BASIC CONSIDERATIONS IN MENTAL RETARDATION:
A PRELIMINARY REPORT

formulated by

the committee on mental retardation

Group for the
Advancement of
Psychiatry
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The work on the present report was started under the chairmanship of Dr. Gale Walker, whose untimely death in 1958 meant a serious loss to the Committee on Mental Retardation and the entire Group for the Advancement of Psychiatry.

The Committee expresses its appreciation to Ethel Ginsburg who served diligently as consultant during the preparation of this report. She brought to our deliberations a wide experience in social work and community agency activity.

**BASIC CONSIDERATIONS IN MENTAL RETARDATION: A PRELIMINARY REPORT**

**I. INTRODUCTION**

The terms “mental retardation”, “mental deficiency”, “feeblemindedness”, “mental inadequacy” and “subnormality” refer to a broad phenomenon indicating unusually slow or arrested rate of mental development. In this report we have decided to use the term “mental retardation”, but we will sometimes use this term and mental deficiency interchangeably.

It is estimated that there are at least five million people (3%) in the United States who have been, or will be, considered mentally retarded at some time during their lives. Together with their families they represent a significant segment of our population. Every fifth state institutional bed is occupied by a mentally deficient individual. Mental retardation is a frequent diagnostic problem in child guidance and pediatric clinics. This syndrome is a major public health problem. Mental deficiency is an aberrant condition affecting the total functioning of the human mind.

While it is self-evident that mental retardation should be of major concern to psychiatry, psychiatrists know little about it and often show, at best, minimal interest in the problem. Since it has attracted increasing attention during recent years, it seems timely to crystallize certain basic principles and clarify some of the concepts essential for understanding and program planning. This report will not delve into details of circumscribed aspects of the problem; they will be considered in future reports.

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*Much credit for the increased interest in mental retardation is due to the pioneer work of a number of local parent's organizations and the influential leadership of the National Association for Retarded Children.*

1 *A Special Census of Suspected Referred Mental Retardation, Onondaga County, New York. Technical Report of the Mental Health Research Unit, New York State Department of Mental Hygiene, 1954-55.*


3 *Patients in Mental Institutions, Part I and Part II. Published annually by U.S. Department of Health, Education and Welfare, Public Health Service.*
This report is directed to members of the medical profession and others concerned with health, education and welfare. It is hoped that it will not only stimulate their interest, but also that of other significant professional and community leaders who must share responsibility for extending state and local services to include this hitherto ignored segment of our population.

II. HISTORY

Throughout history there have always been those who are totally or partially incapable of keeping pace with their contemporaries and meeting the demands of society. Today it is clear that because psychiatry is concerned with the study and treatment of mental and emotional disorders, it must include within its province mentally deficient individuals. One hundred years ago, however, when the interest in mental deficiency began to gather momentum, psychiatry was almost exclusively concerned with the “insane”, especially those in the state asylums. Therefore, little attention was paid to the mentally retarded. The earliest interest in mental deficiency came from those physicians who placed emphasis primarily upon the educational aspects of retarded persons.

In April, 1846, Dr. Samuel Gridley Howe of Boston began a two-year survey of “human beings—condemned to hopeless idiocy”. He visited 63 towns and personally examined 574 patients. His report was presented to the legislature of Massachusetts in February, 1848. This document closed with the words: “There is not one of any age who may not be made more of a man and less of a brute by patience and kindness directed by energy and skill”.

These prophetic words stimulated the first interest in the care of “idiotic pupils”. Dr. Howe, in association with a teacher, Mr. James B. Richards, opened the first experimental school in the Perkins Institute for the Blind. There were ten children. In 1850 this experimental school achieved permanent status and was incorporated as the Massachusetts School for Idiotic and Feeble Minded Youth.

From that time on interest in mental deficiency began to spread over the rest of the country. However, it was not until 1887 that the legislature of Massachusetts provided sufficient funds and the Trustees engaged the first Resident Superintendent, Dr. Walter Elmore Fernald. Dr. Seguin, the famous French psychiatrist, held a temporary position as Director of the School in 1842, but it was under Dr. Fernald’s leadership that the school expanded from a population of 230 “pupils” in 1890 to over 1620 in 1920.

Two aspects of this early evidence of concern for the mentally defective should be noted. First, there was the interest in education for youngsters who appeared otherwise hopeless. Second, there was the use of the word “idiotic” to describe youngsters who today would undoubtedly be called slow learners or mildly retarded. Severely handicapped children were not statistically significant 100 years ago since most of them died at an early age. During their brief lives they were taken care of in mental hospitals as is still the practice today in some European countries.

It is only comparatively recently that mental deficiency has come to be recognized as a medical responsibility. This explains some of the residual confusion in the field, particularly the question of whether the mentally retarded should be placed in the trust of educators, psychologists, psychiatrists or others.

III. DEFINITION AND CLASSIFICATION

Mental retardation is a chronic condition present from birth or early childhood and characterized by impaired intellectual functioning as measured by standardized tests. It manifests itself in impaired adaptation to the daily demands of the individual’s own social environment. Commonly these patients show a slow rate of maturation, physical and/or psychological, together with impaired learning capacity.

*The World Health Organization Technical Report Series, 1954, No. 75, “The Mentally Subnormal Child”, adopts a somewhat different approach and differentiates between mental deficiency and mental retardation as follows:

“To standardize the terminology, the term ‘mental retardation’ has been used in this report to refer only to those whose educational and social performance is markedly lower than would be expected from what is known of their intellectual abilities. When terms are needed to describe conditions in which the mental capacities themselves are diminished as a result of pathological causes, as opposed to environmental causes which may lead to mental retardation, ‘mental defect’ and ‘mental defective’ are used. (Those who suffer from mental defect may, of course, also be retarded).”

See also A Manual on Terminology and Classification in Mental Retardation, prepared by Richard Heber, a monograph supplement to American Journal of Mental Deficiency, Sept., 1969.

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Any approach to the problem of the mentally retarded involves not only consideration of the individual per se, but also of the cultural mores and social and economic environment in which he lives. This means that the care and treatment of such individuals will involve not only a therapeutic approach to each patient, but also a program involving his family and his community. Much remains to be done before real acceptance of the mentally retarded by their families and community can be achieved. The presence of a mentally retarded individual frequently acts as a catalyst to intensify already existing aberrant social factors within his environment. Thus it is obvious that the thorough study of the mentally retarded will extend into many facets of our society.

In recent years there has been excessive emphasis on certain intelligence quotients, as the dividing lines between degrees of mental retardation as well as between “normality” and retardation. This concept has made it easier to establish prevalence rates for mental deficiency, but has also tended to obscure the role of the total personality in this syndrome. The diagnosis, mental retardation, must involve the evaluation of the psychodynamics as well as the general adaptation to life. If it is viewed under this definition without overemphasis on I.Q., the prevalence rate in the United States will generally be about 3%, or 5 million people. The degree of retardation will range from complete amnesia to mild incapacitation more clearly observable under severe stress conditions. Distinction must be made between the mild, moderate and severe forms of mental retardation. These differences are not only quantitative, but qualitative.

The most common criterion used in the classification of mental deficiency today, however, is the degree of measurable deficiency. Categories are established on the basis of psychometric tests alone and individuals are grouped in terms of I.Q. scores. On this basis a breakdown of the estimated 5 million mentally retarded in the United States would include the following categories:

1) The “severely retarded” or “totally dependent”, with I.Q.’s of 0 through 19. In this category the diagnosis of deficiency itself is relatively uncomplicated. It is estimated that this group numbers approximately 180,000 or .1% of the total population and 34% of the total 5,000,000 mentally retarded.

2) The “moderately retarded” or “trainable”, with I.Q.’s of 20 through 49. The size of this group is estimated at 540,000 or .3% of the total population and 11% of the 5,000,000 mentally retarded.

3) The “mildly retarded” or “educable”, usually with I.Q.’s of 50 through 69. The upper limit of 69 is in common use and generally accepted as the cut-off point for special school placements, institutionalization, etc. However, the consideration of social, psychological, and cultural factors in the diagnostic process will tend to lessen the validity of an arithmetic demarcation between a “normal” and a “mentally retarded” individual. Diagnosis, therefore, presents a more challenging problem. On the basis of such broad criteria, however, it is now estimated that the “mildly retarded” number of 4,280,000 or less than 3% of the total population and the overwhelming majority (85%) of the 5,000,000 mentally retarded.

The terms “trainable” and “educable” are commonly used by physicians, educators, legislators and others to refer to the moderately and mildly retarded group respectively. Generally, “trainable” describes an individual who can benefit from specialized training programs to the extent of developing self-care and simple skills which will enable him to live in the community and achieve semi-productivity in a sheltered setting. “Educable”, as used by teachers and others, describes those individuals who, with the help of special educational programs can participate in elementary academic activities and acquire vocational skills sufficient for self support.

It would be preferable to classify mental retardation on the basis of etiology, but present knowledge makes this difficult. Therefore, classification is largely dependent on the use of symptomatology and the severity of the deficiency as the major criteria. Evalua-

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tion of mental retardation must include organic, psychological and social factors which are closely interwoven in this as in any other condition affecting the individual and his adaptation to the environment.

The diagnostic process is by no means complete with a mere determination of “mental retardation.” An adequate diagnosis is concerned with the implications of the specific symptomatology, an understanding of etiology, a realistic prognosis and a comprehensive program of care, treatment and training. Diagnostic study and the subsequent treatment of the mentally retarded not only requires collaboration between the psychiatrist and pediatrician, but often calls for the help of many other medical specialists because of the frequent coexistence of multiple handicaps. The role of other professions such as education, nursing, psychology and social work cannot be overemphasized.

IV. ETIOLOGY

Modern advances in the medical sciences have made us increasingly aware of the multiplicity of the factors in the etiology of mental retardation.\(^6\) While the individual with an I.Q. below 50 usually has a concomitant organic involvement, psychological, social and cultural factors play a role in determining his overall status. On the other hand, the mental status of the mildly defective individual usually is less influenced by organic involvement than by early cultural influences, social environment and psychopathological problems.

The following factors should be considered in every case of mental retardation.
1. Somatic
2. Cultural
3. Social
4. Psychological

These factors will differ quantitatively in the etiology of mild versus moderate or severe retardation. Figure 1 attempts to depict their relative roles schematically.

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Relative Importance of Etiologic Factors in Mental Retardation

(These figures are schematic and are not intended to represent exact proportions.)

Somatic Factors

Patients with moderate or severe mental retardation usually show definite evidence of “the organic brain syndrome”. Genetic factors, abnormalities of gestation, maternal dietary deficiencies and metabolic disorders, pathological birth processes with asphyxia, jaundice or hemorrhage, postnatal trauma or infections are common etiological agents. It is seldom possible to attribute full responsibility to a single organic factor in the chain of events which has occurred. In some instances, even though definite evidence of an infection is present, it also appears that other factors have prepared the brain for such an invasion. Therefore, even though the infection produced the mental defect, often a series of events was responsible for making the brain an area of lowered resistance.

Genetic factors are included here under somatic factors because they may result in generalized abnormalities of the central nervous system either structural or metabolic, e.g., phenylketonuria. Somatic factors undoubtedly play a primary role in the production of the more severe forms of retardation. However, even in some
mildly retarded children and adults the condition can be traced to a chronic brain syndrome such as a post-traumatic, post-infectious or developmental difficulty.

**Cultural Factors**

Cultural factors play a large role not only in determining which children in a given community will be considered mentally retarded, but also when they will be identified. The concept “mental retardation” is in itself more of a cultural label than a clearly defined medical condition. Epidemiologic studies indicate that most cases of mental deficiency in any community are identified among the school age population. Children from certain sub-cultures may score low on psychometric tests primarily because these tests are culturally biased. Studies have shown that the children from culturally deprived homes will score progressively higher on successive psychometric tests after exposure to social and educational stimulation. Thus, in many community settings certain children may be classified as mentally retarded primarily because they fail to meet the expectations of the particular school culture.

**Social Factors**

Of importance, particularly in the etiology of mild mental retardation, are the complex physical and psychological deprivations to which some youngsters are exposed in their families and communities. It would be difficult to enumerate all of these factors, which include such hazards to sound growth and development as poor nutrition, unhygienic environment, general neglect, inadequate or lack of intellectual stimulation. Children born with reasonably normal intellectual potential who are penalized by such deprivation will fail to realize their potential unless remedial action is taken. Furthermore, in the families of these children this condition tends to repeat itself generation after generation unless the sociological pattern can be reversed. Where such improvement does not occur, one finds progressive deterioration, increased dissention and turbulence, accompanied by further retardation. An unfavorable social environment, disorganized family life or other stress situations may of course also result in an ego defect with or without mental retardation.

**Psychological Factors**

Psychological factors include the individual’s total mental apparatus with its intellectual and emotional components. Anxiety itself may often result in an apparent lowering of intellectual functioning. In public school special classes for the mentally retarded one can usually find a few children who are functioning at a retarded level primarily because of an emotional disorder. Another group of children who function at a retarded level are those suffering from “early infantile autism”. These children have gross distortions and defects in ego growth and this often, but not invariably, produces a picture of intellectual retardation. The developmental history of such children gives evidence of original intellectual potential, but the longer the psychotic process continues, the more the child becomes almost indistinguishable from those with primary mental retardation.

**V. RESIDENTIAL CENTERS**

With the exception of a few states and some large cities community educational facilities until recently provided no special programs for the mentally retarded youngster with the result that sooner or later he was excluded from public school. The only setting in which education was then available to him was the state residential school. These institutions were called variously “The Home,” “The School,” “The Colony,” etc.

Accepted psychiatric principles do not support the separation of any child from his family if the only purpose is to make an educational program available to him. In recent years more communities have developed special public school programs for the educable mentally retarded and some now also include provisions for the trainable children. When such facilities are available, the admission of a retarded child to a residential setting is determined by the severity of the other related factors—psychological, social or somatic. This trend, which has significantly altered the composition of institutional patient populations calls for a reconsideration of the aims, programs, facilities and personnel of such institutions.

Figure 2 depicts the relationship of those factors which determine the probability of residential placement of the mildly retarded in contrast to the moderately and severely retarded. A mildly retarded individual is seldom admitted to a residential center simply
on the basis of his impaired intelligence. However, the disintegration of the family constellation, distorted sociocultural attitudes and lack of available community facilities and programs often result in further psychological impairment in the retarded child. He may then become a psychiatric casualty and, since adequate help is rarely available to him in his own community, placement in a residential facility becomes necessary even though it could have been avoided had other resources been available.

Factors Precipitating Residential Care
1. Patient's physical status.
2. Patient's psychological status.
3. Family's structure, attitudes and economic status.
4. Availability of community facilities and programs.
5. Availability of residential facilities.

Mildly Retarded

Moderately and Severely Retarded

(These figures are schematic and are not intended to represent exact proportions.)

(Figure 2)

Table I shows the approximate distribution of the retarded in state institutions and communities. These are average figures for the United States as a whole and there may be considerable geographical variations which will depend upon the extra- and intramural facilities existent in each area.

<table>
<thead>
<tr>
<th>Degree of Retardation</th>
<th>Total Number of Mentally Retarded</th>
<th>Not Institutionalized</th>
<th>Institutionalized</th>
<th>Percent of Total Institutional Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe</td>
<td>180,000</td>
<td>135,000 or 75% of severe group</td>
<td>45,000 or 25% of severe group</td>
<td>30%</td>
</tr>
<tr>
<td>Moderate</td>
<td>540,000</td>
<td>than 85% of moderate group 4,250,000 or more</td>
<td>than 15% of moderate group 30,000 or more</td>
<td>50%</td>
</tr>
<tr>
<td>Mild</td>
<td>4,280,000</td>
<td>more than 99% of mild group</td>
<td>less than 1% of mild group</td>
<td>20%</td>
</tr>
<tr>
<td>Total</td>
<td>5,000,000</td>
<td>4,850,000</td>
<td>150,000</td>
<td>100%</td>
</tr>
</tbody>
</table>

(Table 1)

The aim of a modern residential institution should be to assist the patient in achieving maximum social, emotional and intellectual maturation and the earliest possible return to his own home. It is no longer valid to look upon the residential setting as a permanent abode for all mentally defective youngsters. Programs should include all the medical techniques together with such other services as our society commonly provides for the development of independent adults.

As noted earlier, residential admission of the mildly retarded is usually the result of a superimposed emotional disturbance in the child or family. However, the admission of any retarded child is almost always accompanied by an emotional upheaval in the family constellation. These facts in themselves point to the essential role in which psychiatry must play in the development of programs for the mentally retarded. The more rapid movement of patient populations and the admission of patients with a specific therapeutic goal in mind clearly demand that residential institutions be viewed as medical facilities. Since it is advisable that this function be reflected in their title, such facilities should be designated appropriately. A cursory view of the 110 present-day public facilities for the retarded indicates that about 63% are now administered by physicians two-thirds of them psychiatrists.8

Historically, the concept developed that deviant children could be classified accurately into a clear-cut categories such as the psychotic, the neurotic, those with character problems, and the mental deficient. More recent experience has underscored the difficulties inherent in differential diagnosis. In a substantial number of cases the diagnostic term attached to a given patient depends upon the orientation of the examiner rather than upon the presenting symptomatology or developmental history of the patient. Though such differences may seem only semantic in nature, they actually represent a serious hazard because in our administrative practices diagnostic terms generally imply therapeutic disposition. From the presumption that differential diagnosis is relatively simple grew the development of separate facilities for so-called psychotic and neurotic children as opposed to those for mental retardation. This unfortunate development deprived each group of the patient’s opportunity to benefit from the professional skills available to the other group.

It is our conviction that there is need to restructure our psychiatric services that all therapeutic skills beneficial to children will be made available to the psychiatrically deviant child regardless of the specific category into which he may have been classified. Such a concept calls for the development of Psychiatric Centers for Children with diversified programs including in-patient, day hospital, and out-patient services.

The Psychiatric Center for Children’s first responsibility would be that of comprehensive differential diagnosis followed by the development of a treatment plan based on the concept that the patient is first a child and only secondarily afflicted with an abnormality. This approach would eliminate overemphasis on diagnostic terms which in the past have determined administrative decisions concerning institutionalization or other disposition. At the present time, contacts between the family and state institutions for the retarded are directed toward the family’s predetermined desire to “place the child”.

A Psychiatric Center for Children would instead first offer diagnosis and then the development of an appropriate plan for constructive treatment, training and care as individually indicated. The center should draw on other community resources in its plan-

ning and should in turn be an integral part of community services for children.

There is a need for flexibility not only in program development, but also in age limits. The delineation between childhood, adolescence and adulthood is often as indistinct as that between the several diagnostic categories. One can only arbitrarily decide when an individual ceases to be an adolescent and becomes an adult. We believe that the child orientation of a treatment facility has much to offer in the care of some older children and young adults with psychiatric disorders. At times it is clearly advisable to continue the treatment of a given child in a given facility so long as therapeutic benefits are to be observed even though the chronological age barrier may be violated.

Disturbed children present a wide range of behavior from the passive, withdrawn child to the over-active, over-aggressive child. They also present a wide range of intellectual functioning. This requires flexibility in grouping the children both by age and symptoms and in the daily programming so that treatment plans for each child can be individualized.

In each institution one group in particular presents special needs. These are the children who manifest intermittent aggressive and destructive behavior. These children require special protection during periods when they are unable to control their aggressive impulses. Though they represent a serious administrative problem to all child care institutions, they should be cared for within the overall structure of each institution, so that as their symptoms abate and self-control improves, they can return easily to the regular program.

On the other hand, aggressive antisocial children who do not present primary symptoms of mental retardation, neurosis or psychosis should not be admitted to a Psychiatric Center for Children or present day hospitals for retarded, neurotic or psychotic children. Wherever these children are cared for, there should be psychiatric services available for consultation work and individual therapy.

VI. FAMILY CONSTELLATION

The recognition or diagnosis of mental deficiency in a member of a family frequently carries with it a disruption of the emotional
adjustment of the other members of the family. In the severely retarded this occurs while the patient is young and usually has an acute and dramatic effect upon the family. In the lesser retarded it often occurs later and the diagnosis is usually the result of some minor delinquency or failure in school which is likely to have an adverse effect on relationships between the patient and his family, between and among the neighbors and the community agencies involved. Though little scientific evidence is available as to the quality and quantity of the effect on the family unit of the presence of a retarded child, certain basic principles can be stated.

The birth of a severely retarded child often produces serious disruption in the marital adjustment, raises anxiety concerning genetic factors, influences the economic and social mobility of the parents and may seriously alter the social ties which the parents have developed in the community. Further changes in the composition or economic stability of the family such as the death of a parent, the loss of a job, or the birth of a new baby make necessary adjustments even more difficult. These traumata increase the psychiatric casualty rates in the parents unless appropriate counselling services are readily available. Without these services, and at times even in spite of them, parental conflicts reflect themselves in the impaired emotional development of the retarded baby as well as his siblings.

Denial of the obvious, overprotection or rejection are common parental responses. These may result in “diagnostic shopping” or dogmatic stereotyped decisions to keep or exclude the retarded youngster. All of these conflicts are heightened and become more manifest in the process of separation when the youngster is admitted to a residential setting. Support for the parents at this trying time must be an integral part of services offered by the public hospital and other community resources.

Deep personal involvement has moved many a parent into organizational activities. The overall effect of the parents’ groups has been beneficial in that they have stimulated support and interest in work with the mentally retarded. The emotional involvement that is inherent in these organizations demands of the medical profession the assumption of responsibility for guidance and leadership in order that the strength of the movement be channeled into sound and productive activity.

VII. COMMUNITY PLANNING

Community planning is fundamentally responsible for the success or failure of our present and future management of the problems of mental deficiency. If it is adequate, both the community and its retarded citizens will benefit. If it is poor, the community suffers and the retarded become unfortunate social and financial burdens. In every city and town a percentage of the population is mentally defective. A few of these individuals are severely retarded, a somewhat larger number are moderately retarded and by far the largest group are only mildly handicapped. Wise community planning takes this undeniable segment of the population into account. It supports research, it educates its citizens to understand and accept, it insures adequate medical care and training for the retarded, and wherever possible it arranges for remunerative employment. In summary, the wise community realizes that it must deal with the problem of mental deficiency and it does so on all levels and in all possible ways.

Studies have shown that prevalence rates for mental deficiency vary from one group to another. Early in life, the severely retarded are usually recognized. Later in childhood, especially as children reach school age, the moderately retarded are identified when they cannot meet ordinary academic standards. Still later, either in the higher grades of school or when life situations become more stressful, the mildly retarded become “statistical cases”. While we consider the proper awareness of a child’s learning capacity essential, we do not feel permanent labeling as “mentally defective” to be an advisable procedure. Mental retardation as a diagnosis is not as simple and clear-cut as for instance pregnancy where one either is or is not. An individual may function poorly under stressful conditions or in a certain educational system, yet be capable of self-sufficient, independent living under different circumstances. To artificially and permanently categorize such a person as mentally defective, not only does him an injustice, but also creates an unnecessary problem for the community. Proper planning will enable society to absorb as useful citizens the greatest possible number
of retarded individuals, while providing care that will enable even the most defective patients to reach their maximum potentials.

Adequate community planning involves several separate but inter-related areas. The first and one of the most essential needs of any community is that of adequate diagnostic services. The diagnosis of mental deficiency, if properly made, is much more complicated than is usually recognized. It is by no means merely a matter of a low I. Q. obtained on one test, or an apparently retarded learning ability in school, or even a mongolid appearance. To be meaningful such a diagnosis should include an adequate evaluation of physical, intellectual, emotional and social factors. Initial suspicion of the presence of mental deficiency may arise in any one or all four of these areas. Obvious physical signs of mental deficiency may be present at birth or may appear on subsequent medical examinations; retardation may first become apparent in school, or the problem may first present itself in the form of social maladjustment. It is essential that members of all professions serving the children of a community be aware of the problem and the need for comprehensive study. Diagnostic facilities function most effectively if they are integral parts of the health, education and welfare structure of the community. The offices of private physicians and the clinics of both general and specialized hospitals must be prepared to initiate this type of service. A multi-discipline approach is essential, involving the participation of the pediatrician, neurologist, psychiatrist, social worker and psychologist, as well as the public health nurse, the educator, and others as required.

One of the goals of the diagnostic process is the realistic acceptance of the handicap and its implications by the parents. This process is often time-consuming. Parents tend either to resist the diagnosis and resume “medical shopping” or to handle the new information in a highly unrealistic manner. They must be helped to come to grips with this harsh reality; to become aware of their own involvement in the situation, and to begin to plan constructively for their child’s future.

Once the diagnostic process has been completed, it is essential that the community have available the proper resources to permit long-range planning. This planning, once again, falls into three main categories. First, appropriate medical care must be available for all children, including those who are mentally defective. These infants and youngsters need and are entitled to the same quality of pediatric care as do all children. There are many occasions when somatic problems may complicate the pediatric and orthopedic care, but no child should be denied adequate modern medical procedures merely because he is mentally defective.

Then, there is the area of emotional health. Many mentally retarded children are not well equipped to meet the demands which will be placed upon them in our society. Resultant emotional problems must be resolved or the child will become a more serious burden upon the community. Unfortunately, it is commonly believed by psychiatrists that psychiatric treatment for the mentally retarded is unrewarding and often unproductive. This is by no means true. Emotional conflicts in a retarded child while similar in type to those found in more gifted youngsters, are usually less elaborated. Psychotherapeutic measures, including interpretations can, therefore, often be simplified and yet be effective.

There is also the necessity for educational and vocational planning for the retarded child. Public schooling for the mentally defective has improved significantly, but differences of opinion concerning school programs are still common, particularly among educators. Some insist that the main goal of the public school is to impart scholastic knowledge and that since mentally defective children have difficulty in this area such youngsters belong in other settings. Others feel that public education has a much broader goal, including the acquisition of any skill or knowledge which will contribute to better and more productive citizenship. They support the inclusion of the moderately retarded in the public school system in a flexible setting which provides a program oriented toward the development of self-care, socialization and general maturation.

There is no question that we still have much to learn about the education of the retarded child, be he mildly retarded or moderately defective. Though limited in intellectual ability, many of the retarded are capable of achieving considerable independence, socially and vocationally. While educational ventures will undoubtedly have to give major attention to the necessity for preparing these children for eventual employment, the community must also take responsi-
bility for helping them get and keep jobs and find other sources of social and emotional satisfaction.

Community planning includes the provision of many other services for the mentally retarded child. Among these are vocational counseling and placement, sheltered workshops, religious programs, day care, public and voluntary social agencies, legal assistance and recreational programs. It is beyond the scope of this preliminary report to speak of them in detail. Psychiatrists and other members of the clinical team have particularly important roles as consultants in these programs, and, therefore, must familiarize themselves with potential usefulness to the mentally retarded as well as the mentally ill.

A sine qua non of adequate community planning is widespread public education concerning mental deficiency. Only when there is realistic acceptance of this problem in all strata of society, will community planning achieve its goal. For instance, one of the dividends of adequate public education is the acceptance by industry of the usefulness and productivity of the retarded. In our highly complex society great emphasis is often placed upon intellectual ability. It is even sometimes assumed that job potentials for the mentally defective do not exist. This is obviously untrue. The mildly retarded often function well in a variety of occupations and even the moderately retarded who may need considerable supervision and assistance, can also become contributing citizens.

The important areas of treatment, research and teaching in mental deficiency are not included in this report; they will be discussed in future reports.

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**Group for the Advancement of Psychiatry**

The Group for the Advancement of Psychiatry has a membership of approximately 150 psychiatrists, organized in the form of a number of working committees which direct their efforts toward the study of various aspects of psychiatry and toward the application of this knowledge to the fields of mental health and human relations. GAP is an independent group and its reports represent the composite findings and opinions of its members only, guided by its many consultants.

Collaboration with specialists in other disciplines has been and is one of GAP's working principles. Since the formation of GAP in 1946 its members have worked closely with such other specialists as anthropologists, biologists, economists, statisticians, educators, lawyers, nurses, psychologists, sociologists, social workers, and experts in mass communication, philosophy and semantics. GAP envisions a continuing program of work according to the following aims:

1. To collect and appraise significant data in the field of psychiatry, mental health and human relations;
2. To re-evaluate old concepts and to develop and test new ones;
3. To apply the knowledge thus obtained for the promotion of mental health in good human relations.

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**Committee on Adolescence**


**Committee on Aging**


**Committee on Child Psychiatry**


**Committee on College Student**


**Committee on Cooperation with Governmental (Federal) Agencies**


**Committee on the Family**


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