INSTITUTIONALIZING MENTALLY RETARDED CHILDREN . . . . . .

attitudes of some physicians

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL and REHABILITATION SERVICE
children's bureau

1963 - reprinted 1968

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Telling parents that something is wrong with their baby is probably one of the hardest things a doctor has to do. How he does this often has an important bearing not only on how well the parents will be able to adjust to the child and his problem but also how they bear the shock of the news.

In addition to knowledge and skill in telling parents that their baby is retarded, the physician's own personal attitude as to what can and should be done for and with the baby has an effect on how well he can do this job. Opinions that all retarded infants should automatically be put into an institution or that they should all be kept at home regardless of circumstances in the past have interfered with some physicians' ability to make best use of their skills and knowledge. Recently, however, considerable progress has been made by physicians in moving away from such blanket recommendations. Opinions have changed radically. More and more physicians today take into account the child, his family situation, and the community in which he lives, before making recommendations.

This pamphlet contains four articles which attempt to evaluate attitudes of certain members of the medical profession. The Children's Bureau believes the articles reflect a healthy change in attitude and, while reporting on a comparatively small sample, are indicative of what is taking place throughout the country.

For the privilege of issuing these articles under a single cover, the Bureau wishes to express its appreciation to the authors and the periodical in which they appeared.

ATTITUDES OF SOME OBSTETRICIANS TOWARD MENTAL RETARDATION

SIMON OLSHANSKY, A.M.,
JACOB SCHONFIELD, Ph.D.,
LEON STERNFELD, M.D.

THIS ARTICLE is a report of findings in a study based on interviews with 18 obstetricians in the Greater Boston area. The purpose was to investigate some attitudes of obstetricians toward mental retardation. We were especially interested in investigating the allegations of some social workers and parents that obstetricians tend to recommend separation of the retarded child from the mother at time of birth, and that they generally favor early institutionalization. What gave immediate impetus to the study was the report of a hospital social worker in the fall of 1960 that 2 obstetricians had advised early separation of 2 mongoloid children from their mothers. Verification of this report was secured in only one of the 2 cases. However, some supporting evidence for these allegations was available from the cases served by the Cambridge Service for Retarded Children.

From the Cambridge Service for Retarded Children, the Community Research Laboratory, and the Cambridge Health Department, Cambridge, Mass.

Submitted for publication Apr. 14, 1961.

The illustration above shows the medieval doctor surrounded by classic reference works. Fifteenth-century German woodcut. (The Bettmann Archive)

METHOD OF APPROACH

A small nonrandom sample of obstetricians was selected for personal interview. The sample included 6 with more than 20 years of experience, 6 with more than 10 years but less than 20, and 6 with less than 10 years of experience. No obstetrician refused to be interviewed though all were extremely busy. The size of the sample was limited by funds available. Two skilled and experienced interviewers were employed for the study, and all interviewing was done during the winter of 1960–61. The agency sponsoring the study was the Community Research Laboratory of the Cambridge Health Department. All respondents were assured of anonymity.

MAJOR FINDINGS

The large majority of respondents (16 of the 18) expressed opposition, with varied qualifications, to the view that "it is best for the mother to be immediately separated from the retarded child at time of delivery."

Some responses were:

No never. She has a right to see her baby—it's hers. The situation must be carefully handled.

Sometimes one cannot tell if the baby will be retarded. A mongoloid or simple case of retardation should not be placed or immediately separated. A "monster" should be.

No, I strongly disagree. It would have a bad effect on the mother. She must say Hello before she can say Good-bye. The psychiatrists might have the best answer. For some women immediate separation might be best because of their own stability.

No, even if the decision is to give him up later. Sometimes, if the condition is very serious, yes. But even mongoloids, the mother should be allowed to care for.

I am not in favor of immediate separation of mother and child unless there is a severe psychological component on the part of the mother. Separation should be gentle.

To separate immediately the mother and retarded child is not a realistic move. The situation is not helped but, rather, more doubts and guilt feelings may come of such a move.

No, I am not in agreement with separation of the mother and child at time of birth and all I have is my experience (25 years) to bear me out. Immediate separation is best only if the retardation is beyond hope and is associated with a physical disability that is horrifying. In the absence of disfigurement no child should be separated from its mother at that time.

This is the mother's decision to make. It's her child; she must decide. It's almost like the decision of an unmarried mother whether to give the child up for adoption or not. She has to think of her present feeling as well as possible future regrets.

Twelve of the 18 respondents felt that the views expressed by them on this matter found consensus among other obstetricians. This latter group included the 2 obstetricians favoring early separation. Two felt that they expressed minority views, though these were among the majority group opposed to early separation. Four obstetricians reported that they did not know the views of other obstetricians, and there were physicians with more than 10 years of experience.

As a partial check to the previous responses, each respondent was asked to comment on the view that "retarded children, especially under 5–6, should be kept at home."

Fifteen obstetricians expressed qualified agreement. One made no reply to this question. Many of these respondents suggested that each case had to be judged individually. Of the two obstetricians who had previously favored immediate separation, one expressed opposition to keeping the child at home, and one was too ambiguous in his response to classify.

Some responses were:

I can't give a general opinion. It depends on how it affects the home situation and other family members. If the child creates a severe problem it is not advisable. It also depends on the defect. In general the care would be better at home by the child's own parents.

The idea that children under 5 or 6 should be kept at home depends on the type of mental retardation, the facilities at home, and the reaction of other siblings at home. Generally, every case should be judged individually.

Keeping mentally retarded children under 5 or 6 at home depends upon the stability of the family. If the mother and father have insight into the problem and can care for the child as well as the rest of the family, then the child should be kept at home. The 3 things to be considered here are intelligence of the parents, capability of the mother, and insight into the problem.

Retarded children, especially under 5 or 6, should not be removed from the home unless there is apparently a severe degree of retardation.

I would keep this type of patient at home if I felt that he would obtain the proper kind of care, as I feel that love, interest, and care at home are better than institutional care. However, if the home situation were not good, then I would find the proper institution.

I agree with that concept. Give the child opportunity to grow up in surroundings that have been congenial because it's his own family. When school age comes he would have some contact with his own level of intelligence and then, often, institutionalization is best.

It is interesting to report that only 3 obstetricians expressed the view that the decision for institutionalization was essentially a parental responsibility. Almost all obstetricians assumed that the decision-making was theirs.

OTHER FINDINGS

Perhaps one of the most revealing findings is the very small number of retarded children reported delivered by these obstetricians during the last 5 years. Four obstetricians reported no deliveries of retarded children; 7 reported deliveries of 1 or 2 retarded babies; 1 estimated deliveries of 3; 3 reported births of 5 or 6; and 3 could not make any estimate. On reflection, given the relatively few births of mongoloid children and severely retarded identifiable at birth, it would be expected that the number of reported deliveries for each obstetrician would be very small. Thus, in a sense, their experiences with the problem of mental retardation are necessarily limited.

Five obstetricians seemed to equate mongolism with severe retardation, a few suggesting a picture of a total, unchanging helplessness. Whether this view of the mongoloid child is prevalent among other obstetricians is not known.

DISCUSSION

The major questions raised by this small sample of interviewed obstetricians are: Do these expressed views represent their true opinion? and How does one reconcile these views with those reported by many parents?

First, of course, we cannot be sure that the views expressed are those which the obstetricians actually accept and which guide them in dealing with their patients. We recognize that the questions asked may have predetermined the replies; perhaps the respondents were dissembling, trying to please the interviewers.

But on the basis of the responses, despite some contradictions and ambiguities, and after checking with the interviewers who talked with the physicians, we believe that these views are not dissembled. We feel that perhaps they reflect the *beginning* of a change in the climate of opinion* at least within the Boston area. It is also a possibility that many of these obstetricians are not accurately recalling what they do say to parents in the concrete situations, since the occasions are so very infrequent; i.e., of the average of 1250 reported deliveries for each obstetrician in 5 years, only a few identified retarded babies were seen.

How do we reconcile these reported views with those of parents who have generally stated that their obstetricians have manifested a deep bias favoring early institutionalization?

If we cannot be sure of the authenticity of the expressed views of these obstetricians, neither can we accept, without qualification, the experiences of parents as they report them. Bad news is bad news, and little can be said to modify the impact of what for many parents is a tragic fact, especially in the stressful time following discovery. Are parents using physicians as scapegoats for their anger and frustrations? E. R. Kramm notes in her study that all parents whose firstborn was a mongoloid child reported that they were poorly handled by their physicians. The smaller the family, Kramm found, the more likely was the parental response to the physician's treatment a negative one. Certainly no one could claim that all these physicians attending small families were inept and biased toward early institutionalization.

Finally, it is fair to say that busy obstetricians and distraught parents are hardly likely to achieve clarity in their communications involving a mutually distressful experience.

* How widespread these views are we cannot say.

SUMMARY

On the basis of a small sample of obstetricians in the Greater Boston area, the writers note the possibility of the beginning of a change in the climate of opinion regarding the institutionalization of severely retarded children. Only further study of a larger and more representative sample in other cities can determine the direction and frequency of attitudinal changes among obstetricians. The value of such a study might be enhanced if it were associated with a study of parental experiences immediately following the delivery of an apparently retarded child.

Some obstetricians would seem to require clarification regarding the widely varied capacities of mongoloid children.

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REFERENCE

1. KRAMM, E. R. Reactions and patterns of adjustment of the family to the mongoloid child. Unpublished Ph.D. Thesis, University of Pittsburgh, 1958.

Attitudes of Some Pediatricians Toward The Institutionalization of Mentally Retarded Children[1]

Simon Olshansky and Leon Sternfeld

A number of professionals employed in institutions and in clinics serving mentally retarded children have reported to one of the authors (S. O.) that many pediatricians tend to favor the early institutionalization of mentally retarded children. In addition, several parents visiting the Children's Developmental Clinic in Cambridge, Massachusetts, and other parents attending meetings of the Boston Association for Retarded Children have reported some evidence of this bias of some pediatricians toward early institutionalization. Finally, reports appearing in the literature (Kugel, 1961; Farrell, 1956; Koch, 1959) provide further data supporting this bias.

To investigate these allegations and reports that pediatricians tend to favor early institutionalization, a study of attitudes of pediatricians in the Greater Boston area was undertaken.

Method of Approach

A non-random sample of 30 pediatricians was selected for *personal* interview. Because the size of the sample was limited by funds available, we were less concerned with the representativeness of our sample than with the dimensions of their experience and their geographical distribution; i.e.' we were intent on contacting those pediatricians who were considered leaders in the field as well as the eight pediatricians practicing in the City of Cambridge. Cambridge, though an independent city, is viewed as part of the Greater Boston Area. The Children's Developmental Clinic participating in this study was interested in reaching the local pediatricians who hopefully would be case finders for its clinic.

The sample included thirteen pediatricians with more than 20 years of experience, six with between 10 and 19 years of experience and eleven with between 1 and 9 years of experience.

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1 *This study was financially supported by The Medical Foundation, Boston, Massachusetts, and the Massachusetts Association for Retarded Children. Gertrude Johnson and Marjorie Kettell of the Children's Developmental Clinic offered many useful suggestions in the preparation of this article.*

All interviewing was done during the winter of 1960-61 by two skilled interviewers, one a social worker and one a clinical psychologist. The majority of questions were open-ended.

The two major questions asked (not in direct sequence) were: Would he comment on the view that "retarded children, especially under 5-6, should be kept at home?" Would he comment on the view that "it is best for the mother to be immediately separated from the retarded child at the time of delivery?"

The Community Research Laboratory[2] of the Cambridge Health Department sponsored the study. The interviewers identified themselves as representing that agency. All respondents were assured of anonymity. No pediatricians, despite busy schedules, refused to be interviewed.

Major Findings

In response to the first question, (Would he comment on the view that "retarded children, especially under 5-6, should be kept at home?") 28 interviewees expressed varying degrees of approval. Even the two physicians who expressed opposition recognized certain exceptional cases of children who should be kept at home. Six pediatricians, including the latter two, favored the early institutionalization of the mongoloid child.

The quality and flavor of the views of the pediatricians on this latter question can be seen from the following selected quotations[3] from the collected interviews.

"I have already commented on this view. Immediate separation of mother and child often creates a lot of guilt feeling in parents which persists for many, many years. The defective child should spend - at least - his early months at home. As a child becomes older, the degree of retardation can be assessed more easily. Until he is six years old, he is not in a competitive atmosphere and it is in the competitive atmosphere that he becomes most frustrated."

"My comment here is that they should be kept at home so that they can get the care and love of the parents. This also prevents the parents from developing guilt feelings or feelings that they have rejected the child."

"This depends upon the parents' attitude and what the child is like. Many mentally retarded children are quite tractable in the home. Then too, the other siblings have to be considered for they too need parental contact which might not be received if there is an MR child to be cared for."

[2] *The Community Research Laboratory, supported by the Medical Foundation, undertakes research investigations which aim to explore and measure community health needs.*

[3] *The interviewers attempted to record responses verbatim.*

"Perhaps these children will get better nursing care in the home and then too, they might not. Each case has to be individually treated."

"I think that on the whole it is better for the child to be at home, particularly during these years. I think he can profit more in a home situation."

"This is a fallacy. I feel bitter because it's a platitude that we hear often and then think it's true. It causes confusion and guilt. The doctor should make the decision and then persuade the parents. Of course there are many cases where it's best for both parents and child to keep child at home."

"Depends on home conditions, facilities, and attitude of parents. Most part - yes, but sometimes too unfair to other children at home. Depends on how "bad" the child is."

"Depends on how badly retarded the child is. If he's not destructive he should stay at home. If he must have everything done for him he should not be kept at home - usually."

"Any child is better off at home than in an institution. The less the child is retarded the more this is true. With the idiot it's an unimportant consideration. Must balance gain for child against adverse effect on family."

"Yes - when possible. Must evaluate each case and each family individually. He spends much time evaluating each family as a whole. A mongoloid can be taken care of at home."

"Yes - perhaps not mongoloid. Also, depends if there are other children, what family economics are (cost less to keep at home). If destructive to other children, it has to be done for their sake."

"Depends entirely on parents' feelings. Depending on severity, diagnoses and prognosis."

"Yes, unless urgent reasons to contrary. The siblings learn from the experience. Help is available through agencies."

Regarding the question (Would he comment on the view that "it is best for the mother to be immediately separated from the retarded child at the time of delivery?"), 27 of the 30 pediatricians expressed varying degrees of opposition. Almost all the pediatricians acknowledged the difficulty of making a diagnosis at time of birth and were aware of the need of the mother to see the child and to live with it, unless it is a "monster".

Some samples of their thinking on this question follow:

"The diagnosis of MR cannot be made at birth. Generally, the child can't be appraised until he is at least six months old. Thus, an immediate separation would not be realistic."

"I don't feel this is right. One might say that to do this is to follow the view that you can repress the emotions, but you can't close your eyes - the problem first has to be faced and then worked out."

"Unless the mother is particularly unstable, separation at this time is not recommended."

"In some cases immediate separation is advised. In most cases, no. It is better for the parents to face reality."

"This is really a big question which has been discussed with many varying points of view. Here again, the whole situation must be considered. Some doctors are in favor of immediate separation of a mongoloid child. Generally, I'm not in favor of this - I'd rather see them in a home situation."

"No, why should she be? Mother has the right to be informed as soon as she is able to understand the information."

"No, raises too many guilt feelings. Mother may feel that she has "thrown away" her baby. Even a mongoloid baby seems normal the first few months. Even with a mongoloid it is usually better to wait until the mother asks to have the child placed."

"Absolute no. She has to suffer at that time if she is not to feel later guilt at throwing the child out. She has to make the decision herself."

"No, not good idea because diagnosis not that good. If grossly deformed, then maybe because of great problems in care."

"Definitely never be done. Even if child is so bad, mother still has to see and work through her feelings."

"Definitely not. Even if grossly deformed, mother should see child and if she wants, take it home. Depends on individual needs, resources, etc."

Fifteen pediatricians felt that their views about institutionalization of retarded children under 5-6 found consensus among other pediatricians; only twelve felt their views regarding immediate separation at birth found consensus among their colleagues.

Other Findings

Perhaps one of the significant findings is the relatively small number of retarded children identified by the majority of interviewees within the last five years. Ten of the pediatricians had identified a total of between 5 and 10 during this five-year period; five had identified between 11 and 20 retarded children; one had identified about 25; three had identified about 50; seven had identified about 100 to 300; one had seen several thousand.[4] Three had refused to estimate the number identified, though they admitted it to be rather small. In short, slightly more than half of the sample population had identified on the average less than a handful of retarded children during each of the last five years. The minority of pediatricians who reported having identified substantially more had included patients seen in clinics outside their private practice.

Another finding which emerged is that only five pediatricians considered that the decision to institutionalize belonged to the parents, and only four pediatricians noted that regarding institutionalization each case should be considered on an individual basis.

A final finding is that 20 pediatricians reported that the counseling of parents is the most important service they could render to parents of mentally retarded children.

Discussion

It would appear that there is some disparity between the views of pediatricians toward institutionalization reported in this study and the reports of some parents and some professionals referred to earlier. Are the physicians dissembling? Or are the parents not hearing what they are told? In the absence of more definitive data we cannot answer these questions. We suspect, however, that pediatricians and parents probably communicate poorly with each other. Busy doctors and harried parents are not likely to talk clearly and understandably to each other about a subject fraught with so many emotions and feelings.

Another interesting question raised by this study is, why do pediatricians report so few children identified by them as mentally retarded? In the absence of more definitive data we can only speculate. First, of course, is the difficulty (Kanner, 1957) of making a diagnosis, except for the severely and visibly retarded which represent only a very small fraction of the total population of retarded. Thus, it is probable that some retarded children are being seen but not identified. Involved in the difficulty is the reported tendency (Korsch, 1961) of some pediatricians to over estimate the level of intelligence of children who are functioning subnormally.

Second, the majority of children in the general population who are identified as mentally retarded are minimally retarded and are more likely

[4] *This physician is employed by a large hospital with a reputation for services to the retarded. His estimate includes both his clinic and private practice. He can be more properly classified as a pediatric neurologist.*

to be found among the poor, who are least likely to use regularly the services of a pediatrician. Though it has been assumed that the severely and moderately retarded are randomly distributed in the population, recent data (Knobloch - Passamanick, 1961) raise questions regarding the validity of this assumption. If the severely and moderately retarded are also over-represented among the poor, this might be another factor explaining the small number of retarded children seen by pediatricians, who are not likely to be in contact with this deprived population.

We had noted that one-fifth of the sample population tended to view all mongoloids with despairing negativism. The variability[5] of mongoloid performance and development has apparently less than universal acceptance among pediatricians. Knobloch and Passamanick report that they have found a number of mongoloid children functioning in the normal range.

If reconsideration of mongoloid variability is indicated so is the assumption of some pediatricians that the mongoloid automatically belongs in a institution. A recent visitor from Switzerland was stunned by the number of mongoloid infants she found who had been "put away" in institutions. The return to the clinical tradition of judging each mongoloid child individually seems indicated.

Lastly, we found few pediatricians who had integrated their views into an organized perspective (Bryant-Hirschberg, 1961) which might guide them in their day-to-day relationship with parents of mentally retarded children. We would suggest that such a perspective would include the following points: (1) that the home generally provides a better setting than an institution for the growth and development of any child; (2) that "immediate separation" at time of birth is contraindicated unless the child is so grossly disabled that it requires continuing nursing care, or the mother is emotionally unable to respond appropriately to the crisis of giving birth to an imperfect child; (3) that in regard to institutionalization, each child should be judged individually, with the ultimate decision to institutionalize to be made by the parents. We would suggest that the physician's role is to state clearly the diagnostic and prognostic facts, and to help parents calculate and consider the psychological costs and gains attending any decision that they may make.

Summary

Within the framework of this study we found relatively little evidence to support the views that pediatricians favor early instiutionalization. However, few pediatricians considered the decision to institutionalize as belonging to the parents.

[5] *Misconceptions regarding mongolism persist in non-medical literature. See Dunn, L.C., and Dobzhansky, Th., Heredity, Race and Society, a Mentor book. (Revised and enlarged edition), 1952.*

The majority of the pediatricians interviewed saw few children in the course of their daily practices whom they identified as mentally retarded.

References

Bryant, K. N. and Hirschberg, J. C., "Helping the Parents of a Retarded Child." *A.M.A.J. Dis. Child,* 102:52, 1961.

Farrel, M, J., "Adverse Efforts of Early Institutionalization of Mentally Subnormal children." *A.M.A.J. Dis. Child,* 9:278, 1956.

Kanner, L., *Child Psychiatry*. Springfield, Ill., Charles C. Thomas, 1957.

Knobloch, H. and Passamanick, B., "Some Thoughts on the Inheritance of Intelligence." *Amer. J. Orthopsychiat.,* 31:454, 1961.

Koch, R. et al, "Evaluation of Parental Satisfaction with the Medical Care of a Retarded Child." *Pediatrics.* 23:582, 1959.

Korsch, B., Cobb, J., Ashe, B., "Pediatricians' Appraisals of Patients' Intelligence." *Pediatrics,* 27:990, 1961.

Kugel, R. B. and Reque, B. A., "A Comparison of Mongoloid Children." *J.A.M.A.,* 175:959, 1961.

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Abstract. The authors report a study of the attitudes of general practitioners toward the institutionalization of mentally retarded children. Though the majority of physicians opposed their early institutionalization, many had not formulated their views into an organized perspective which would facilitate their dealing with parents. The majority of physicians had seen relatively few children whom they identified as mentally retarded.

by Simon Olshansky
Gertrude C. Johnson
Leon Sternfeld

Attitudes of Some GP's Toward Institutionalizing Mentally Retarded Children

This is a report of findings of a study based on interviews with general medical practitioners within the city of Cambridge. The purpose of the study was twofold: to determine certain attitudes of general practitioners toward mental retardation, especially specific attitudes toward the early institutionalization of retarded children; and to determine their acquaintance with the Cambridge Service for Retarded Children, a facility sponsored by the Children's Bureau, the Massachusetts Department of Public Health, and the Cambridge Health Department. The clinic in existence since July 1, 1957, has been offering, during the last three and one-half years, diagnostic and treatment services to families with children who are retarded or suspected of being retarded.

Method of Approach

The Cambridge Health Department furnished a list of 64 names representing all the general medical practitioners working in Cambridge.

Each physician was contacted by telephone for a personal interview and visited at a time fixed by the physician.

All of the interviews which took place during the winter and spring of 1960 and 1961 were conducted by two social workers who were representatives of the Community Research Laboratory of the Cambridge Health Department. The Laboratory, supported by the Medical Foundation, undertakes research investigations which aim to explore and measure community health needs. Each interview was 30 to 45 minutes in length. All physicians were assured anonymity at the beginning of the interview.

Fifty-seven interviews were completed. Seven physicians refused to be interviewed, offering as the major reason for their refusal that they saw "no retarded children."

Thirty-five of the physicians interviewed (61% of the sample) had been in practice for more than 20 years; 12 (21%) were in practice between 10 and 19 years; and 10 (18%) were in practice between one and nine years. The sample was biased toward the older, more experienced physician as most of the interviewees were in their late fifties and early sixties.

The two major questions asked (not in direct sequence) were:
(1) Would you comment on the view that "retarded children, especially under 5-6, should be kept at home"? and (2) Would you comment on the view that "it is best for the mother to be immediately separated from the retarded child at time of delivery"?

Findings:

In response to the question, "Would you comment on the view that 'retarded children, especially under 5-6, should be kept at home'?", three-fourths of the respondents expressed some degree of approval, while 10 (18%) responded with varying degrees of disapproval. Four responses (7% of respondents) were too ambiguous to classify.

Some verbatim responses to this question follow:

"I go along with that. A mother's care up to four or four and one half is good, although this should be qualified according to the individual case."

"I agree. A child prospers better at home. His parents are more interested in him than any institutional staff could be, and he needs love and attention to bring out his greatest potential, whatever that may be."

"No hard and fast rules — it depends on individual situation. If the child is teased by older children, then yes. If the child can be accepted at home, it is best he stay there."

"No. It's better to institutionalize early. The longer it takes, the longer 'the knife is in the side.' "

"Yes, except for grossly retarded child — it is better for the child and family to keep the child at home. For moderately retarded child, it is best to have loving care as long as possible."

"Not a real question. The retarded can be easily detected at birth. He should be institutionalized and tidy up family situation."

In response to the question, "Would you comment on the view that 'it is best for the mother to be immediately separated from the retarded child at time of delivery'?", about three-fifths of the interviewees expressed varying degrees of opposition to immediate separation; 23, about two-fifths, favored immediate separation. One physician refused to answer the question. When asked if their views on this question applied to the mongoloid child, slightly less than half of all respondents favored immediate separation. The feeling was expressed that the mongoloid was "hopeless" and it was not a good idea for the mother to get "too attached to the mongoloid child."

Some verbatim responses to the above question follow:

"Yes. If they are going to do it at all, that's the time.

"A child means nothing until you have handled it, cared for it — there's no attachment."

"A final diagnosis is impossible at delivery. Any such separation would be entirely out of line without a much more careful work-up. Indeed, I'd be slow to reach a drastic negative opinion for several years."

"Very often retardation cannot be detected at birth. When it can, it's usually so severe I do try for immediate institutionalization. I try to get the father to persuade the mother too. It's bad enough, but I'd rather see the mother suffer for a shorter time and get over it and be free to go ahead with other plans."

"Many children cannot be picked up as retarded until long after delivery. The rest, the mother must see to understand what the situation is." (He does not recommend breast feeding; this makes the mother too attached to the retarded child.)

"That's right. She shouldn't get too attached; it's bad for her. And neither should the child get too attached — it's bad for him in the end when he has to be separated."

"I'm surprised even to hear this. What are you supposed to do with a kid? Shoot it? Fernald and the other schools are full of mistaken commitments, people with potential who never had a chance. This is archaic. It's no answer to put a child away."

Another significant finding is that within the last five years the large majority of interviewed physicians had seen very few children whom they had identified as mentally retarded. Forty-one (72%) of the 57 physicians had seen five or fewer children whom they had identified as mentally retarded; 10 respondents had identified between six and 10 children as mentally retarded; three reported identifying between 11 and 15 retarded children; one reported identifying about 18 such children, and two stated that they had identified about 25 retarded children. For five years, the total number of children identified as mentally retarded was 274, one-fourth of whom were mongoloid. On the average each physician had identified slightly less than five retarded children within the last five years.

It is worth reporting that the length of experience and the frequency of contact with retarded children were not consistently related to the attitudes expressed.

Acquaintance with Service

To determine the physician's acquaintance with the Cambridge Service for Retarded Children, each physician was asked if he had heard of the Service. Though 30 of the 57 general practitioners responded positively, only 8, about one-seventh of the sample population, could provide any identifying data regarding the clinic, such as its location, its sponsorship, and its services.

Though this finding will be discussed later, the above responses should be judged against the following facts. The clinic, part of the Cambridge Health Department, has been in operation for more than three years. Innumerable releases in local newspapers have been published regarding the clinic and its services. Each physician had received a personal letter from the physician at the clinic giving information about services. In addition, more than six mailings in regard to the clinic were sent from the Cambridge Health Department. The annual report of the Cambridge Health Department which includes a description of the clinic is sent to each physician. The annual report of the Cambridge Service for Retarded Children had been sent to each physician prior to this study.

Finally, each respondent was asked what he thought the Cambridge Service for Retarded might do to encourage its increased use by local physicians. Thirty-five physicians suggested a personal interview by a clinic representative; 18 suggested contact through the local medical society; seven suggested reaching physicians through local hospitals, and six had no suggestions to offer.

Discussion

Before discussing the reported findings, it is important to note that the general practitioner in the United States sees about 75 per cent of all children. As a casefinder and source of referral, therefore, he might be of great significance.

Why then, it might be asked, has the local general practitioner in Cambridge seen so few children whom he identified as mentally retarded?

First, of course, it is extremely difficult to make a definitive diagnosis, except in the cases of the severely retarded and the mongoloid child. These latter groups represent only a small minority of the retarded population since 75 to 80 per cent of the retarded fall within the category of the "mildly retarded." What adds

difficulty to the general practitioner's diagnostic task is the nature of medical practice, at least within the Cambridge area. The lower class family who takes its child to the general practitioner does so only occasionally and intermittently during episodes of acute illness. At the time of such single contact, both the family and the doctor are intent on dealing with the acute illness, not in investigating clues of subnormal functioning. A few physicians expressed the fear such an investigation, even if indicated, might alienate the family.

If this sample is representative and not only of local significance, it would appear that the bulk of retarded children who are minimally retarded will continue to be identified by the schools. A recent epidemiological study (New York, 1955) of mental retardation would support this latter statement. That such delayed identification for some retarded children may carry with it certain costs is accepted, especially where early intervention is advantageous in controlling, reducing, or eliminating retardation (as in such infrequent conditions as galectosemia and phenylketonuria). The assumption, however, that early identification is necessarily beneficial for the child and/or the parents requires investigation. For some children we would contend (in the absence of firm data) that early identification may provide greater psychological costs than gains, especially if such identification is not associated with continuing, appropriate and adequate intervention. We may note that at the present time, that kind of intervention is available for few patients.

Expressed attitudes of the physicians may be judged in terms of their limited experiences and of their limited interest in mental retardation, or in terms of their medical school education, which for a large majority had been completed more than 20 years ago. Moreover, many other pressing issues demand the general practitioner's attention and time. Too often professionals working in specialized services forget that there are other problems beyond those they are compelled to deal with.

The physician's responses might also be judged against "the new views" (Bryant & Hirschberg, 1961) developing in the field of retardation which the authors accept and support. These "new views" are that in large measure the home (S.A. Centerwall & W. R. Centerwall, 1960; Farrel, 1956; Kugel & Reque, 1961) provides a better setting than an institution for the growth and development of any child, that "immediate separation" at time of birth is contra-indicated unless the child is grossly disabled requiring continuing nursing care, or the mother is emotionally unable to respond appropriately to the crisis of giving birth to an imperfect child. In regard to institutionalization in the framework of the "new views," each case should be judged individually, and that ultimately the decision to institutionalize should be made by the parents. The physician's role is to state clearly the diagnostic and prognostic facts, and to help parents calculate and consider the psychological costs and gains attending any decision they may make.

In the light of the above it would appear that a large number of general practitioners have a long way to go in developing attitudes which blend with all aspects of the "new views." But it is important to note that the data we have gathered clearly show that the majority of interviewed physicians favor keeping the pre-school retarded child at home, and oppose the immediate separation of mother and retarded child at time of birth. That a substantial minority is still willing to separate mother and child immediately following birth is disturbing. Equally disturbing is the assumption that the decision to institutionalize belongs to the physician. Though the absence of institutional facilities often provides a veto to the

physician's recommendation to institutionalize, the psychological outcome for many parents in disregarding their physician's recommendation may be increased discomfort and anxiety. Our own clinic experiences suggest that in some cases the outcome is a reduced confidence in the physician's wisdom when he suggests institutionalization in a dogmatic way, without prior and patient discussion with the parents.

In consideration of the mongoloid child, the attitudes of many of the interviewed physicians were still quite traditional. The mongoloid child was viewed by too many respondents as "hopeless," and best placed in an institution as soon as possible. Recent data (Knobloch & Pasamanick, 1961) suggest that there is some variability in the capacities of mongoloid children, and that they, like other children, benefit from maternal affection. In any case, the decision to institutionalize need not be a hurried one and each case should be considered individually.

Moving on to a more general issue, this investigation raises the problem which many agencies and clinics experience: how to reach the busy physician in order to tell him about the community services available to him which may be useful to some of his patients.

Though the majority of respondents suggested personal contact, this suggestion carries with it a major obstacle: the physician's lack of time. During these interviews many physicians were quite restive, eager to get back to their major task—treating the ill. Whatever solution might be developed, it is quite clear that newspaper releases and personal mailings are not generally effective ways of communication, especially when the physician's interest and attention are elsewhere. Physicians like other professionals are selective in their responses, and will disregard material not perceived as relevant to their day-to-day work. For the majority of interviewed physicians the knowledge of the clinic for the retarded was not a relevant matter since they saw few patients whom they identified as mentally retarded.

Summary

On the basis of interviews with 57 general practitioners, about 90 per cent of all general practitioners working in Cambridge, it was found that they treated relatively few children whom they identified as mentally retarded. It was noted that the bulk of retarded children will continue to be identified by the schools.

Though the majority of physicians favored keeping the pre-school retarded child at home, and opposed the immediate separation of mother and retarded child at time of birth, many have a long way to go in developing attitudes which blend with all aspects of the "new views." Many physicians were quite traditional in their views on the mongoloid child.

The difficulty of reaching the local physician for the purpose of acquainting him with a community service was discussed.

References

Bryant, K.N. and Hirschberg, J.C., "Helping the Parents of a Retarded Child." *A.M.A.J. Dis. Child,* 102:52, 1961.

Centerwall, S.A. and Centerwall, W.R., "A Study of Children with Mongolism Reared in the Home Compared to Those Reared Away from the Home." *Pediatrics,* 25:678, 1960.

Farrell, M.J., "Adverse Effects of Early Institutionalization of Mentally Subnormal Children." *A.M.A.J. Dis. Child,* 9:278, 1956.

Knobloch, L. and Pasamanick, B., "Some Thought on the Inheritance of Intelligence." *Amer. J. of Orthopsychiat.,* 31:454, 1961.

Kugel, R.B. and Reque, B.A., "A Comparison of Mongoloid Children." *J.A.M.A.,* 175:959, 1961.

New York State Department of Mental Hygiene, Mental Health Research Unit. *Technical Report,* 1955.

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Attitudes Of Some Internes And First-Year Residents Toward The Institutionalization Of Mentally Retarded Children[1]

Simon Olshansky and Marjorie Kettell

This is a report of findings based on interviews with internes and first-year residents in four private general hospitals. All hospitals were located in the greater Boston area, three serving all age groups and one serving only children. The major purpose of the study was to determine to what extent young physicians accept the "new views" (Bryant and Hirschberg, 1961) which are gaining recognition in the field of mental retardation. By "new views" we mean that home life is generally preferable to institution life, that separation of mother and retarded child at birth is contraindicated except in special cases, that the decision to institutionalize should be determined case by case, and that ultimately the decision should be made by the parents. Further, it is felt that the role of the physician is to state as clearly as possible the diagnostic and prognostic facts, in order to help parents calculate the psychological costs and gains attending their decision.

In addition, the physicians' knowledge, training and interest in mental retardation were investigated to provide a context within which their attitudes might be evaluated.

Method of Approach

The four hospitals contacted furnished a list of forty-five internes and first-year residents who could be made available for interviews. Each physician was telephoned for an appointment and then interviewed at a time suggested by him. All the interviewing was done during the spring and summer of 1961 by two social workers who identified themselves as representing the Community Research Laboratory[2] of the Cambridge Health Department. Each interview took twenty to thirty minutes. All interviewees were assured of anonymity.

Forty interviews were completed; five interviewees were unable to keep the appointments made by them because of their busy schedules. The

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2. The Community Research Laboratory, supported by the Medical Foundation, undertakes research investigations which aim to explore and measure community health needs.

sample consisted of twenty internes and twenty first-year residents. The young physicians had come from a variety of medical schools. Harvard Medical School had the largest representation with nine graduates and Boston University Medical School ranked second with six graduates. Five had been trained abroad. The remaining twenty were widely distributed among many medical schools.

The fields of expected specialization for our interwiewed population were as follows: internal medicine was selected by 17 respondents; pediatrics was selected by 12 respondents; surgery, psychiatry, neurology, pathology, radiology and research were selected by the other 11 respondents.

Thus, the sample population may be unrepresentative since so many interviewees are graduates of two medical schools (Harvard and Boston University) and since so many are planning to become internists and pediatricians.

The two major questions asked, not in direct sequence, of each physician were:

1) "What is your opinion of the view that retarded children, especially under 5 or 6 years of age, should be kept at home?"
2) "What do you think of the view that it is best for the mother to be immediately separated from the retarded child at the time of delivery?"

Findings

In response to the first question of keeping retarded children at home, 32 of the interviewees expressed varying degrees of approval. The major factors that would be considered by the respondents in their decision to keep the child at home were as follows: general family stability (cited by 27); severity of retardation (cited by 17); impact of siblings (cited by 12).

Only fourteen respondents of the total sample felt that each case should be judged individually. Three felt that the decision to institutionalize is the responsibility of the parents. Only two respondents who had favored keeping the pre-school retarded child at home would make an exception in the case of the mongoloid child.

Some responses recorded verbatim to the first question were:

> *Yes. Children in institutions lack mothering. Actually ambivalent. Depends on the family situation. A child like that could destroy the equilibrium. If the parents don't want the child don't force them to keep it. Is an individual matter, but would probably keep at home until that age (5 or 6).*

Too general a view. Depends on the home and if there are younger children. If the child were unable to do anything, mother would have to neglect other children and this wouldn't be good. Also child may need medical care and attention which cannot be gotten at home. Other than these reasons it's better for the child to remain at home during the formative years.

Would say no to a categorical statement like that, on principle. In general, yes. Criteria for determining retardation are not perfectly clear. Child has a better chance to develop at home. Retardation is relative to level of functioning. Emotional and sociological aspects of the home are more compatible with getting the most out of the child.

Depends on the individual situation. Would consider parental stability and their ability to take it, and their ability to care for the child.

In response to the second question of separating the retarded child from the mother immediately at delivery, 39 of the 40 respondents expressed varying degrees of opposition. Twenty-three respondents opposed the idea of separation because of the extreme difficulty of making a definitive diagnosis at that time. Six respondents said that they would consider separation only if the child were a "monster" or "vegetable". Six felt that early separation was a parental decision. Five would consider separation if the mother were adjudged "unstable". Five physicians favored early separation if the child were a mongoloid.

Some verbatim responses were:

It's poor for the mother to be immediately separated. For one thing, the diagnosis can rarely be final at that time. For another, the decision should be hers, and she should have plenty of time to get to know the various possibilities.

Don't agree! Mother's got to have a chance to live with and accept it gradually.

Bad idea. You never know how retarded they are at birth. You don't know mother's attitude. Not prerogative of M.D. to decide.

This is a funny view. You don't know they are retarded at birth. Mother should see the child. If she has put up with the difficulties of pregnancy for 9 months she certainly should see the child. If she doesn't want the child then separate. Should be taken home if at all possible.

Regarding the mongoloid child the feeling expressed by a majority of respondents is that the mongoloid is generally pleasant and manageable and can benefit from home life as much as any other child.

Other Findings

This section will focus on the respondents' training, knowledge and interest in mental retardation.

Regarding training in the field of mental retardation during their medical school careers, 10 of the 40 respondents said that they had received no lectures in the area of mental retardation. Fourteen reported having heard one to five lectures by psychiatrists, pediatricians, or pediatric neurologists. Two of these 14 physicians reported field trips to an institution for retarded children. Nine had from six to ten lectures and 7 had eleven or more lectures in the field of mental retardation.

In answering questions on the etiology of mental retardation, 27 respondents cited birth trauma and 25 considered heredity as important etiological factors.

In response to the question, what proportion of the retarded population is mildly retarded, 18 of the respondents estimated that between two-thirds and three-fourths of all retarded fall into the category of the mildly retarded. Nine of the respondents did not know and offered no estimate; 6 estimated the proportion to be about half of all the retarded; and 7 estimated the proportion to be between one-third and two-fifths.

Each physician was asked to name one authority in the field of mental retardation. Only 12, 30 percent of the sample, could cite a single authority.

Each respondent was asked to classify his degree of interest in the field of mental retardation as an area of future work. Twenty-six expressed no interest in the field; 10 expressed some interest; and 3 expressed much interest. The latter 3 were interested in biochemical and genetic research. One respondent did not care to classify his degree of interest.

Discussion

Despite rather limited knowledge, training, and interest in the area of mental retardation, the attitudes of the large majority of respondents were clearly in the direction of the "new views", especially toward keeping the pre-school retarded child at home. Early separation of mother and child was opposed by almost all respondents. However, contrary to the "new views", few physicians perceived the parents as the decision-makers in determining the institutionalization of a child. More than a third said that each case should be judged individually. Somewhat surprising, though gratifying, was the fact that the large majority expressed positive feelings toward the mongoloid child, describing him as pleasant and manageable. Few equated mongolism with idiocy.

The attitudes of these young physicians would suggest that the climate of opinion regarding the institutionalization of the mentally retarded may be changing.

Compared to the more experienced physicians (obstetricians, pediatricians, and general practitioners) whose responses to the same questions have been studied (Olshansky, 1962), these younger physicians seem considerably more sophisticated about the psychiatric implications of institutionalization and separation.[3] And it would seem that their attitudes toward the institutionalization of mentally retarded children have probably been influenced by their training in psychiatry and by some of the psychiatrics' assumptions which are operating increasinly within the American middle-class culture. However, it would be interesting to follow these young physicians to determine whether, under the impact of further hospital training and further experience in private practice, these reported attitudes would continue unchanged or regress to the more traditional views favoring the early institutionalization of mentally retarded children.

3. It may be noted that at present there seems to be developing among young professionals an "anti-institutional" ideology, based, first, on the feeling that family life is generally better than institutional life, and based, second, on the reported (and documented) fact that so many institutions are not of a high quality; i. e., they are overcrowded, understaffed, etc.

Summary

A sample of 40 internes and first-year residents in four private hospitals in the greater Boston area were interviewed. Their exposure to and interest in mental retardation were rather limited.

Despite these limitations, the large majority of respondents favored keeping the pre-school mentally retarded child at home, and almost all opposed the separation of mother and retarded baby at time of delivery. Regarding institutionalization, almost all respondents viewed themselves, rather than the parents, as the decision makers.

References

Bryant, K. N. and Hirschberg, J. C. "Helping the Parents of a Retarded Child'.' *A.M.A. Amer. J. Dis. Child.* 102: 52-66, 1961.

Olshansky, Simon, et. al. "Attitudes of Some Obstetricians Toward Mental Retardation" (Editorial). *Obstetrics & Gynecology,* Vol. 19, No. 1, January, 1962.

Olshansky, Simon, et. al. "Attitudes of Some Pediatricians Toward the Institutionalization of Mentally Retarded Children". (Unpublished)

Olshansky, Simon, et. al. "Attitudes of Some General Practitioners Toward the Institutionalization of Mentally Retarded Children." (Unpublished)

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