, or both.
2. It may point directly or indirectly to certain kinds of distortion of the child's personality or to specific pathogenic elements in parental attitudes and the emotional climate of the family as a whole.
3. It may suggest the deviant levels of adaptation of child to the family.

If it tells little about the child himself, it may provide some immediate insights into family trends. Whatever it would tell something.

Once the initial referral has been assessed, most clinicians depend mainly on the history of the child obtained from his parents and on direct clinical examination of the child in an office interview.

There are three facets of the clinician's role in examinational interviews:

1. his participation in an evolving emotional relationship with the patient;
2. his trained observation of the dynamics processes of the relationship;
3. his organization and evaluation of the data to arrive at a diagnostic judgement.

The data from the interviews with child and with parents and in home visits falls into four categories:

1. The organization of the child's personality in present time and place;
2. The child's relations with his family;
3. The character of the child's environment and the family as a group;
4. The onset of the clinical aspects of the child's difficulty - his emotional illness and the history of the development of his personality.

The first emphasis must remain and obtaining a definitive picture of the present status of the child's personality. Also it should be emphasized that because the child and his family are part of one another, it is no way possible in a clinical estimate to dissociate child from family.

There are always many questions in interviewing the family to know about the child; who is the first one to

interview? the mother or the father? do we take the information about the child from both of them or one of them is enough? All these questions and others must be answered by the clinician according to what he thinks is the best way.

The parents of disturbed children are conflicted people. They are concerned for the welfare of the child and the same time they are worried about their feelings of guilt, which they try to cover. Their conflict reveals itself in inappropriate behavior in the initial interview.

It is advantageous for the clinician to observe the child and parents together on the first occassion. To interview the child alone is an experience that is akin to the child's nature.

Interviewing the child with his family gives us?

1. A quick glimpse into (a) the relations of the child and parents, (b) the areas of tension and conflict.
2. It reveals the characteristics of the parents as a couple, and the tensions that emerge between them concerning the child's problems.
3. It provides some clues about the interconnection between certain patterns of parental conflict and the child's internal emotional state.

In the multiple interview situation, the clinician acts as a catalizer for free emotional between child and parents and also between the parents. Of course, in the beginning the absence of free expression is common. At first it might be a period of restraint and self consciousness. Sometimes the mother waits for the father to begin or vice verse, or both wait for the child to begin.

In another variation the parents may be distrustful of the clinician. They may be very careful about revealing themselves and they may be very willing to push the child into an exposed position.

Through these early interviews the clinician acts as neutral arbitrator as well as catalizer. He stirs the process by leading questions, by challenging the behavior of one member, by checking with another, and at the same time, he makes certain that each member has a chance to be heard and understood.

Occasionally, a child will refuse to be interviewed together with his parents, particularly in cases in which the relations are characterized by deep mistrust and defensive isolation of child from parents. Usually, the child accepts the family interview as more natural than an isolated interview with him alone. He derives a feeling of acceptance and satisfaction from the opportunity

of having his case heard. He also waits to hear directly what his parents have against him, the basis of their disapproval and criticism.

The child with the interviewer alone has his problems, but he is not like an adult who has the knowledge of which behavior is inappropriate and which is appropriate. He goes to the interview because his parents ask him, sometimes for other reasons such as: "the doctor is going to advise you about playing football." So it is very important to establish a good relationship between the child and the interviewer. For the child it is important that he thinks that all this is for his own good and for the interviewer to understand as much as he can about the child. To reach that the interviewer or the clinician himself must leave the relationship between the child and himself relatively unstructured, undefined. This will provide the widest possible range of freedom for the child's own initiative and self-expression. The child may for his own security require some sense of distance, both physical and emotional between himself and this stranger. So the clinician must bear that in mind unless he derives some cue from the child's behavior that such action would be welcome.

Not all the children are the same, some shrink from

the contact as much as possible, and show extreme attitude of avoidance. An inhibited child may seem paralized, rooted to one place in the room, and fearful of making any move. Another child may immediately launch into motor activity, walks in the room to explore its contents. Another child may show a minimum of movement and engage only in talk. Also there is a child who talks too much and plays hardly at all. Another one may choose exclusively to play while refusing to talk.

It's important for the clinician to estimate the quality of communication that is activated between the child and him. Then he will be able to build up the body of information about the child and his family which is necessary for diagnosis.

It is often that when diagnosis have been made the clinician ignores that the child is a human being, immature, and in a state of rapid growth, and that he is totally dependent on his environment.

There are many differences between adults and children and we should bear these differences in mind when we deal with children.

1. The adult is conceived as being responsible for his behavior, the child is not.
2. The adult constrains his impulses, the child

characteristically acts out.

3. The adult requires some insight into the social and personal implications of his emotional illness, the child ordinarily has little such insights or perhaps none at all.
4. The sick adult takes his own suffering, the sick child tends to impose his suffering onto his environment.
5. The adult holds some power to control his environment and within limits to change it; he can take himself voluntarily out of one situation and place himself in another. The child cannot.
6. The adult knows sharply the line between normal and abnormal behavior, the child does not. Ackerman, 1958.

The disturbances of children are patterned responses to stress in a child's relations to his inner and outer environment.

> "All types behavior disorders psychoneurotic and psychotic reactions are profoundly affected by the experiences of reactions are profoundly affected by the experiences of interactions of child and environment." (Ackerman, 1958, p.201)

The broad grouping of primary behavior disorders according to Ackerman, 1958, embraces the subgrouping of

habit disorders, conduct disorders and neurotic traits.

Habit disorders tend to arise at an earlier stage of development than conduct disorders. Habit disorders emerge in a child - parent relationship in which the child cannot project his affective needs with satisfaction. Habit disorders occur on a background of emotional deprivation and are usually expressed as one or another form of autoerotic activity, the purpose is to reduce disagreeable inner tension derived from accumulated aggression and to provide pleasure from one's own body.

Conduct disorders require the psychomotor maturity essential to the motive of attacking the family environment. They are found on a background of failure of parental responsibility. The parents are withholding love and approval or fail to give their child security, they fail in the goal of socializing the child. The child's reaction to parental denial is revolt and he defends himself against parental hostility with egocentric aggression. The energy of the child's aggressiveness remains externally oriented. The level of conflict continues to be focused in the zone between the child and the environment.

Neurotic traits are transitional between the personality organization represented in primary behavior disorders,

and organized psychoneuroses or the other. Structurally and functionally, neurotic traits are related to that phase of personality development in which the processes of identification with parents and internalization of parental standards to form the inner functions of conscience are only partly completed. Fear of parental hostility and relationship is displaced from the parent figure to some symbol such as animal or thunder. The dynamic pattern is not one of internal guilt and self punishment but anticipation of punishments from without.

A given piece of behavior cannot be accurately diagnosed simply in terms of its overt form; its dynamic and developmental basis must be understood.

The foundations of diagnosis must consider differences in heredity and constitution, differences in temperament and reactivity at birth in body structure and function, in rate of growth, and in social development. It is necessary to take into account abnormalities both of body equipment and of family environment. Body equipment and physiological response may be impaired before birth or after birth by heredity, disturbance in embryo, abnormalities of physical development, disease, or accident. A general distinction must be drawn between deviations of development and behavior influenced by organic conditions in which there

is impairment of body structure and function and deviations of behavior and development in which the body structure and functions are normal. The organic conditioning include deviant behavior patterns associated with hereditary conditions, disorders of the central nervous system, mental deficiency, the convulsive states, post-infectional disorders, and conditions associated with other forms of somatic disease of defect. Some types of disturbance behavior disorders, neurotic and psychotic reactions are secondary to and engrafted upon an organic defect.

But once data have been collected by means of history-taking, office observation, interviews, and home visits, the clinical team is faced with the problem of organizing these materials in a workable form. Ackerman, 1958, provided a guide which he found helpful if used flexibly and with discrimination. Included are a grid for data leading to family diagnosis, a guide for the evaluation of marital and parental interaction, a guide for the evaluation of the personality of a child here and now and a guide for the sequential stages of child development. p. 138-145

VI. Theraputic intervention in the family

Before World War II two ways of treating were popularly utilized - the individual and the group. At the beginning of the century child guidance clinics was developed, which provided interpersonal relationship using the unit of mother and child based on the belief that child's behavior was influenced by what the mother did.

There were two uses of the interpersonal relationship; one was conceived in self-child guidance, and the other was worked out in group therapy.

After World War II, came another kind of treatment, known as marital counseling for the husband and wife. They had the picture of how to treat groups of individuals, the mother-child unit, and the husband-wife unit. There were two other units present in the family, but left out; the father-child unit and the sibling unit.

A psychiatric entity called "schizophrenia" which in years past usually meant that nothing much could be done for people to whom it was applied. But after a while, some curious people began to think about how a person who was labeled a schizophrenic might look at his own family. Gregory Bateson (1954), also Murray Bowen (1959), hospitalized whole families just to look at this situation. Some interesting things emerged in the studies of the

schizophrenic and his family, a direct link was found between what the labelled person was presenting and the family of which he was a part.

It was not a very long step then to look at all other kinds of behavior to see if the behavior of any individual could be linked to the system of which he was a part. (Satir, 1967)

Many studies had been done to prove the importance of treating the whole family together than one member alone.

Engeln and Knutson, et al, (1968) studied focusing on behavior modification by involving the entire family unit, rather than just the identified child patient and the mother.

The family was a working class family, made up of father, mother, and four children. The mother went to the clinic seeking assistance for relieving the behavior problems of her 6 year old son who was the second oldest of her four children.

The major complaint expressed was that no one could in any way control his behavior. He would not respond to any demands of the parents or of his teachers. When he did not want to do as he was told, violent temper tantrums involving hyperactivity, swearing and aggressive attacks were likely to occur. His behavior was extremely aggressive

towards other children and as a result had left him isolated from potential friends and caused fear in the community that he would seriously injure someone.

After an intake interview with the mother, the family was seen each week for almost 11 months for one hour each session. Three therapists were involved in working with the family. One of the therapists worked with the mother gaining information about the reinforcement contingencies operating at the home, and later explaining the basic concepts of operat conditioning. The other therapists: one worked with the boy in a playroom, sitting, observing his behavior, and establishing himself as a strong social reinforcer. Following six unstructured playroom sessions, a decision was made to concentrate on commands given by an adult. The therapist would say the boy's name and record whether he made eye contact with him, as a measure of attention. Then command him to perform some small manipulation with the toys in the playroom. Eye contact and obeying had to occur withing 15 seconds for the response to be considered correct. After four sessions commands were made contingent on eye contact. The third therapist visited the boy's home, observing the reinforcement contingencies operating there and establishing a relationship with the father.

The following steps in therapy were sustained and actually carried out.

1. Systematic reinforcement of
   a. eye contact
   b. compliance with a command in the clinic playroom
2. Concurrent training of the mother in the relevant principles, thorough observation of the therapist's behavior and by discussion
3. Training the mother in the playroom in reinforcement and extinction of her own complaint behavior
4. Establishing in the home a program of systematic reinforcement of the boy and his older brother
5. Establishing cooperation between the boys in the playroom by making reinforcement for both boys contigent of such behavior.

After the treatment, changes had occurred in the family including improvement both in the home and at school.

If this treatment included only the boy and one therapist, it might not have had the same results. So including the whole family helps the improvement to occur.

Zuek 1967 wrote about a technique that can be used in family therapy, which is based upon fact that family therapy is the transaction of a therapist with at least two or more

persons, who have had an extensive history of relating to one another.

> A cornerstone of the technique is a definition, "Family therapy is the technique that explores and attempts to shift the balance of pathogenic relating among family members so that new forms of relating become possible." (Zuek, 1967, p. 71)

This definition presumes Jackson's notion that the family is a homeostatic system in which change in one part is likely to effect changes in other parts.

Another cornerstone of the technique is the fact that the expression of conflict in family therapy is like that in no other form of therapy, and that conflict generates the energy required to shift fixed patterns of relating among family members. The therapist must be an expert in searching out the main issues in the family, in keeping these issues in focus, and in exploring the sources and intensity of disagreement. Only in family therapy do patients come with an established history of conflict, and with well-developed means for expressing or disguising it. Zuek, 1967.

Zuek 1967 described go-between process in family therapy in four variations. In two of the variations the initiative in conducting go-between process visits with the therapist. In the other two variations the

initiative resides with the family members.

Zuk explained three steps in the go-between process:

.... from the view point of therapist vis-a-vis family:

The therapist conducts go-between process when term one (a) he probes issues in the family establishing the existence of conflict by eliciting expressions of disagreement, and encourages the open expression of disagreement. (b) He exposes and otherwise resists the family's efforts to deny or disguise disagreement. (c) He encourages the expression of recent or current disagreement rather than rehashes of old. (d) He encourages expression of conflict between members who are present rather than absent from the treatment session.

Term one sets conditions for the therapist encouragement of expression of conflict. Families differ greatly in the extent to which they will express it; some appear only too eager to do so; others are most reluctant. The therapist must be aware of each family and know how to deal with them. He should encourage the family to talk about their recent conflict because memory for its details is still fresh and emotions running high. Also encourage them to talk about their family members who are with them right now, in another word the therapist conducts go-between process to encourage families to talk about their recent

problems, and to discourage them to express their feelings about other family relatives or friends who are not in the session. But if the therapist feels that talking about these things will open up sources of conflict between family members who are present, it will be better to let them talk about it.

The therapist conducts go-between process when Term 2-(a) he selects specific disagreement worth of discussion, rejects others as unworthy, and resists the family's expected efforts to establish its own rules of priority. (b) this selection is part of his move into the vote of the go-between. He then seeks to establish his authority in the role and resists the family's expected efforts to displace him. p.229. In the role of go-between the therapist is constantly structuring, and directing the treatment situation.

The therapist conducts go-between process when: Term (3) He sides either by implications or intentionally with one family member against another in a particular disagreement. The problem of the therapist is to decide when and with whom to side intentionally. (b) He may side with or against the entire family unit in a disagreement as well as with or against single family members.

> Not only is siding unavoidable in family therapy, it is a legitimate tactic of therapeutic value in shifting the balance of pathogenic relating among family members. (Zuk, 1967, p. 75)

..... The family's defensive tactics vis-a-vis therapist.

Families exhibit a marvelous assay of tactics which serve to forestall the therapist in his conduct of go-between process. The therapist must be alert to these tactics, and act to circumvent them.

There are three major defensive tactics. First, the family member seeks to lead the therapy astray by subtle denials or evasions of his allegations of conflict. For example, sometimes the family says that its never had an arguement in this subject which is the area of the conflict; that may mean that they never differ in the subject but it doesn't want to agree or its true that it never was a subject to talk about. Hence the therapist may use one of these ways:

1. give up the issue
2. hit on some device to split the family
3. return to the issue when it seems less anxiety provoking

Second, with the complicity of other family members, one becomes the family spokesman and there's a kind of go-between who blocks the therapist's access to this critical

role. Most of the time there is a one of the family members who tried to explain everything the family member's says to the therapist and some time comments on. Most of the time mother is the speaker and sometimes the father and infrequently by one of the children. The family spokesman is in the role of a go-between, and as long as he occupies a go-between role, the therapist's capacity to assume it is impaired. Sometimes the therapist will decide early in treatment to prohibit a member from taking the role of family spokesman; sometimes, he will permit the member to be the spokesman in the hope of learning about the key dynamics of the family.

Third, the family attempts to trap the therapist into becoming an over-rigid type of go-between such as; the family judge, or accuse him of siding unfairly with one family member against another or others.

It is a main hypothesis of Zuek's paper that family change in order to forestall the therapist's expected demands for much greater change, or in order to fail his other attempts to control the relationship. Illustration of such change are given in which the phase of treatment seemed also a critical factor; that is, whether treatment was the onset phase or termination. The ratio of change entertained here is believed consonant with Helarp which

was designed to contrast with the insight-centered psychoanalytic model.

Bell's (1967) interest was to use family group therapy as the role method of treatment. The results from his experiments with seven initial groups seen for one and a half year have been proved that the technique has wide applicability. It's made an improvement in family living and direct changes in the maladapted behavior of children.

Talking was the technique that he used with the family, that is why it's not good enough with very young children. He assured that a lower age limit might be about 9 years of age, perhaps higher in the cases of children with limited ability or severe emotional blocking.

His method had involved the following programs:

1. The Initial Interviews: A beginning is made by a joint conference with the father and the mother, to know from them the story of the problem the child is facing, the history of the development of the child, and to explain to them the methods that will be used. The parents will be told that the therapist's job is to give everyone the chance to take part in the discussion, and he will support the child; because it is necessary to win his confidence to express himself freely. The goal of this treatment is to develop a new and better communication between all mem-

bers of the family. Also it is to set the stage for the children to speak freely about what they really have in their minds.

It is very important to support the child to express his own point of view and to encourage him to grow, to take responsibility and to experience freedom for self-direction.

2. The Child-Centered phase: After the orientation statement has concluded the therapist encourages the child to tell what he thinks is making the family unhappy. It is important not to push the child to speak but give him time to be ready to speak about the problem. Then ask him how he would propose to solve the problem. At the beginning the parents should go as far as the child wishes to see what is going to happen. Then see if anyone needs to talk about it later. The speed of improvement in therapy at this point depends on the willingness or ability of the parents to readjust the family to fit in with the child's wishes. Then the therapy enters the next stage.

3. The Parent-Centered Phase: This major period of the therapy begins when the child gets to the point of saying "Everything is going good." Then the parents enter the picture actively. They begin to complain about ways in which the child imitates them, worries them, and so on.

Often this is initiated by talking about difficulties out of the home, for example, at school. The therapy then brings the center into the home by interpretation that

> "We can do little in the conferences that about those things that take place outside the home and that often these difficulties are signs of disturbances in the home." (Bell, 1961, p. 29)

Most of the time parents express hostility, which was built up in the first therapy stage, this is not bad, because it makes the parents express their feelings and protect the relationship of the therapist with the child.

According to Bell (1961) there are three methods of handling this:

a. Stating that the child will and must have his way, too.

b. Interpreting to the parents the normalcy of child's behavior when it is inappropriate for his age.

c. Helping the child to express his point of view regarding the complaints by interpreting that he must have his reasons for acting this way.

The consequence of this parental explosion is defense on the part of the child - defense and frequently the expression of hostile feelings that have been repressed, the things that have never been spoken of with the parents, the expression of anything going wrong.

The parent-centered stage of the therapy develop into concern with the parents' problems. From this stage it was found that if one of the family members cannot come, it is more helpful to postpone the session. The only exception to this is when it is preplanned in a conference of the whole family for the therapist to see him alone, as for instance the parents which sometimes is necessary.

After all this, the therapist makes a brief report to the whole family on the contents of what has been talked about.

4. The Family-Centered Phase: Normally the final stage has been marked by the following:

a. disappearance of many of the referral symptoms;

b. the appearance of laughter in the conferences;

c. the reporting of incidents during the week when the whole family worked together to resolve a problem that had arisen; or

d. incidents in which the family engaged pleasurably in some mutual activity;

e. the volunteering of the child to take on necessary chores for the family;

f. the eporitaneous expression of the feeling that the family life is going so well that the conferences are no longer necessary. (Erikson, 1972)

VII. Mental Retardation and the Family

When we talk about a family with a mentally retarded child we must recognize that the inherent disposition and nature of each parent, their educational and cultural backgrounds, their financial and social status in the community, these and other factors will have some bearing on the kind of problems the family will have. Obviously the problem will be somewhat different in a professional family to that of a day-laborer with an elementary school education. Situations which may present very acute problems to one family may scarcely be noticed in another.

In addition to the difference in family situations, we must also take into consideration the vast differences in the children themselves. The totally dependent bed or wheel-chair patient will present an altogether different set of problems from the trainable or educable child whose life will not only touch the family member but other persons in the community.

In a study done by Anderson (1975), 22 biographical and psychological variables which were thought to have some possible bearing on manifestations of parental interest in their institutionalized children were explored. Two measures of parental interest were used: Frequency

of family visit to the institution and attendance at parent conferences.

The departments of psychology and social service of the Husom Memorial Center (Sand Springs, O.K.) provide data on 200 children and their families. The 22 biographical and psychological variables for which information was provided are: sex, age, length of institutionalization, race, mental age, IQ, social age, social quotient, physical abnormalities, family income, distance of parental home from institution, fathers occupation, father education, mother's education, parents married, parents divorced and parent having custody living alone, parents divorced and parent having custody remarried, parent having custody widowed, parental status, financial contribution to child's maintenance required, financial maintenance required and current in payment, and finally the financial maintenance required and delinquent in payments.

Subjects were grouped into four categories based on attendance or nonattendance at parent conferences and frequency of visitation. The attend-visit group (N=88) consisted of retarded children whose parents attended the conference and visited their children often. The attend-do not visit group (N=65) consisted of retarded children whose parents attended the conference but visited their

child seldom or never.

It was found that the difference between the attend-visit group and the attend-do not visit group related to characteristics of the child. Children who were functioning at a higher level of intelligence and social maturity were more likely to be visited often.

Also it was found that family income and the requirement of making financial maintenance payments, were important factors related to visits.

The frequency of visits also appeared to be related to the distance between the parents home and the institution.

The social quotient and the requirement of financial maintenance are the best predictors of visitation. It appears that variables such as intelligence, social maturity and other child characteristics are important factors related to parent involvement only when actual contact with the child is involved. Also it was found that parents who were divorced and remarried were less likely to attend parent conferences.

Parents who neither attended the conference nor visited their children had completed fewer years of education than parents who did both.

Murray (1959) also lists six basic problems common to

the families of the retarded.

1. Acceptance of the fact that the child is retarded: Dr. Leo Kanner, (Murray, 1959) a leading psychiatrist in the field of mental retardation, described parents' reactions to mental retardation as variants of three specific types:

> a. "Mature acknowledgement of the actuality and acceptance of the child;
> b. disguises of reality with search for either scapegoats upon which to blame the retardation or the seeking of magic cures;
> c. complete denial of the existence of any retardation." (Murray, 1959, p. 1078)

Various reasons can be supplied for parents who fall into any one of these categories but the nature and disposition of the individual parents, their educational, cultural, economic anc social backgrounds, their fundamental philosophies for living, all of these aspects as well as many others will help to determine how parents meet this basic problem.

2. Intelligent use of income in relation to retarded child within total family need: In the low or even middle income group the amount of money required in seeking a diagnosis providing proper medical care and possibly in later years a special training program for the defective child, can become a serious financial burden. Many parents in their overwhelming anxiety for the welfare of the child

will lose their sense of perspective and decide that money is of no consequence where the needs of the child are concerned. When this happens, the results are almost inevitably disastrous to the home situation because added to the terrific emotional strain through which they are passing is the additional burden of anxiety over the critical financial situation.

3. Learning how to live successfully with the emotional tension builds up by carrying a burden which they cannot find it possible to satisfactorily share with their fellowmen: The parents who refuse to admit their child is retarded must carry the double burden of grief and pretense, both of which tend to build within them great dams of emotional turmoil for which there seems to be no release. But even the parents who can and admit their child's limitations often find it difficult if not almost impossible to share their sorrow because their friends, neighbors and relatives are hesitant to ask about the child's welfare. The inability to share our problems exists through no fault of the parents, or of the general public. It is the result of having looked upon mental abnormalities with superstition, fear, ignorance, or perhaps with the naive belief that if we just refuse to look at them or discuss them objectively they will somehow cease to exist.

4. Resolving the theological conflicts which arise in the minds of parents when faced with this situation: This problem is almost totally ignored by professional persons whom parents are most likely to consult in regard to their child. Death, physical illness, broken bones, loss of jobs, economical security, and serious injury by accident are all familiar to every adult and are in everyone's minds because they are natural and always happen. But to suddenly face the fact that their child is mentally retarded and will remain so for the rest of his life, this places them outside the providence of God's mercy and justice, sometimes they lose their faith and they don't believe in God anymore. This presents a serious problem, a problem with which he must have help lest he finally sink into a state of despair from which there is no return. Also their sense of guilt makes them unable to see their problem from a rational viewpoint.

5. Seeking a solution to the matter of satisfactory lifetime care for the handicapped child, who, in many instances will need adult guidance and care throughout his normal life span: The professional doctor, teacher, social worker, psychologist or psychiatrist's help is very important to help the family to cope with the new situation and it is imperative in meeting the problems of the moment. But

the professional person must always keep in mind that with the child's parents the problem is not just for now but for always. Understanding the permanence of the problem from the standpoint of the parents will enable the professional person to work more constructively with the parents in meeting the problems immediately at hand.

In families where there are other children to be considered the problem of life time care is intensified because one must take into consideration not only the handicapped child but the other children as well.

6. Learning to sift the wheat from the chaff in the professional advice given us over a long period of time: Parents can be spared much emotional damage and conflict if the professional persons they consult have two things:

> A. A comprehensive knowledge of all factors concerning mental retardation so far as they are known.
>
> B. The ability to counsel parents in a straightforward, honest but gracious manner. (Murray, 1959, p. 1082)

The reaction of parents to their problem will depend to a great degree on the emotional and spiritual maturity of the professional person whom they consult as well as the professional person's knowledge or lack of knowledge concerning mental retardation.

> The parents of a mentally retarded child need "constructive professional counseling" at various stages in the child's life which will enable them as a parent to find the answers to their own individual problems to a reasonably satisfactory degree." (Murray, 1959, p. 1827)

Now let me give an example how the family faced the problem of having a retarded child.

After the initial shock of being told that their child is retarded, the first reaction of many parents is one of disbelief and denial. They hope that this doctor may be wrong. It is hard for them to accept the fact that their child is mentally retarded. Then the father and the mother console each other with this for a period of time according to the strength of their relationship before. When they feel that it is true and no doubt that their child is mentally retarded, their worry increases and many questions arise in their minds. What do they have to do to help their child? and if they have another child how are they going to explain that for them? and if they don't have any, are they going to have the same problem if they have another child? What will the neighbors think? Then they started to blame themselves or each other and then blame the doctor. Then they start to worry about the future of their son, about the effect on the rest of the family, about their own ability to handle the situation. Now they face the

fact that their child is retarded. Now they are lost. They don't know what to do. Here the disagreements between the parents may arise; one may want to send the child to an institution, the other feels bound by love and duty to keep him at home. Some times they reject the child and become antagonistic toward society in general. Some parents, mother in particular, withdraw from social contacts and devote all their time to the retarded child. This results in neglect of other members of the family and maladjustment of the mother. Some parents on the other hand, react the opposite way and pull away from the confusion by becoming deeply involved in outside activities that keep him away from the problem.

When the parents reach the stage when they are ready to make a more intelligent adjustment to the situation, they start to solve the problem. But when they don't find the solution they become frustrated and confused. Then they realize that must either change the situation or change their attitude toward it. Of course then they will realize that they can't change the situation but they can change their attitude toward it. Now they are ready to see what can be done to protect the child and to help him.

A study had been done at the Mental Retardation Center

in Toronto to see what the parents with mental retarded child concern about. Parents of 90 children admitted at an institution for the retarded, and parents of a contrast group of 38 retarded children who remained at home, were asked their primary areas of concern with regard to the retarded child.

The parents identified seven prime areas of concern as most troublesome to them. The prime areas of concern were essentially the same in both groups:

1. Training and education were needed for the retarded child. The parents want to provide the best possible education for their retarded child to prepare him to compete or at least survive in the world. This was the chief concern of 42% of Community parents and 23% of Institution parents.

2. The retarded child interfered with family life. Parents in 25% of Institution families complain that the retarded child interfered with family life to a serious degree. They felt that their long hours of effort in caring for him went to little purpose - as far as improvement was concerned.

Interference with family life was the chief concern of 22% of community parents. They complained that the

aggresive behavior of the child of the retarded child against his parents and siblings. It seemed that having a retarded child at home is an added stress. Counseling for the whole family around understanding and coping with the problems presented by the retarded member might be of assistance.

3. The ability to care for the retarded child. 19% of the Institution sample and 8% of the Community sample expressed their prime concern is this area. There are many reasons why care of the retarded child in his home presented special problems such as the illness or the death of one parent particularly the mother, illness or retardation of one of the siblings, birth of a baby, and behavior problems of siblings.

4. Physical care and protection sought for the retarded child. The study revealed that 17% of Institution and 11% of Community families considered this their prime need, particularly when the children were severely physically handicapped, or so mentally handicapped that they were victimized by neighborhood children.

5. A living situation was sought for the retarded child. The prime concern of 11% of both Institution and Community centered around finding a suitable living situation for the retarded person after his parents were gone, or when

living at home was no longer possible.

6. Recreation and companionship was sought for the retarded child. This was the chief concern of 5% of Cummunity and 3% of Institution parents.

7. The retarded child caused problems in the community. Reaction to community complaints was listed as the prime concerns in only 4% of Institution cases, and none of the Community sample.

All the seven major areas of concern in this study can be grouped under three broad headings:

1. Concern for the welfare of the retarded child;
2. Concern for the welfare of the family;
3. Concern for the welfare of the community.

The Institution sample expressed significantly greater concern for the welfare of the family than did the Community sample. Greater concern for the retarded child was shown by the Community sample than by the Institution sample, also to a significant degree.

Mental retardation and emotional disorders frequently are associated, but they are two separate concepts.

> "Mental retardation is a permanent, though not unalterable state and a condition of life, in contrast, an emotional disorder is a more or less episodic occurrence, which may be

> and calls for prompt diagnosis and medical relief." (Hofstalten, 1969, p. 583)

Emotional disorder must be considered a complication of mental retardation, which further reduces the child's level of intellectual functioning and often a challenge to the physician.

Much of the retarded child's abnormal behavior and emotional disorder has been considered not to be the result of brain damage, but most, if not all of it stems from the repeated traumatic experiences in his environment, or maternal affection deprivation, continued rejection, overprotection and humiliation. The mental retarded child with emotional disorder will cause serious defects in physical, emotional, intellectual, and speech development, hyperactivity, and even bizarre symptoms, such as, head banging, body-rocking and elimination.

To help the mental retarded child to avoid as much emotional disorder as he can, these things must be considered:

1. Establishment of warm and dependent interpersonal relationships with consistent adults

2. Encouragement of learning through exploration and testing

3. Encouragement of socialization and communication between the patient and most of the people around him.

Emotional disorders may occur at all levels of subnormal functioning. If it is affecting the person of normal IQ it will be more with person who is mentally retarded because of his incomplete biologic equipment and greater emotional vulnerability, besides the stress of our culture.

> "The frequent association of mental retardation and emotional disorder was observed in the St. Louis State School and Hospital, a residential facility for the mentally retarded with a population 813 of all degrees and ages. Aside from the group of about 100 neurologically impaired bedcare patients, the majority of the remaining patients presented social or behavioral problems with which their parents could no longer cope. Prominent among these retarded patients was some mild degree of pervasive, lingering chronic depression, revealed in a somber negative concept of the self and expressed in self-deprecatory terms of inadequacy, uselessness, incompetence, repeated experiences of rendering themselves disliked or rejected. Some responded favorably to psychotropic drugs and also showed a significant increase in their IQ." (Hofstalten, 1969, p. 584)

Another study in an outpatient setting at the Langley-Porter Neurophychiatric Institute in San Fransisco, where 227 retarded children and their families were evaluated

was similar, and revealed that emotional maladjustment more often than not accompanies mental retardation. Actually, it was uncommon to see a retarded child who presented no emotional maladjustment as part of his clinical picture. The child or person with mental retardation is more vulnerable to emotional disorders and has more problems of personal and social adjustment than normal children. So the retarded child or person needs to be handled with particular care and tact to avoid more serious emotional disturbances.

Individualized child-parent training program at the institution are necessary when one considers the various reasons why parents seek institutionalization for their children. In some cases, a child's truly in need of individualized intense, objective, specialized treatment which cannot be provided in the home or community. In other circumstances, the community might not provide the vocational or educational programs required by the child. Still others revolve around attitudes, feelings, and personalities of the parents themselves, how they interact with each other and with their children. Sometimes parents need help in adjusting to the fact that their child is retarded. At other times, they might require guidance in how to teach their child the adaptive skills.

With all of these considerations, the institution can be of great service not only to the child but to parents as well. But the institution should not function apart from the community. It should be viewed as one of hopefully many community agencies which serve the retarded. With this philosophy, institutionalization of a child is not considered to be a step which forms a dichotomy of parents on one side and institution on another.

By having parents come to the institution to participate in their child's training, the parents become more familiar with the progress and activities which are taking place in the institution. So when the child is ready for vacations and/or return home, parents can be essentially considered para-professionals in the use of behavior modification. Parents with knowledge and skill in an area such as behavior modification would appear to be valuable volunteers or employees in community programs for the retarded.

VIII. Case Studies

Case number 1

B.M. is a twenty seven year old white male. He is aware of his immediate surroundings and spends most of his time playing with squeezy toys and chewing on them. He had a twin brother who died in 1963, and he was mentally retarded too. B.M. has two brothers, one is older than he and the other is younger than him. He also has a step sister.

His father graduated from Washington University. He was 25 years old when B.M. was born. He is 52 years old now. He divorced his wife in October, 1972 and remarried in December, 1972. He used to visit B.M. regularly for several years, but he quit visiting when he became convinced that B.M. didn't recognize him.

His mother is 50 years old. She was 23 when B.M. was born. She bled between her third and fourth month of pregnancy. She has a high school education. She never visited him. She is a nervous woman.

His step mother visits him sometimes and she provides clothes for him. She is a pleasant woman. It appears that his father is concerned about him and his welfare.

Case number 2

M.J. is eighteen years old. Black female. She is blind but she walks to and from the dining room and classroom with minimal assistance from staff and she uses her wheelchair rarely. She is nonverbal but she makes some sounds. She is one of five children. Her father is her legal guardian. He visits her occasionally due to his age. Her mother doesn't visit, but she did attend some of the staffing. Her parents are presently divorced. In 1978 her parents took her home on Christmas Day.

Her father is interested in her and her program. He does take an active participation in any conferences that is scheduled for her and he signs all needed forms.

M.J. spends afternoons with her foster grandmother and seems to have a good time with her.

Case number 3

B.D. is a thirty one year old. White male. He was born at six months. His disabilities were first discovered at about one month of age. He is bed resident requiring total care. He doesn't move any parts of his body other than hands and fingers.

He is one of nine children; three brothers, four sisters, and one half sister. He lived at home until 1964 when his care became more than his mother could manage.

His father was born in 1905. He died in 1979. He had finished the eighth grade in school unemployed, he was a boat pilot. His mother is 75 years old, a housewife but she used to work as a waitress. His mother is unable to visit him due to her age, health, and unable to drive. One of his brothers is his guardian.

Case number 4

S.R. is a thirty three year old. Black female. She lived at home until 1978 when she became too large for her mother to manage. She is the third of five children. Her father was 21 when she was born and her mother was 25. She was full term baby. At 6 months her mother began to notice that her daughter was developing more slowly than her other children. No one can say for sure if she had convulsions or not.

No one from her family visits her. But her mother asks about her by phone sometimes. When S.R. was at home, her mother was physically exhausted from caring for the completely dependant child. In addition, the four children in the family resented being so restricted to their home by S.R.

Case number 5

B.K. is a sixteen year old. Black male. He spends much of his time sleeping, although he is becoming more alert. He sometimes smiles when someone talks to him and sometimes appears to be watching movement around him. He is totally dependant.

He was at home care until 1975 when he became more than his mother could manage. He has one sister and one half sister. His mother visits him and sometimes she brings other members of the family with her. They also remember him on his birthday and his mother attends annual staffing whenever possible.

Case number 6

M.K. is a twenty eight year old. White male. He seldom smiles, he would vocalize or cry to express discomfort. His mother had toxemia during pregnancy which is the cause of his deformities and retardation.

He lived at home until 1966 when his mother needed to go to work and couldn't find anyone to care for him. She's now working in the hospital and she has continued to see him daily. She has also taken him home for short visits. He enjoys being held and rocked by her.

His parents divorced in 1963. His father is 63 years old. He never visits him. His mother is 59 years old. She remarried three times and divorced. He has a step brother and 22 year old brother living with his mother. Everything he needs his mother asks for it and he gets as soon as possible.

Case number 7

M.M. is a twenty two year old. Black female. She is one of three children born to her parents. Her brother and sister reported to have no health problems.

M.M. remained at home until she was 9 years old, and she was placed in the institution because the parents were unable to cope with the stress of M.'s needs.

Her father is 45 years old, he completed 2 years of high school and he is a mechanic. Her mother is 47 years old. She completed high school.

Her family doesn't visit her but they sign all forms needed. Her mother still becomes upset about M.'s condition.

Case number 8

J.D. is a thirty five year old. White male. He is alert to his environment. He smiles when someone speaks to him. He explores his environment by observing what occurs around him and by reaching out and touching objects and people. He seems to communicate through the use of eye contact and facial expressions. He's totally dependent in all self help skills. He enjoys attention from the staff and laughs a great deal.

He was the fourth child and last one born to his parents. He was a full term baby. He progressed normally until at 2 months of age when he fell down from his crib. Then he began having convulsions and did not learn to talk.

His parents divorced. His father was 36 years old and healthy when J.D. was born and his mother was 33. She remarried but now she is a widow.

His mother visits him as often as she is able. She does have some health problems, and she does not have transportation so it does become difficult for her to visit as often as she would like to. She used to call by phone to see how he is doing.

He has two brothers who are normal but never visit him.

Case number 9

B.V. is a sixteen year old. Black female. She has facial irritation on her left cheek from self abuse by slapping her face occassionally.

Her parents are her legal guardian, and they maintain contact with staff by letter or by phone.

She was the second child. She has also one younger sister and one younger brother.

Her father is 32 years old and in good health. He is serving in the U.S. Air Force. He has completed third year of college. Her mother is 30 years old. She finished the twelfth grade. From the record, she had been under a physician's care for anemia. B.V. interacts well with her foster grandmother.

Case number 10

R.T. is a fifty five year old. White female. She can say a few words. She spends much of her time screaming for no consistant reason. She can feed herself and sit up. But she is dependant in all other self help skills. She was a full term baby at birth, then she started her first seizure at one year of age. Her severe mental retardation is due to prenatal influences. She has been hospitalized most of her life.

She is the sixth child of six children; two sisters and three brothers. Her family never visit her.

Her father was 30 when she was born. He died when she was 11 years old. Her mother was 32 when she was born and she was a homemaker. She died in 1961.

Summary:

From the ten cases above one can find:

1. two types of family organization - the nuclear family and the blend family
2. five divorced parents
3. death of two fathers and one mother
4. only three parents still married
5. only two families take their children home for visits on specific occasions
6. one father visits his child
7. three mothers visit their children
8. three parents ask by phone and letters
9. one family the siblings visit their brother sometimes
10. nine of the ten families place their children in the institution because they can't handle them at home.
11. children who have foster grandmothers enjoy their time and they looked happy and their behavior could be considered appropriate as in case 9
12. the child whose mother visit him daily loves her and looks happy when she holds him besides all his needs from the institution provided to him as soon as possible.

These findings give us that all parents concern about their retarded child although some of them might not show it. They really care about them so why they don't visit by asking some of the people who work in State Hospital and by reading some of the files in the State Hospital.I found that the parents don't visit because they think that will not make any difference as in case 1 or because they can't cope with the situation as in case 1 or because of health problems as in case 8.

Also it gives us the idea that the families don't function well because no one support the other, if the mother visits the father doesn't and if the father visits the mother doesn't and as was said before each members influence the whole family and the whole family influences the individual, so if all the family against the visiting the mother might not visit as often as if the whole family encourages her. Also mothers can perform adequately only if supported tangibly and emotionally by her husband. But as noticed from the cases that the most of parents are divorced which may be because of having a retarded child. Defects in child have serious implications for the entire family which may dismay structure and dynamics to a pathological degree. Also change - one part effect changes in other parts for example when the parents separate their

life will change, maybe for the better or for the worse, but it also changes the children's life, too. Also it shows that the family intraction helps the individual emotionally and socially besides it helps them to get their needs, and care, and attention from the staff members.

When the parents visit their children as often as they can this might not increase the IQ in the patient but it will help them emotionally and socially.

To improve that I observed a resident in the State Hospital.

Case No. 1

I started observing, B.V. on January 27, 1982 in the classroom, in the dining room, and in bowling section. On the first of March, 1982, I observed her with her foster grandmother who stayed with her for five years. I kept observing her until the eighteenth of March, 1982. I also did a program for B.V. to teach her to play on Xylon.

From these observations I found that B.V. who is a self abuse, slapped her face most of the time if she did not wear the hand puppet in her both hands. But when she was with her foster grandmother she didn't slap her face.

During the program:

Time:	Number of times the slapping occurred:
1:35-1:39	2
1:39-1:40	6
1:40-1:45	0
1:45-1:47	2
1:47-1:50	3
1:50-1:57	5
1:57-1:59	0
1:59-2:10	8

During the class:

Time:	Number of times the slapping occurred:
1:35-1:39	2
1:39-1:57	4
1:57-2:00	3
2:00-2:10	2
2:10-2:30	5

IX. Discussion:

During the program she did wear only one hand puppet on her left hand and she reinforcement with water each time she played with the Xylon. I made her relax by rubbing her face between 1:40-1:42 and between 1:57-1:59. In this time she looked happy. (smiled) During the dinner time she didn't slap her face but she did pang on the table until they brought the dinner then after she finished she started again panging on the table and jumping up and down from her chair.

When she was with her foster grandmother from 9:30 - 10:30, she looked happy, she smiled and made some sounds and she didn't slap her face. Once she tried in the beginning when her foster grandmother told her without holding her hand to stop and she did. Her grandmother told me that with her she didn't slap her face also she said that her face after the weekend looks worse, her grandmother doesn't come during the weekend. And she enjoys going out in the garden.

During the class she did wear only one hand puppet on her left hand and each time she tried to slap her face the teacher held her hand and said to her, "no, don't do that." She tried to slap her face but she did not succeed 10 times.

From B.V. case I can say that her behavior (slapping her face) decreased when she was with her foster grandmother or when she has the attention of the people around her. That means that she recognized the people and that she needs love, care and attention which her parents are the best people to provide that to her.

If we can't help him to improve mentally at least we can make them happy.

There was ample evidence in the Toronto study and in other studies reported by Fortheningher, et al, 1969 that families in the Institution sample suffered more family problems and functioned less adequately according to a Family Functioning Scale than did Community Families (Skelton, 1972).

Saenger 1960 and Tizard and Grad 1961 noted a high association between broken homes, deprived home situation, parental inadequacy, and mental and physical health problems of other members of the family with the decision to hospitalize.

The family is the core of society, whenever the relation between its members is good, positive relationships, society is far away from disturbance and worry, so do the individuals. The family contains several members, each has his own thoughts and characteristics, which may differ

completely from the others, each one has his own feelings, good points, and faults. If each one's goal was to please and live happily with the others, then there would be no serious problems. But how can several people live under the same roof without problems? To make it happen several things must be followed:

1. Every one must regard the other as a normal human being who may make mistakes.
2. Every one must share other person's problems and try to help.
3. They should unite and make decisions together.
4. They must accept each other as they are and not try to force any one to change.

To convince the families of retarded children to interact with their children in institutions is not an easy job but it is worth all the effort to do it is not only helping the child but it is also helping the family member, too, because it makes them stick together as a unit, much the same feeling and do the same things to one of their member who need all love, care, and attention he can get.

Placement of a retarded person in an institution may relieve the family situation to some extent, but may aggravate rather than alleviate the feelings of guilt of the parents, which they express in different ways such as visiting their child in the institution every day and for a long period of time.

How can we make the family come to visit and participate in their child's progress? To do so many steps must be taken, but before talking about these steps, I believe that the earlier the family seeks counseling the better the chance to avoid many unwanted feelings such as worry, fear, denial, guilt, shame, anxiety, depression, and most of all the loss of faith.

1. Show a great deal of sympathy and understanding for the family situation from the first meeting and that can be by listening to them and talking

to them.

2. Gives the family a clear picture of the level of their retarded child and what is expected from him, so they won't disappointed when this child doesn't progress as they thought of.
3. Gives the family a clear picture about the institution, what they can do and how they do it.
4. Tells the family how important is to the child to be in touch with him by visiting him as much as they can. Also it must be saying that nobody ask for daily visit because the family might have some problems to do so, such as, transportation, sickness, and unexpected situations. Also tells them to bring the whole family members to visit at least once in a month. That makes the family stick together.
5. Provides them with any changes that occur as immediately by phone or letter.
6. Home-visiting will help make the relationship between the institution and the family stronger.
7. Arrange meetings between the families to talk about their situation, experience, and their feelings and that is important because, first, people understand each other better if they pass

the same kind of problem; each of the family need to find that there are others who really understand what they are going through. Second, listening to other people who have the same problem make the family feel that they are not the only people who suffer in this world.

8. Makes contest between the families such as, which family decorated her child room better, which family design a successful program for her child. Then choose the ideal family.
9. Arrange meeting between the families and the people who work with their children to discuss the children situation and what they progress and what they need. All their steps must be done by the people who work in the institution for the lowest to the highest member. This might not work with all the families but it will with some of them because they do care about their children but they don't know how to help with all their confusion feelings.

Family counselor, friends, relatives, and the society have its role to help those families to cope with their situation and to help their children. The media has its power to influence the family attitude toward their insti-

tutionalized child.

I suggest the following implications for further research.

1. Further researcher in the same area with different methods.
2. Research to improve how useful the 9 steps are?

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