Parental Attitudes Toward Their Retarded Child

Barbara Burman Bronston

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PARENTAL ATTITUDES TOWARD THEIR RETARDED CHILD

A Thesis
Presented to the
Department of Special Education
and the
Faculty of the Graduate College
University of Nebraska at Omaha

In Partial Fulfillment
of the Requirements for the Degree
Master of Arts

by
Barbara Burman Bronston
December 1975
THESIS ACCEPTANCE

Accepted for the faculty of The Graduate College of the University of Nebraska at Omaha, in partial fulfillment of the requirements for the degree Master of Arts.

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<tr>
<td>Eugene K. Freeland</td>
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Date: December 1, 1975
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Special appreciation to all the parents of mentally handicapped children who returned the questionnaire, and an extra thank you to Mr. and Mrs. Leighton Goodrich for their letter of support.

To many friends for their support, and to my husband Mitch, a final word of appreciation is extended.
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Chapter I

INTRODUCTION

The attitudes parents have towards their retarded child are formed by many people. Previous contact and knowledge about mental retardation is one. The others are, contacts with the medical profession, reactions from other family members, and how the community supports and helps this group of people. Guilt and anger that parents have also contribute to their attitudes. In many cases the parents will feel a groundless personal guilt. (World Health Organization, 1954)

Research of a questionnaire indicates when and where parents first found out about their child's retardation, and from whom they received help. If the medical profession had been consulted, the results will show how the doctors handled the situation, and if their attitudes influenced the way the parent felt about the retarded child. It also discloses services the community offered at the time.

Attitudes and feelings the siblings of the retarded person has also influence to a great extent the family life and the way the retarded person is treated.

"Whenever a mentally retarded child becomes a hub about which all family activities rotate, whenever emotions, unfettered by reason, dictate the procedures employed in the care and training of a mentally retarded child, happy family relationships become endangered." (Slaughter, 1960:7)
The questionnaire probes the following areas: 1) how doctors respond to parents who have a retarded child, 2) how siblings of a retarded child feel, and 3) parental attitudes towards their delayed child.

STATEMENT OF THE PROBLEM

1. Only parents of a retarded child who have received support from the medical profession and community resources fully accept their child as retarded.

2. Parents perceive that their view of the retarded child affects the way other family members feel towards the retarded person.

3. Parents of retarded children perceive their other children needing guidance and understanding in developing their feelings and relationships with their retarded brother or sister.

HYPOTHESES

An investigation of the problems stated will test the following hypotheses:

1. The manner in which doctors inform parents that their child is retarded greatly influences the parents acceptance of the retarded child.

2. The way the parents view the retarded child affects the way other family members feel towards the retarded person.
SIGNIFICANCE OF THE STUDY

The information gathered and conclusions of this study will be interesting to the following groups of people: parents of the retarded and handicapped, teachers of special education classes, social workers, counselors, doctors, psychologists, the Associations for Retarded Citizens, and other groups that deal with specific disabilities.

PROCEDURE FOR COLLECTION OF DATA

A nine point Likert-type opinionnaire will be sent to parents who have children attending classes in the trainable mentally retarded classes at Westside Community Schools. (District 66) They will be asked to return the questionnaire within a two week period. A self-addressed stamped envelope will be enclosed. After this time, a follow up postcard will be sent out as a reminder. There will be 58 questionnaires mailed out.

PROCEDURES FOR TREATMENT OF DATA

The results of the questionnaire will be placed through a computer program to receive the statistical information desired. The questions will be tabulated on a percentage basis. The standard deviation, mean, mode, median, minimum, maximum, and range will also be determined for each of the 34 variables and the general family information data.
LIMITATIONS OF THE STUDY

This study is limited to Omaha, Nebraska. The questionnaire examines attitudes of parents who have children in one of the trainable mentally retarded classes in Westside Community Schools. The parents represent upper middle class income group, and are a predominately white population. All of the children in the study have been living at home as a member of the family.

DEFINITIONS OF TERMS

The following definitions will enhance understanding of the study.

**community based services:** Services provided for the mentally retarded citizen within the community he lives in, i.e., not in an institution. These services include services for the pre-school child, school, vocational services, and residential facilities.

**delayed:** Does not follow the normal patterns of development and in most cases is mentally retarded.

**institutions (for the retarded):** A building or set of buildings occupied by retarded people. The institution is the most restrictive alternative in providing the least restrictive services possible.

**mainstream:** To place retarded persons in classes with so called "normal" children. The purpose is to help retarded persons observe normal peer behavior, and to integrate the
retarded into other programs.

**normalization:** Utilization of means which are as culturally normative as possible, in order to establish and/or maintain personal behaviors and characteristics which are as culturally normative as possible. (Wolfensberger, 1972)

**retardation:** Mental retardation refers to significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior, and manifested during the developmental period. (American Association of Mental Deficiency, 1973)

**ORGANIZATION OF REMAINDER OF THE STUDY**

The remainder of the study is divided into four chapters. These are, a review of the related literature, relating to information the doctor gives the parent, impact on parents, and the feelings of the siblings; a description of the collection and treatment of the data, the results of the study, and a final chapter with summary, recommendations for future research, and conclusions. The results of the questionnaire will be sent out to all who returned the survey.
Chapter II
RELATED LITERATURE

The review of the related literature is divided into three areas. There is not a great deal of information in one area, and an overwhelming amount in others. The questionnaire probes for information in the fields of parental attitudes, retarded children's effect on their siblings, and how the doctor approaches the subject of mental retardation. The review of the related literature will be divided into the above three subject headings.

Attitudes of Physicians Towards Mental Retardation

The medical profession is very uncomfortable handling mental retardation. Therefore the amount of published information is very limited. Doctors are afraid to admit not knowing the answers, and therefore handle retarded children and their parents very badly. The physicians are treating parents in ways which seem to reflect their own uncertainty about retardation. (Bryant and Hirschberg, 1961) Many examples of physicians being unsure how to handle the situation are found. Parents become anxious and expect physicians not only to have answers to their difficulties, but also to do something immediately. These pressures may mobilize the physician's need to appear omniscient and prescribe immediately what he hopes will be a specific cure. (Group for the Advancement of Psychiatry, 1963) This reaction may come from a desire to be rid of the whole
problem. The physician then deals with the parent in a hasty manner instead of setting up positive, long term medical management for both the child and the family. Doctors have admitted to their lack of experience with the associated professions and agencies involved in retardation and to the inadequacy of their own training in the subject.

However, even though doctors are aware of their own limitations, they are not admitting it to the parents of retarded children. Doctors make statements that predict the future capabilities of the child even though to predict the future of a retarded child is not acceptable in modern day medicine. Many physicians decide what to say according to the level or degree of retardation. (Solomons, 1965) Being non-committal is often one way in which doctors get off the hook.

The manner in which the physician deals with the parents is, to a large extent, dependent upon the parental relationship with the physician. (Freeman, 1971) Solomons (1965) stated that parents go through three phases with their physicians: hostility, "shopping", and acceptance. Hostility refers to the parents inability to accept what the physician is saying. Because it is the doctor giving the unfortunate news about the child, the parent logically feels hostility towards him. "Shopping" refers to the parents going from one doctor to the next trying to find someone who will say there is nothing wrong with the child. Consequently, if parents "shop" long enough, they'll find someone who will tell them
what they want to hear. Acceptance is the final stage. At this point parents are fully aware of a problem and are willing to work on it. This final stage must be reached before any programs for the retarded can be considered. (Freeman, 1971)

Another problem doctors encounter is telling parents about a defective child at birth. Too many physicians unfortunately make decisions that should really be left up to the parents. These include, telling the parents to institutionalize the child, and to not see the baby at all. (Freeman, 1971) Sometimes the husband, (unconsciously thinking it best for his wife) sees the baby and decides that his wife should not see it at all. This may have serious consequences to the marriage at a later date.

Once a couple is faced with a handicapped child the question of what to do for the child arises. The attending physician is in the best position to give the most guidance, but unfortunately this isn't always the case. Many physicians, with all good intentions toward parents and child, recommend institutionalization. The attitude doctors have toward institutionalization is peculiar. Only a few physicians see the decision to institutionalize as belonging to the parents. (Solomons, 1965)

The decision to institutionalize a child should be strictly a family one. As one of many alternatives institutionalization should be considered, but not necessarily advocated by the doctor.

At this point the physician should diagnose
the problem. Wolfensberger (1965:131) has listed the problems of human management (programs for the retarded) based upon the medical model.

1. Diagnosis is better than no diagnosis.
2. Early diagnosis is better than late diagnosis.
3. Diagnosis is essential to successful treatment or case management.
4. Differential diagnosis is important for differential treatment.
5. Extensive evaluation is better than limited evaluation.
6. Team diagnosis is better than individual diagnosis.

All six statements can be applied to a medically ill patient that the doctor has, as well as the way he describes diagnosis for a retarded child. The diagnostic study may have an academically and intellectually satisfying goal, but service programs are open ended and much more frustrating. (Wolfensberger, 1969) This is especially so when the physician is unaware of community services.

Institutionalization seems to be the only alternative doctors give to parents with a retarded child. Many do not know of the services available in their own communities.

Olshansky interviewed 90% of the doctors who practice at outstanding medical clinics in the United States. 48% had never heard of the local mental retardation clinic. Only 14% could give data about its location, purpose, etc.
Previous to conducting the interviews, Olshansky had mailed the physicians six communications about the services available in their communities. (Schwartz, 1970)

The physician has many tasks to perform when talking with parents. One of the first steps to be taken is to decide how much information to give the parents at one time. This is especially so when the parents are learning of the retardation at a time other than birth. According to Freeman (1971), balanced, truthful information should be given, some hope along with the pathology, and emphasis upon the whole child and not just the handicap. There are many areas the physician needs to cover during the initial session with the parents. These areas include, nature and cause of the problem, dispelling of irrational parental guilt, treatment to be required, services available to help the family cope, arrangements for continued counseling, and discussion of institutional placement and alternatives. (Freeman, 1971:405)

This amount of information is a lot for parents to take in and assimilate at any given time. They may seem stunned, apathetic, or just unbelieving. Several subsequent appointments may be necessary before they can express their feelings and formulate their questions effectively. (Journal of the American Medical Association, 1965)

Just as the parents have many reactions to being informed of a retarded child, the physicians' response and feelings toward retardation affect their actions. Physician's
may also have a difficult time refraining from overly severe value judgements. They may begin to resent the parents for their unanswerable questions, their time consuming demands, their desire for dependency, and their maladaptive behavior. (Journal of the American Medical Association, 1965)

The physicians, like the parents, should recognize that their reactions are not unusual reactions, and they should not be denied. However, the physicians do need to work towards familiarity with community programs, and be willing to have an open mind in dealing with mentally retarded children.

Training of the medical personnel should be focused on assessment of the mental and physical handicap, the need for early referral to the appropriate center for full investigation, parent counseling, and cooperation with educators and the other professions that work with the defective child. (Australian Journal of Mental Retardation, 1974: 56-57)

Published papers and books tend to look and represent the "new" points of view, such as home care, and community based services. They mislead us about the typical practices.
Parental Reaction

No one can be fully prepared to be the parent of a handicapped child. The necessary socialization to the role of parent of a handicapped child is a transition to an unwanted and distasteful status for most if not all who find themselves in this position. It would be unrealistic to expect that parents should be happy about having a retarded child. The retarded child cannot always offer the parents the same rewards and satisfactions that a normal or gifted child can offer.

When parental expectancies are suddenly shattered, the parents undergo novelty shock. (Menolascino, 1974) Novelty shock may exist when the birth of an obviously atypical child occurs. An example is Down's Syndrome, but can also occur when a parent learns of a child's possible retardation at a time other than birth. Parents in novelty shock tend to become very inward directed, usually in a selfish and self-pitying manner. (Menolascino, 1974) It is up to management, (those persons that counsel parents) to help move them to a better frame of mind.

Aside from novelty shock, many parents experience other feelings and reactions when they learn about their child's retardation.

Guilt is said to be almost universal. (Freeman, 1971) Regardless of how much counseling is done, parents tend to look at themselves to see how they might have caused their child's retardation. If the child is known to be retarded
at birth, the parents rethink the pregnancy, trying to find some specific reason to blame it on. Depending upon the psychological make-up of the parents, some parents give up feeling guilty altogether, while others feel guilty the rest of their lives. The self blame is derived from many sources. The first source is producing a defective child. The others include, parents not feeling towards their child as they think they should, desire to send their child away, anger toward their child, and others. (Freeman, 1971) In addition to being universal, guilt is also misunderstood. Guilt covers a wide range of feelings. The tendency in the literature to stereotype parents of the retarded as guilt-ridden, anxious, insecure and emotionally traumatized, probably does violence to reality since wide individual differences are found to exist. (Begab, 1963)

Anger may be projected onto spouse or professional, but rarely upon the child directly. Lawson, (1968) reported that most of the parents of 20 severely handicapped Australian infants later described wishing that the infant would die and get it over with. This is admittedly a small population, but it does express the feelings of many parents. Olshansky brings this out in his classic article, "Chronic Sorrow: The Response to Having a Retarded Child" (Social Casework, 1962) The parent of a mentally retarded child suffers from chronic sorrow. The sorrow is a natural response to a tragic fact. According to Olshansky, (1962) professionals should stop asking parents to "accept" their child's
defectiveness. Olshansky submits that every parent, whether he has a normal or a mentally defective child, accepts his child, and rejects his child at various times, and in various situations. With time, the majority of parents mobilize their efforts on behalf of their children. The professional would be able to help parents more by realizing that chronic sorrow is a natural, and not a neurotic response to a tragic fact. If the worker accepts the concept of chronic sorrow, the goal in counseling the parents will be to increase the parents comfortableness in living with and managing his defective child. (Olshansky, 1962:119)

Denial of a disability seems to depend partly upon outward visibility, and may be a self protective reaction. (Freeman, 1971:396) Mechanisms of denial, repression and selective inattention have been described in detail as techniques whereby people are able to exercise control over the extent of their awareness. (Roos, 1963) There is really nothing unusual, therefore, to hear parents say "There is nothing wrong with him." Temporary denial is a natural and useful defense. However, carried to an extreme it can be harmful to all involved. (Love, 1973:169)

Most of the readings in the literature indicate that mothers are the first to see any type of delay, if it is not first apparent at birth. Many handicaps become apparent only during the course of development. The most obvious reason for this is that the mother is at home with the child
most of the time. She sees his day to day development and recognizes when something goes wrong. In a study by Hewett in 1970, 90% of the mothers were suspicious, i.e. sensed something wrong before a diagnosis was made, however, 1/3 of them became even more anxious in that no one would confirm that something was wrong with the child. (Hewett, 1970)

The average mother made an early decision to seek medical help, without depending upon advice from neighbors, friends, and relatives. She may have discussed the symptoms with the neighbors or a friend, but made the decision to seek help on her own. (Ehlers, 1964)

According to Farber, (1960) the mother's determined the impact that retarded children had on the family. Father's reactions tended to be neglected in the literature. Fathers were definitely more disturbed at having a retarded child, and especially if the child was a boy. This was true regardless of the social status of the family. (Farber, 1968) Grossman also describes the students who participated in her study as describing their mothers, but particularly their fathers, as more accepting of a girl than a boy retarded child. (Grossman, 1972:182) This reflects societies conception that boys are more valuable and worthwhile to a community, whereas girls will always need someone to take care of them. The father sees the boy as a leader, and a winner, possibly an extension of himself.

Once the parents have gone through the stages of having a
mentally retarded child, the family organization begins to take place. According to Farber, (1960) there are three types of family organization patterns developed by parents of a mentally handicapped child. The first of these is parent oriented. The parents focus on themselves, on their careers, while the child is in second place. The second pattern is child oriented. The child has a subordinated relationship between the parents, where the husband works and the wife is at home. The third pattern of family organization is home oriented. In this case, the parents completely sacrifice their life chances for the sake of their retarded child.

The parents of any child see him or her as an ego extension. When a retarded child enters the family, marital problems can be aggravated, and problems can develop for other family members. As a result, parents automatically tend to build defenses. Society tends to view defective children as different, or strange. Perhaps it is because society is angry, or afraid of defective people, but for whatever the reasons, the parents of a defective child have to be prepared for cruel comments and learn how to live with a retarded child.

Mental retardation is one of the most pervasively negative labels with which a person in this society can be labeled. According to Goffman, (1963) the parents have stigma contamination. Because of their defective child, there is a barrier to parents relationship with others.
Not only do parents of a retarded child have to learn to accept the child, but the question of management becomes more difficult. The main question often heard is, "Should we keep our child at home, or should we place him (or her) in a residential school?" (Mandelbaum and Wheeler, 1960) Even though many physicians recommend the institution as being 'best' for the child and the rest of the family, parents will question this, and rightly so. Until the child has had a chance to be a part of the family, no one will know how his presence will affect other family members. According to Menolascino, (1973) the institution for the retarded is culturally sanctioned. Many professionals have pointed out that all an institution does is teach the child how to live in the environment of an institution, or how to be deviant. The fact that the parents of retarded children keep their children home as well as in institutions shows that value conflicts exist. (Menolascino, 1973) There have been numerous reports of parents who were well equipped with intelligence and resources who found themselves blocked by inner value conflicts relating to their retarded children. Many families have struggles hard against poverty and situational burdens and managed to raise their retarded children to productive citizenship. (Menolascino, 1973) Many parents have conflicts about a retarded child, not because the child is an extraordinary burden of care, but because they devalue the meaning of the child. Retardation is a deviancy by definition. In other words, retarded persons are
significantly different from others, and in our society this difference is unfortunately negatively valued. Thus, common historical role conceptions of the retardate included the descriptions of menace, sub-human, animal-like, as an object of ridicule, and as an object of pity. (Wolfensberger, 1969) A parental value conflict could result in various degrees of emotional and physical rejection of their child. (Menolascino, 1973) Whatever decisions the family may make concerning the management of their child, it should be their decisions completely, and they should not be made to feel guilty about it.

Guilt, shock, and denial are all feelings the family learns to overcome, (hopefully) and deal with. Not only do the parents have to consider other family members, but their own marriage can be placed in a stress situation. Most professionals agree that a retarded child may augment problems, but not necessarily cause family problems. These problems had to be present before the birth of the child. (Menolascino, 1975) A well adjusted parent is generally capable of enduring the emotional hurt and anxiety of a retarded child without severe personality disorganization and readjustment. In working with parents who did not achieve a satisfactory adjustment to marriage prior to the birth of the child, casework treatment of a therapeutic nature was aimed ultimately at the parent's personal and marital conflicts rather than their feelings toward the retarded child. (Begab, 1969)
Being a parent to any child is not easy, but having the extra task of being a parent to a handicapped child is an additional burden. Many professionals, counselors, and physicians need to keep in mind the state of mind in which the parents are in, and help them along the road to good management of their child.

_Siblings of the Retarded_

Much has been written about the crisis that families experience in response to the diagnosis of a handicapping condition in childhood. Admittedly, parents of a defective child have a great task ahead of them, but what about the siblings of the retarded? What are their reactions to having a retarded brother or sister?

The siblings of the retarded or handicapped, have reactions not only to the death or defect of their brother or sister, but also to the parental preoccupation and emotional withdrawal. (Freeman, 1971:401) For this reason, parents and professionals often figure it would be best to institutionalize the defective child based on their belief that his presence will necessarily damage other children. (Freeman, 1971) According to Grossman, (1972) the sibling of the retarded imitates the behavior exhibited by the parents. The extent to which mothers and fathers were accepting or rejecting of the retarded child and his or her handicap related most strongly to the young peoples own ability
to deal adaptively with the meaning of the handicap to themselves and their own lives. (Grossman, 1972)

Ultimately, if the parents want to keep the handicapped child in the home the other siblings will adjust. Evidence collected by Farber, (1972) suggests that the relationship of some siblings with the rest of the family may suffer after the retarded child has been institutionalized. In general, normal brothers seemed to decline in their adjustment when their retarded sibling left home. Evidently, the handicapped child served as a kind of buffer in these families, absorbing so much of the parent's attention that there was less frequent conflict with the normal brothers who became more closely involved with their age mates outside the home. (Robinson and Robinson, 1965:537)

On the other hand, normal sisters were sometimes helped by placing the retarded child outside the home. This phenomenon seemed to stem from the fact that the sisters had borne undue responsibility, taking over many of the tasks ordinarily carried on by the mother. (Robinson and Robinson, 1965)

The final effect on siblings of placing a retarded child in an institution depends upon the nature of the relationship between the children and their parents, not upon the relationship of normal children and retarded sibling. (Robinson and Robinson, 1965)

Grossman, (1972) found that siblings of the retarded had both benefitted and lost from the experience of having a
retarded brother or sister. She found that many of the siblings were very tolerant, compassionate, and aware of prejudices. However, they were also resentful, guilty about the rage they felt toward their parents, and fearful that they too could be defective. These feelings are normal, and the sibling needs to be made aware that there is nothing wrong with having these thoughts.

The role of the teacher to a child with a retarded sibling is also important. (White, 1973) The teacher needs to help the sibling of the retarded by being aware and alert to their problems. In the case of a girl, the teacher may help the family situation by helping the parents see that it is important they do not overload her with responsibility for the retarded child. (White, 1973)

Occasionally the sibling of a retarded child will require help in dealing with his or her parents. Parents may force the child into roles which deprives him of his individuality. Freeman, (1971:402) describes these problems as, a) a child is expected to grow up to enter the health profession and find a cure for the condition (affecting sibling) or be a better doctor or nurse than the parents had encountered, b) a child is continually reminded that he or she will have the total care of a handicapped sibling when the parents are dead, c) a child is expected to forego usual activities to assume a major caretaking role while still a youngster, and d) a child is expected to provide the
parents with all the satisfactions or affections which the defective child could not give them. Parents with a defective child need to take precautions against pushing other children into roles they want the child to have. Family counseling is sometimes needed to work out the conflicts involved.

Often the birth order of the children influences the reactions of the sibling. According to Farber, (1968) parents assign status to the child equal to the age. Yet, in the event of a retarded child, regardless of the birth order the retarded child is the youngest socially.

As with their parents, siblings may have or will develop feelings regarding their adequacy. In other words, they may ask the question, "Is it possible for us to be normal even though we have a retarded sibling?" (Love, 1973) Sarason (1969) noted that siblings show great concern about how their family relates to the community and how they themselves relate to their own peers. It was also indicated that most siblings felt that they could tell only their good friends, and then only if their friends would have to come into contact with the retarded child. (Sarason, 1969)

Retardation is not simply a defect that occurs to or resides in an individual. Rather it is an event that involves and includes the total family unit, the school, and often parts of the larger community as well. The fact that families thrive despite or because of the retarded child suggests that there are potentially many ways of coping. (Love, 1973)
PROCEDURES FOR COLLECTION AND TREATMENT OF DATA

PROCEDURES FOR COLLECTION OF THE DATA

The questionnaire (appendix A) will be sent to parents who have children attending classes in the trainable special education program of Westside Community Schools, (District 66) Omaha, Nebraska. The schools within District 66 that these classes are held in are, Arbor Heights Elementary, Oakdale Center, Prarie Lane, and Swanson. The District contracts with the Ralston, Gretna, and Millard Schools, so therefore some of the returned questionaires will be from there. This population is for the most part white, upper middle class.

The questionnaire will include a support letter from a parent who has a child in the trainable program explaining the study to the other parents. This will be used as a means to gain parent support.

A cover letter from the author will explain the purpose of the study, and will ask for parental support. This letter will state that the parents will not be identified, and will receive a copy of the results upon completion of the study.

The questionnaire will obtain general family information including, age of retarded child, number of other siblings, number of siblings younger than the mentally retarded child,
Number of siblings older than the mentally retarded child, services that the child attended other than public school, approximate income of family, home owner or rent, and the organizations belonged to such as Council for Exceptional Children, (CEC) Greater Omaha Association for Retarded Citizens, (GOARC) coalitions, Pilot Parents, and District 66 parent group.

The questionnaire will ask 34 questions in the areas of, attitudes of parents towards their retarded child, how the doctors handled the situation and the information they gave, and the feelings of the siblings as the parent interprets them. Each question will have a scale from one to nine indicating a range of strongly agree to strongly disagree.

The study is a blind questionnaire. The identity of the parents will not be known. It will also not be known if the parents filled it out together, or whether it reflects the attitudes of just one of the parents. The questionnaire will be assigned a number as it is returned. A self addressed stamped envelope will be enclosed to facilitate return. After a two week period, a post card will be mailed out as a reminder to return the survey. 58 questionnaires will be mailed.
PROCEDURES FOR TREATMENT OF THE DATA

The data will be programed to go through the computer to obtain the statistical results. The mean, mode, median, minimum, maximum, range, and standard deviation will be found. The frequency distribution and percentage for each question will also be computed.

The computer program that will be used is the Statistical Package for the Social Sciences. (SPSSH - version 6.01) The results for each area, general information and the 34 variables, will be placed on a frequency distribution chart. This information will be discussed in relation to the hypotheses and will also include a discussion of the data.
Chapter IV

RESULTS OF THE STUDY

The purpose of the study was to determine the attitudes of the parent population of those parents who have children in the District 66 trainable special education program. Data were described from the 40 questionnaires that were returned. The questionnaire probed the areas of physicians attitudes toward mental retardation, attitudes of the siblings, and parental attitudes and reactions.

Questionnaires were mailed to 58 parents. 40 were returned, giving a 69.25 percent return. The data is presented by tables indicating frequency distribution and percentage. The mean, mode, minimum, maximum, range, median, and standard deviation are also given.

PRESENTATION OF RAW DATA

Table 1 shows the age range of the retarded children included in the survey.

Table 1

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<td>2</td>
<td>5</td>
</tr>
<tr>
<td>8</td>
<td>6</td>
<td>15</td>
</tr>
<tr>
<td>9</td>
<td>4</td>
<td>10</td>
</tr>
</tbody>
</table>
The minimum was age 7, representing 5%, and the maximum age was 18, representing 2%. The mean age was 12.5, mode 8.0, and the median was 12.5. There was a range of 11 years.

The majority of the children had brothers and sisters. Tables 2 through 4 show the results of the number of siblings, the number that are older than the mentally retarded child, and the number that are younger.

Table 2
Number of Other Children

<table>
<thead>
<tr>
<th>N of Other Children</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>5</td>
<td>13</td>
</tr>
<tr>
<td>1</td>
<td>6</td>
<td>15</td>
</tr>
<tr>
<td>2</td>
<td>12</td>
<td>30</td>
</tr>
<tr>
<td>3</td>
<td>13</td>
<td>32</td>
</tr>
</tbody>
</table>
The mean was 2.325, the mode 3. There was a minimum of 0 with a maximum of 8. The median was 0.370, and there was a range of 8.

Table 3
Number of Children Younger than Mentally Retarded Child

<table>
<thead>
<tr>
<th>N of Children</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>23</td>
<td>57</td>
</tr>
<tr>
<td>1</td>
<td>5</td>
<td>13</td>
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<tr>
<td>2</td>
<td>9</td>
<td>22</td>
</tr>
<tr>
<td>3</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>6</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

The mean was 0.875, the mode 0, the minimum 0, and the maximum 6. There was a range of 6. The median was 0.370.

Table 4
Number of Children Older than Mentally Retarded Child

<table>
<thead>
<tr>
<th>N of Children</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>14</td>
<td>35</td>
</tr>
<tr>
<td>1</td>
<td>8</td>
<td>20</td>
</tr>
<tr>
<td>2</td>
<td>10</td>
<td>25</td>
</tr>
<tr>
<td>3</td>
<td>6</td>
<td>15</td>
</tr>
<tr>
<td>4</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>
The mean was 1.45, the mode 0. The range was 8 with a minimum of 0 and a maximum of 8. The median was 1.25.

The majority of the parents, 57%, (Table 3) didn't have other children after having a mentally retarded child. Table 4 shows that 14 of the children, 35%, were the youngest, or an only child. The average, (mean) number of other siblings was 2.325. (Table 2)

Most of the children had some kind of school experience before District 66. Nursery school was the most prevalent service before the child entered public school. Table 5 shows the services parents sought for their child before public school.

Table 5
Other Services

<table>
<thead>
<tr>
<th>Name of Service</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meyer's Children Rehabilitation Institute</td>
<td>7</td>
<td>17</td>
</tr>
<tr>
<td>Eastern Nebraska Community Office of Retardation</td>
<td>8</td>
<td>19</td>
</tr>
<tr>
<td>Coordinated Early Education Program</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Montessori</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Nursery School</td>
<td>17</td>
<td>42</td>
</tr>
<tr>
<td>Church School</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>Opportunity Center</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Public School (other than District 66)</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>
The possible number of services a parent could have the child attend was 9. (range) The minimum was 0, the maximum was 9. The total percent of Table 5 totals more than 100 because 38% of the children attended more than one program before starting with District 66. 13% did not have any school experience before starting public school. 18% had attended an ENCOR (Eastern Nebraska Community Office of Retardation) developmental center, or program. The Coordinated Early Education Program (CEEP) was run by ENCOR. Retarded children were placed in Omaha pre-schools in order to learn from non-retarded peers. Only 2% of those surveyed had attended. The majority, 42%, attended a nursery school program.

The parents in the study group have been married for many years. Table 6 shows the frequency distribution for the number of years the parents have been married.

Table 6

<table>
<thead>
<tr>
<th>N of Years</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>11</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>12</td>
<td>3</td>
<td>7</td>
</tr>
</tbody>
</table>
2% did not answer the above question. The mean was 20.1 years, the mode 20.0. The minimum was 8, the maximum was 33, with a range of 25. The median was 20.0.

The average income for the families was high as expected for the group studied; however, 5% chose not to report their income. Table 7 shows the approximate income levels of the families.
Table 7
Approximate Income Level

<table>
<thead>
<tr>
<th>Income</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. under $10,000</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>2. $10,000-$20,000</td>
<td>24</td>
<td>60</td>
</tr>
<tr>
<td>3. $20,000-$30,000</td>
<td>9</td>
<td>22</td>
</tr>
<tr>
<td>4. over $30,000</td>
<td>3</td>
<td>7</td>
</tr>
</tbody>
</table>

The mean was 2.225. (between $10,000-$20,000) The mode was the same as the mean. Only 5% had an income below $10,000. The median was also between $10,000-$20,000. The minimum was under $10,000, with a maximum of over $30,000.

90% of the families own their own homes. 2% did not respond to the question, while only 7% rent.

The majority of the parents belong to at least one organization that benefits the parents of the mentally handicapped or the child. Table 8 shows the organizations in which the parents were members.

Table 8
Organizations Belonged to by Parents

<table>
<thead>
<tr>
<th>Organization</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greater Omaha Association for Retarded Citizens (GOARC)</td>
<td>24</td>
<td>60</td>
</tr>
<tr>
<td>Council for Exceptional Children</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Coalitions</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
The majority of the parents belonged to GOARC (Greater Omaha Association for Retarded Citizens) and the District 66 Parent Group. (70%) The latter is a group of parents who have children in the trainable special education program in the District 66 schools. Table 9 shows the total number of organizations the parents belong to.

Table 9

<table>
<thead>
<tr>
<th>N of Organizations</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
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<tr>
<td>0</td>
<td>9</td>
<td>22</td>
</tr>
<tr>
<td>1</td>
<td>11</td>
<td>27</td>
</tr>
<tr>
<td>2</td>
<td>15</td>
<td>38</td>
</tr>
<tr>
<td>3</td>
<td>5</td>
<td>13</td>
</tr>
</tbody>
</table>

The mean was 1.4, the mode 2. The minimum was 0, with a maximum of 3. The range was 3, the median 1.5. 38% belonged to two organizations, while 22% didn't belong to any.

The questions one through thirty-four (Appendix A) are tabulated on Table 10. The frequency, mean, mode, minimum, maximum, range, median, and standard deviation are given for each question.
<table>
<thead>
<tr>
<th>Frequency Distribution for the Questionnaire for 34 Variables</th>
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<tbody>
<tr>
<td>0</td>
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<tr>
<td>---</td>
</tr>
<tr>
<td>1.2</td>
</tr>
<tr>
<td>10.1</td>
</tr>
<tr>
<td>18.1</td>
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<td>26.1</td>
</tr>
<tr>
<td>34.1</td>
</tr>
<tr>
<td>42.1</td>
</tr>
</tbody>
</table>

**Table 10**
<table>
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<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
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<th>mode</th>
<th>min.</th>
<th>max.</th>
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<th>std. dev.</th>
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<td>6</td>
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<td>10</td>
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</table>
The questionnaire dealt with areas including, reactions parents received from the public, attitudes of the physicians, the parents attitudes, and attitudes of the siblings of the retarded had. A discussion of the data given in Table 10 follows.

The parents perceived the reactions of the community in the following way: Question 1: The omaha community offers good programs for preschool age children. Table 10 shows that 14 (35%) were undecided. Only 1 parent (2%) strongly agree, whereas 5 parents (13%) strongly disagree. All of the parents felt strongly about the public needing more information about the abilities of the retarded. Question 7: The majority of the public needs considerably more information about the capabilities of the retarded. 26 parents (65%) strongly agree, 1 parent (2%) was in between strongly agree and agree on the scale, and 13 parents (32%) agree. The mode was 1, strongly agree, the mean 1.675, the median 1.269 and the standard deviation .994.

The parents also felt very strongly about the community providing work opportunities. Question 8: The community should provide work opportunities for the retarded after age 18. 17 parents (42%) strongly agree, 18 parents (45%) agree. 7% were in between, and 5% were undecided on this. The mode was 3, agree, the mean 2.275, the median 2.611, and the standard deviation 1.219.

On the subject of the retarded working outside of the sheltered workshop the parents, as a group, were
undecided. Question 9: With proper training the majority of the retarded persons will be able to be in a work situation outside of a sheltered workshop. 17 parents (42%) were undecided. The mode was 5, undecided. 30% agreed, and 15% strongly agreed. The median was 3.5, and the mean 3.575. The standard deviation was 1.599. No parents were in disagreement with the statement.

Question 37: The general public viewed me/us as deviant and treated us differently because I/we have a retarded child. 19% agreed. 3 parents strongly agreed, 3 chose number 2, and 2 parents agreed. A total of 30% were in the disagreement range. 15 parents (38%) disagreed, 7% were in between, and 27% (11 parents) strongly disagreed. The mean was 6.6, mode was 7, and the median 7.1. The standard deviation was 2.394. 5% were undecided.

Question 32 referred to the Omaha citizen advocacy program. It states: Because of our/my retarded child, close friends or a brother or sister has joined the Omaha citizen advocacy program. 5 parents (13%) didn't respond, 6 parents (15%) agree. The majority (47%) disagreed. The mean was 5.5, the mode was 7, with a median of 6.658. The standard deviation was 2.689.

There were many questions about the doctors attitudes. Question 2: Doctors always know everything about mental retardation. Only 1 parent (2%) strongly agreed. The heaviest percentages were on the scale from 7 - 9, disagree
to strongly disagree. 19 parents (47%) disagreed, 14 parents (35%) strongly disagreed. The mean was 7.45, the mode 7, and the median 7.342. The range was 8 with a standard deviation of 1.632.

Question 3: Doctors should tell parents at the time of their child's birth if there is any sign of mental or physical abnormality. The parents strongly agreed (65%). 30% agree. No one was in disagreement or undecided on this. The mean was 1.7, the mode 1, and the median 1.269. The range was only 3 with a standard deviation of .992.

In the area of institutionalization there was a wide range of opinions. Question 6: Doctors who recommend institutionalization without considering other alternatives need further in-service and community training about the capabilities of the mentally handicapped. 60% strongly agree, 27% agree, while only 2% disagreed. 5% were undecided. The mean was 2.05, the mode 1, and the median 1.333. There was a range of 6 with the standard deviation 1.552.

Question 15: Doctors need support and knowledge of community programs for the retarded when telling parents their child is retarded. Half of the parents (20) strongly agreed. 10% were in between, and 35% agreed. Only 2% disagreed. The mean was 2.05, the mode was 1 and the median 1.5. The standard deviation was 1.319.

Another question concerning doctors and the community services is question 18. It says; The doctor or doctors who told us
that the child was retarded were able to tell us where to turn for help. 5 parents (13%) strongly agreed, 17% agreed, 25% disagreed, and 30% strongly disagreed. The mean was 5.7, the mode 9, and the median 6.8. The range was 9, with a standard deviation of 3.021.

The majority of the parents suspected delay before it was diagnosed. Question 19: If not informed of the child's retardation at birth, please answer: Before doctors told us of our child's handicap, we had suspected that there was developmental delay. 14 parents (35%) did not respond to the question, indicating they chose not to answer or were told at the birth of the child. 22% strongly agreed, and 32% agreed that they had suspected delay. 5% were undecided, and only 2% disagreed. The mean was 1.725, the mode 0, and the median 1.167. The standard deviation was 1.768.

Questions number 20 through 24 dealt with the attitudes and advice physicians gave parents concerning the management of their retarded child. Question 20: The information and advice that physicians give concerning mental retardation lead me/us to believe that our child was dangerous. A total of 87% were in disagreement. 45% disagreed, while 42% strongly disagreed. Only 2% agree, and 2% are undecided. 7% circled number 8 on the scale. The mean was 7.775, the mode 7, the median 7.5, and the standard deviation 1.310.

Question 21: The doctors told me/us to take our child
home and just love him. 4 parents did not respond. 10 parents, 25%, agreed, 17% disagree, and 27% strongly disagree. The mean was 5.5, the mode 9, the median was 6.643, and the standard deviation 3.105. There was a range of 9.

Question 22: The physician told me/us that the child was like a sick person. 45% disagree, and 45% strongly disagree. The remaining 10% were divided in the following manner, no response, 2%, strongly agree, 2%, and agree, 5%. The mean was 7.375, the mode 7, and the median 7.389. There was a standard deviation of 2.168.

Question 23: The information and advice that physicians give concerning mental retardation lead me/us to believe that the child was like an animal. 50% strongly disagreed, and 38% disagreed. 2% did not answer, 2% strongly agree, and 2% were undecided. One parent circled number 2 on the scale. The mean was 7.55, the mode 9, the median 8.5, and the standard deviation was 2.112. The range was 9.

Question 24: Doctors said that the retarded child would be a burden to society, not capable of anything. 7% strongly agree, 13% agree, while only 2% were undecided. The majority, 38%, disagree, and 38% strongly disagree. The mean was 6.575, the mode 7, the median 7.167, and the standard deviation 2.745. Again the range was 9.

Question 25: The information and advice physicians give concerning mental retardation lead me/us to believe that early intervention programs such as pre-schools were
the best for the child. 13% did not respond. 25% strongly agree, 5% were in between, and 27% agree. 2% were undecided, 20% disagree, 5% chose number 8 on the scale, and 2% strongly disagree. The mean was 3.325, the mode 3, the median 2.773, and the standard deviation 2.777. The range was 9.

The questions dealing with parental attitudes had to do with the parent's feelings at having a retarded child. Question 4: Once a couple has a mentally retarded child they should never have any other children. 84% of the parents were in disagreement with this statement. (42% disagree, and 42% strongly disagree) Only 5% agree, and 10% are undecided. The mean was 7.45, the mode 7, the median 7.647, and the standard deviation 1.663.

Question 10: When I/we found out my child was retarded, I/we felt guilty. One parent did not answer. 7% strongly agree, 17% agree, 7% mildly agree, and 7% were undecided. The majority either disagreed, (27%) or strongly disagreed, (30%) The mean was 5.9, the mode 9, the median 6.773, and the standard deviation 2.808. The range was 9.

Question 11: At certain times I/we have rejected the child because of the retardation. Only one parent strongly agreed. 13% agreed, 5% mildly agreed, and 7% were undecided. One parent mildly disagreed. The majority were on the disagreeing side of the scale. 17% disagree, 50% strongly disagree. One parent was in between disagree and strongly disagree. The mean was 7.05, the mode 9, and the median 8.5.
The standard deviation was 2.417, the range was 8.

Question 14: It is easier for parents to accept the fact of retardation when it is found out when the child is 2-3 years of age, rather than at birth. 5% strongly agree, 7% agree, and 22% were undecided. 27% disagree, 2% were in between, and 35% strongly disagree. The mean was 6.675, the mode 9, the median 7.045, and the standard deviation 2.314. The range was 8.

Question 17: It was very difficult to tell other family members (grandparents, aunts, uncles, etc.) of the child's retardation. 13% strongly agree, 27% agree, 7% mildly agree, 5% were undecided. The strongest opinion was 32% who disagreed. 2% were in between disagree and strongly disagree on the scale, and 10% strongly disagreed. The mean was 5.025, the mode 7, the median 5, and the standard deviation 2.547. There was a range of 8.

Question 28: Finding out that my child was retarded was the very first experience that I had with mental retardation. 27% strongly agreed, and 45% agreed. 22% disagreed, with 2% mildly disagreeing, and 2% leaning towards strongly disagree. (number 8 on the scale. The mean was 3.55, the mode 3, the median 3, and the standard deviation 2.32. The range was 7.

Question 29 was asked only of those whose retarded child was not the youngest. Question 29: Regardless of the birth order of my children, my delayed child is the
youngest socially. 22 parents (55%) did not answer the question indicating the child was not the youngest, or an only child, or another reason. 2% strongly agree, 25% agree, and 2% mildly agree. 7% were undecided, 2% mildly disagree, and 5% disagree. The mean was 1.75, the mode 0, no response, and the median .409. The standard deviation was 2.227, the range was 7.

Question 33: As parents of a retarded child we/I found that our own attitudes toward the child reflected the way other family members and friends felt toward the child. 25% strongly agreed, 2% chose number 2, and 42% agreed. 10% were undecided, 13% disagree, and 2% were in between disagree and strongly disagree. Only 5% (2 parents) strongly disagreed. The mean was 3.6, the mode 3, the median 3.029, and the standard deviation 2.373. The range was 8.

The last question pertaining to parents dealt with the Pilot Parents, a parent group under the auspices of the Greater Omaha Association for Retarded Citizens. (GOARC) Question 34: As a parent, I feel the Pilot Parent program serves a definite need to both new parents of a retarded child, and to parents whose children are older and face different kinds of problems. 10% did not respond. 22% strongly agree, 27% agree, 2% chose number 2 on the scale, and 2% mildly agree. 14 parents (35%) were undecided. The mean was 2.95, the mode 5, the median 3.045, and the standard deviation 1.825. There was a range of 5.
There were four questions asking specifically about the feelings of siblings of the retarded. Question 5: Keeping the retarded child in the home has caused problems for other siblings. 5% did not answer. 2% strongly agree, 13% agree, 13% mildly agree, 7% are undecided. The majority was 40% who disagreed. 15% strongly disagreed, and 5% were in between disagree and strongly disagree. The mean was 5. 825, the mode 7, the median 6.75, the standard deviation 2.49, and the range 9.

Question 12: Siblings of the retarded have been embarrassed at having a delayed child in the home. 5% didn't respond, 5% were in between strongly agree and agree, 10% agree, 15% mildly agree, 10% were undecided, 5% mildly disagree, 38% disagree and 13% strongly disagree. The mean was 5.55, the mode was 7, the median 6.5, the standard deviation 2.375, and the range 9.

Question 30 and 31 were asked if the child was not an only child. Question 30: It is the retarded child's brother and sisters responsibility to take care of their retarded sibling when the parents are no longer able to do so. 15% did not answer. 13% agree, 5% mildly agree, 10% were undecided, 2% mildly disagree, and the majority, 32%, disagree. 22% strongly disagree. The mean was 5.525, the mode 7, the median 6.654, the standard deviation 3.030, and the range was 9.

Question 31: Having a retarded sibling will affect
a sister or brother's life chances of success; such as, maintaining jobs, positions in the community, becoming a professional, doctor, lawyer, etc. 13% did not respond. Only 2% strongly agree, and 2% were undecided. 17% disagree, 5% were in between, and 60% strongly disagree. The mean was 7.175, the mode 9, the median 8.667, and the standard deviation was 3.129. The range was 9.

One question dealt with attitudes toward mainstreaming. Question 13: A special education child should be placed in other classes such as physical education, music, language arts, shop, etc. to get as much exposure as possible to normal peers. 52% strongly agree, 5% were in between strongly agree and agree, and 30% agree. 2% were undecided, and 2% mildly disagree. The mean was 2.025, the mode 1, the median 1.452, and the standard deviation 1.25. There was a range of 5.

ANALYSIS OF HYPOTHESIS

After the data had been collected, the answers were tabulated. Hypothesis number 1 states that the manner in which doctors inform parents that their child is retarded greatly influences the parents' acceptance of the retarded child. This hypothesis would have to be rejected after examining the data from questions 20, and 22-24. (Appendix A)

Question 20 states: The information and advice that physicians give concerning mental retardation lead me/us
to believe that our child was like an animal. 42% said they strongly disagree and 44% disagree. Question 22: The physician told me/us to treat the child like a sick person. Again, 44% strongly disagree and 44% disagree. Question 23: The information and advice that physicians give concerning mental retardation lead me/us to believe that the child was like an animal. 38% disagree and 50% strongly disagree. The last question exploring the manner in which doctors inform parents about mental retardation says, Doctors said that the retarded child would be a burden to society, not capable of anything. 38% disagree and 38% strongly disagree. According to these results, the doctors generally were not negative about the child's capabilities, and the parents do not depend on the doctors statements and advice to accept the child.

The second hypothesis states: The way the parents view the retarded child affects the way other family members feel towards the retarded person. This hypothesis was proved to be true by examining data from question number 33. The question says, As parents of a retarded child, we/I found that our own attitudes towards the child reflected the way other family members and friends felt toward the child. The mean was 3.6. 10 parents, 25%, strongly agree, 17 parents, 42% agree. The mode was number 3, agree. The other questionnaire data which supports the hypothesis states: It was very difficult to tell other family members (grandparents, aunts,
uncles, etc.) of the child's retardation. 27% disagree, and 35% strongly disagree. This indicates that the parents accepted the child, and were not embarrassed at having a retarded child. Question 12 asked the parents about feeling embarrassed at having a retarded child. 15 parents, 38%, disagree. This also shows that the parents own attitudes will influence those persons they come into contact with.
Chapter V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

SUMMARY

This study was devised to describe the attitudes parents had towards their retarded children. The study was concentrated on parents who have children in the trainable special education program of Westside Community Schools. Essential data was derived from the questionnaire sent out to parents. 58 questionnaires were mailed, 40 were returned.

The parents reported on children ranging in age from 7 to 18 years. All the parents have children attending a class within Westside Community Schools. However, since District 66 contracts with outside school districts in the area of special services, the parents also live in Millard, Ralston, and Gretna.

CONCLUSIONS

There was a small percentage of parents whose children attended an ENCOR, Eastern Nebraska Community Office of Retardation, developmental center, or other facility. One reason for this could be that the mean age for the children studied was 12.5. ENCOR services have only been provided in the last five years or so. A majority of the children were older at the time the services were being developed, and therefore didn't make use of them. Although they would
have been allowed to attend, the public schools accepted many of the children.

The income level of the families did not seem to make any difference as to their awareness of community programs. The parents grouped closely together in their response to questions dealing with their feelings towards programs the Omaha community provides for the retarded.

In the area of public attitudes, the parents all agreed that the majority of the public needed further information about retardation. However, a strong percentage didn't feel the public viewed them as being deviant because they had a retarded child.

As a group the parents felt unsure about their children working in a situation outside of a sheltered workshop. Although the parents were hesitant to have their child working outside of a sheltered workshop, the majority are for mainstreaming the retarded into so called 'normal' classrooms. The trend in special education is toward mainstreaming in order to allow the retarded child to lead as normal a life as possible, and for exposure to peers. The trend of mainstreaming is in conjunction with current normalization trends; to provide as normal a learning environment as possible for the retarded or handicapped child.

The parents all appeared to suspect delay before it was confirmed by the doctors. The doctors as a group were not negative, but were generally not helpful to the
parents in helping set up management for the retarded child. As a group the parents want to know immediately, (at birth) if there is any abnormality, and feel that it is the doctors responsibility to inform the parents of this. The parents also felt that the doctors should provide printed literature about retardation and about the services available to parents in the community.

Many of the parents wrote comments on the questionnaire. One parent explained that their child's retardation came about as a result of a brain infection at the age of four years. Another parent quoted the doctor as saying, "This is not a good baby. The parents should put her in an institution." This same parent commented that the general public is very indifferent to those persons who have a retarded child, or are retarded, and do not go out of their way to help.

The questions about siblings of the retarded brought many comments. A parent said that the other siblings were above average, one with a genius I.Q., and two of her children had graduated "cum laude". This same parent said that having a delayed child in the home has been a "beautiful teacher in the development of the other siblings character".

Two of the questionnaires indicated that there was more than one retarded child. One set of twins was indicated.
The other parent told of having two retarded children, having them both through ENCOR as foster children. The children had lived at Beatrice State Home before being placed with this family. This parent reports that the doctors they worked with at first were very negative, gave them no encouragement, said they were crazy to take such a child, and that they should send him back to Beatrice.

The Pilot Parent program is a group of parents who have retarded children, who help other parents of retarded children deal with problems they have. Surprisingly, one parent wrote that they had never heard of the Pilot Parent program, or the Omaha Citizen Advocacy program. Most of the parents were undecided if the Pilot Parent program had been beneficial to them.

RECOMMENDATIONS FOR FUTURE RESEARCH

It is the writer's suggestion that future studies should be designed which would:

1. Determine if parents of a retarded child go through many developmental stages.

2. Determine whether income level of a family with a defective child affect the manner in which the child is treated.

3. Investigate further the attitudes that fathers of retarded children have concerning their child's retardation.

4. Determine whether parents who have a retarded child, and decide not to have other children, use any means of
birth control.

5. Determine whether questionnaires of this nature are answered in the same or different manner when the mother answers one and the father responds on another one.
APPENDIX
August 1975

The enclosed questionnaire is part of the research required for my Master's Thesis in Special Education from the University of Nebraska at Omaha. The topic is, *Parental Attitudes Towards Their Handicapped Child*.

I would appreciate very much your filling out the questionnaire and sending it back to me in the attached, self-addressed, stamped envelope. There are two questionnaires, one to send to me, and one for you to keep for your own files. I assure you that all the information will be kept in confidence, no names are used, and you need not put your name on the questionnaire. Upon completion of the study, I will send a summary of questionnaire results to all participants. Please return the questionnaire by September 2, 1975. The questionnaire is being sent to all parents who have children in the trainable program of District 66 schools.

This study will not only be important to me, but will help School District 66 provide better educational programs.

I appreciate your time. Thank you very much.

Sincerely,

Barbara Burman Bronston
Special Education Teacher
District 66
Dear Fellow Parents,

Mrs. Barbara Bronston, a Special Education teacher in School District 66, is continuing her education in teaching handicapped children. She wishes to obtain her Master's Degree this year.

She has demonstrated a unique understanding of our problems and of our children, and wishes to use this subject as the basis for her thesis.

This is a most worthwhile project and I urge all of you to complete and return her questionnaire promptly. As parents of handicapped children, the results should be beneficial to all of us.

Thank you for your cooperation.

Sincerely,

Leighton L. Goodrich
GENERAL INFORMATION

present age of child: __________
number of other children: ________ younger than mentally retarded child:______ older than mentally retarded child:______
pre public school experience: such as ENCOR, nursery school, church school, or other __________________________

number of years parents have been married:__________

Approximate income of family:

under $10,000________
$10,000 - $20,000________
$20,000 - $30,000________
over $30,000 __________

own your home________ rent home __________

organizations belonged to: GOARC________
CEC________
coalitions_____
Pilot Parents ____
District 66 Parent Group _______
The following statements represent opinions, and your agreement or disagreement will be determined on the basis of your particular beliefs. Kindly circle the number or phrase on the scale as the statement first impresses you. Indicate what you believe, rather than what you think you should believe.

Example: All children are entitled to public school education.

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1. The Omaha community offers good programs for preschool age retarded children.

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2. Doctors always know everything about mental retardation.

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3. Doctors should tell parents at the time of their child's birth if there is any sign of mental or physical abnormality.

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4. Once a couple has a mentally retarded child they should never have any other children.

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5. Keeping the retarded child in the home has caused problems for other siblings.

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6. Doctors who recommend institutionalization without considering other alternatives need further in-service and community information about the capabilities of the mentally handicapped.

1 2 3 4 5 6 7 8 9
strongly agree undecided disagree strongly disagree

7. The majority of the public needs considerably more information about the capabilities of the retarded.

1 2 3 4 5 6 7 8 9
strongly agree undecided disagree strongly disagree

8. The community should provide work opportunities for the retarded after age 18.

1 2 3 4 5 6 7 8 9
strongly agree undecided disagree strongly disagree

9. With proper training the majority of retarded persons will be able to be in a work situation outside of a sheltered workshop.

1 2 3 4 5 6 7 8 9
strongly agree undecided disagree strongly disagree

10. When I/we found out my child was retarded, I/we felt guilty.

1 2 3 4 5 6 7 8 9
strongly agree undecided disagree strongly disagree

11. At certain times I/we have rejected the child because of the retardation.

1 2 3 4 5 6 7 8 9
strongly agree undecided disagree strongly disagree
12. Siblings of the retarded have been embarrassed at having a delayed child in the home.

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13. A special education child should be placed in other classes such as physical education, music, language, art, shop, etc., to get as much exposure as possible to "normal" peers.

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14. It is easier for parents to accept the fact of retardation when it is found out when the child is 2-3 years of age rather than at birth.

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15. Doctors need support and knowledge of community programs for the retarded when telling parents their child is retarded.

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16. As a parent (s), I/we were completely bewildered, baffled, and confused when first learning of my/our child's retardation.

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17. It was very difficult to tell other family members (grandparents, aunts, uncles, etc.) of the child's retardation.

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18. The doctor or doctors who told us the child was retarded were able to tell us where to turn for help.

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19. If not informed of the child's retardation at birth, please answer: Before doctors told us of our child's handicap, we had suspected that there was developmental delay.

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20. The information and advice that physicians give concerning mental retardation lead me/us to believe that our child was dangerous.

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21. The doctors told me/us to take our child home and just love him.

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22. The physicians told me/us to treat the child like a sick person.

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23. The information and advice that physicians give concerning mental retardation lead me/us to believe that the child was like an animal.

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24. Doctors said that retarded child would be a burden to society, not capable of anything.

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25. The information and advice that physicians give concerning mental retardation lead me/us to believe that early intervention programs such as pre-schools were the best for the child.

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26. If the doctor tells parents their child is retarded, they should offer printed material about mental retardation and also help the parents contact a community agency for help.

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27. The general public viewed me/us as deviant and treated us differently because I/we have a retarded child.

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28. Finding out that my child was retarded was the very first experience that I had with mental retardation.

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29. If the retarded child is NOT the youngest child please answer: Regardless of the birth order of my children, my delayed child is the youngest socially.

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30. If the child is NOT an only child, please answer the following 2 questions:
   It is the retarded child's brothers and sisters responsibility to take care of their retarded sibling when the parents are no longer able to do so.

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31. Having a retarded sibling will affect a sister or brothers' life chances of success; such as, maintaining jobs, positions in the community, becoming a professional, doctor, lawyer, etc.

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32. Because of our/my retarded child, close friends or a brother or sister has joined the Omaha citizen advocacy program.

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33. As parents of a retarded child we/I found that our own attitudes toward the child reflected the way other family members and friends felt toward the child.

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34. As a parent, I feel the Pilot Parent program serves a definite need to both new parents of a retarded child, and to parents whose children are older and face different kinds of problems.

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VITA

Barbara Burman Bronston was born January 26, 1950 in St. Louis, Mo. Her elementary and secondary education was obtained in the University City Public Schools.

After graduating from University City Senior High School in June, 1968, she attended Drake University in Des Moines, Iowa. She graduated in May, 1972 with a Bachelor of Science in Education.

Currently Ms. Bronston is a teacher with the Westside Community Schools, District 66, Omaha, Nebraska. She teaches in the trainable mental retardation program. In December, 1975 she will receive her Master of Arts in Special Education from the University of Nebraska at Omaha.