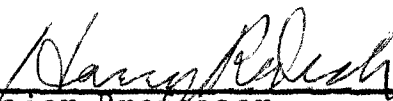




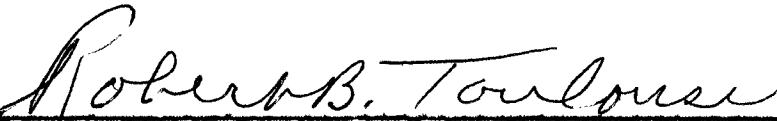
AN EXPLORATORY STUDY OF PARENTAL VISITATION  
AND SELECTED CHARACTERISTICS OF  
THE INSTITUTIONALIZED  
MENTALLY RETARDED  
CHILD

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CHILD

THESIS

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By

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//  
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## CHAPTER I

### INTRODUCTION

#### Statement of the Problem

Traditionally the study of mental retardation has been limited largely to the fields of biology and psychology. Thus, the major proportion of scientific research in the past has focused upon the retarded child per se. These disciplines have contributed much to understanding in the areas of etiology, classification, and treatment of the retarded child, but partly because of their characteristic orientation, some important problem areas have tended to be neglected. Some of these neglected areas legitimately fall in the realm of sociological interest.

Mental retardation is actually not a new area of study in sociology. As Lewis Dexter points out: ". . . during 1910-25, the literature showed considerable concern by sociologists and social workers with mental deficiency. . . ." <sup>1</sup> However, after 1925, sociological interest began to wane, and by 1949 there was "virtually no interest by sociologists in the topic." <sup>2</sup> Since the late fifties sociologists have again

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<sup>1</sup>Lewis Anthony Dexter, "A Note on Selective Inattention in Social Science," Social Problems, VI (Fall, 1958), p. 176.

<sup>2</sup>Ibid. Dexter advances four major reasons why sociologists have tended to turn their interest away from mental retardation.

begun to carry out research in mental retardation, but on a modest scale. The result has been a small but noticeable trend towards understanding the social, as distinguished from the individual, aspects of mental retardation.<sup>3</sup>

Richard Kurtz lists two factors that are important in explaining this renewed sociological interest. First, he sees this interest as part of a larger trend towards research in the relatively new field of medical sociology. In this field "some sociologists have been addressing their attention to the mentally retarded."<sup>4</sup> Second, Kurtz points to the development of a broader conceptual view that adds a sociological dimension to retardation: "Individual phenomena that are ordinarily approached on a one-to-one clinical level are generally neglected by sociologists. However, when such phenomena are placed in a larger social context, the sociologist exhibits interest. . . ."<sup>5</sup>

Similarly, Elaine Cumming and John Cumming in discussing the clinical one-to-one relationship with mental patients state: "The business of the psychiatrist is to understand, prevent, and cure suffering, but the business of the sociologist is to examine related suffering and the social systems

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<sup>3</sup>Ibid.

<sup>4</sup>Richard A. Kurtz, "Implications of Recent Sociological Research in Mental Retardation," American Journal of Mental Deficiency, LXIX (July, 1964), p. 16.

<sup>5</sup>Ibid.

in which it occurs, the family, the neighborhood, and the community."<sup>6</sup>

Kurtz sees three areas of renewed sociological concern in mental retardation: (1) interest in the extent, type, and distribution of retardation in society; (2) interest in patterns of interaction among members of social systems involved with mental retardation; (3) studies of attitudes concerning mental retardation.<sup>7</sup>

This study falls most properly in the second of these areas, the interaction patterns among members of a certain social system, broadly defined. The social system under consideration is the one comprised of the institutionalized mentally retarded child, his family, and the institution of which he is a resident.<sup>8</sup>

As Kenneth Downey points out, empirical investigation of this particular social system has largely been ignored.<sup>9</sup> Indeed, until recently there has been an almost virtual absence of research not only in the social systems surrounding mental retardation, but in mental illness as well. As late

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<sup>6</sup>Elaine Cumming and John Cumming, Closed Ranks, (Cambridge, 1957), p. 118.

<sup>7</sup>Kurtz, op. cit., p. 16.

<sup>8</sup>The term social system, as employed in this study, refers to an interdependent set of statuses and roles. It may be defined as ". . . a plurality of individuals interacting with each other according to shared cultural norms and meanings. . . ." William F. Ogburn, Myer F. Nimkoff, Sociology, (Boston, 1964), p. 417.

<sup>9</sup>Kenneth J. Downey, "Parental Interest in the Institutionalized Severely Mentally Retarded Child," Social Problems, XI (1963), p. 186.

as 1957, Theodore Lidz, Georgina Hotchkiss, and Milton Greenblatt in a discussion of the patient-family-mental hospital social system prefaced their discussion with the following statement: "So little has been done in this field that this chapter cannot do more than raise questions or delineate areas for further investigation noted in the few exploratory studies. . . ."10

During the last decade a few significant social-system studies have been conducted. Perhaps the most noteworthy research is Erving Goffman's analysis of the mental hospital.<sup>11</sup> However, generally these studies have focused on mental illness rather than mental retardation.

The general purpose of this study, then, is to contribute to the understanding of this social system by examining a limited aspect of the system, the nature and extent of parents' interest in and interaction with their institutionalized mentally retarded children and certain characteristics of the child. These characteristics are age, sex, degree of retardation, and length of time the child has resided in the institution.

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<sup>10</sup>Theodore Lidz, Georgina Hotchkiss, and Milton Greenblatt, "Patient-Family-Hospital Interrelationships: Some General Considerations," The Patient and the Mental Hospital, edited by Milton Greenblatt, Daniel J. Levinson, Richard H. Williams, (Glencoe, Illinois, 1957), p. 535.

<sup>11</sup>Erving Goffman, Asylums: Essays on the Social Situation of Mental Patients and Other Inmates, (Garden City, New York, 1961).



### Significance of the Problem

The role of the family in the patient-family-institution complex has been subjected to increasing exploration in recent years. One question that has been examined is the extent to which parental interest, through its various modes of expression, can be utilized in the treatment of mental illness and in training programs in mental retardation.

Historically, in studies of mental illness this question has been answered in the negative. Parental visitation in the past was viewed as anti-therapeutic. As long ago as 1863 Isaac Ray wrote:

The surrounding of the patient should be entirely changed so that he shall see no face . . . familiar to him in his previous stage of his disease . . . What would be a sacred duty under ordinary circumstances may be a source of serious mischief here.<sup>12</sup>

This same view was expressed by Harry Stack Sullivan in 1940:

It is only natural that relatives should demonstrate some interest . . . in what is being done for the patient . . . it is natural . . . that relatives should be firm in the conviction that their visits . . . are wholly beneficial while they are often precisely the opposite.<sup>13</sup>

Recent re-evaluation tends to view visits to mental patients in a more favorable light. Parental visitation can

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<sup>12</sup>Isaac Ray, Mental Hygiene, no page given, cited in Greenblatt, Levinson, and Williams, op. cit., pp. 536-537.

<sup>13</sup>Harry Stack Sullivan, Psychiatry, III (1940), p. 117. Cited in Greenblatt, Levinson, and Williams, Ibid, p. 537.

be therapeutic. Clarence Groth, Hiram Gordon, and Frank Dietrich state, "It is generally conceded that the visits of relatives, except in some unusual cases can be of considerable help in the treatment and rehabilitation of mental patients."<sup>14</sup>

It may not be altogether appropriate to view parental visitation as either therapeutic or anti-therapeutic in mental retardation, if the term is taken to denote an attempt to restore the individual to a previous normal condition.<sup>15</sup> Mental retardation programs are designed to train the child, i. e., to develop his highest potentialities. Moreover, a major function of the institution is to provide the highest possible degree of custodial care, and the "approach . . . is to protect him from a multiplicity of roles and social situations."<sup>16</sup> Optimal "treatment" of the institutionalized retardate is more a matter of habilitation than of

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<sup>14</sup>Clarence Groth, Hiram Gordon, and Frank Dietrich, "Problems of Unvisited Patients in a Mental Hospital," Mental Hygiene, XLIV (April, 1960), pp. 210. The researchers support this statement by citing the following articles: Jacob Brown and Richard R. Brown, "The Relatives Conference in an Isolated Neuro-psychiatric Hospital," Journal of Psychiatric Social Work, XXIV (September, 1955), pp. 215-219; Mildred T. Farris, "Casework with Mentally Ill Patients and Their Relatives - Casework with Relatives," Journal of Psychiatric Social Work, XXIV (January, 1955), pp. 108-112; Arthur Kaplan and Louis Wolf, "The Role of the Family in Relation to the Institutionalized Mental Patient," Mental Hygiene, XXXIX (October, 1954), pp. 634-639.

<sup>15</sup>Downey, op. cit., p. 186.

<sup>16</sup>Ibid.

rehabilitation, and of providing the physical and social circumstances that will maximize the morale and well-being of the child.

The function of parental contact (or any other relatives' visits, for that matter) in this context has not been empirically demonstrated, but its value can perhaps be safely assumed, at least if the parent-child relationship is a warm and supportive one. At any rate, there is evidence that retarded children benefit from a close, personal, primary relationship within the institution. Such evidence comes from evaluation studies of the "foster grandparent" program, a federal program initiated to provide work for elderly citizens. These people work in the capacity of foster grandparents to institutionalized mentally retarded children. Their major function is to provide tender loving care to the children by singing, playing games, and other forms of expressive interaction. A result of this program, according to one evaluation study, has been to increase at least temporarily the child's morale and well-being.<sup>17</sup> In the words of Harry R. Dick and Hiram J. Friedsam,

No matter how fleeting the contact or how limited the carry over, the program does enrich the lives of the children it touches, and anyone who is familiar with the institutions for the retarded children will not judge this to be a minor success.<sup>18</sup>

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<sup>17</sup>Harry R. Dick and Hiram J. Friedsam, "Evaluation of the Foster Grandparent Program at Denton State School, Denton, Texas: Final Report," mimeograph, (June, 1968), p. 26.

<sup>18</sup>Ibid, p. 92.

Foster grandparent contact and parental (or other visitor) contact are not the same thing. However, either type of interaction pattern is a significant means of reducing the deleterious effects upon the child of what Goffman has termed the "total institution."<sup>19</sup>

This study will describe relationships between characteristics of the retarded child and the amount and types of parental visitation. Visits by parents are one measure of the degree of involvement, or the role they desire to play, in increasing the morale of the child. The study will not attempt to evaluate the quality of visits, but by isolating important factors in visitation and describing existing visiting patterns it will provide information that can be used by the institution to increase the value derived from visitation.

#### Review of the Literature

Visitation of institutionalized persons by parents, relatives, and friends has received little attention from either sociologists or other social scientists, but a few significant studies of patient-family-institution social systems do exist. Most of these are in the area of mental illness, with a considerably smaller proportion in mental retardation.

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<sup>19</sup>Goffman, op. cit., p. 4.

Robert Sommer in a study of visitors to a state mental hospital was concerned with analyzing characteristics of patients who were visited. He was interested in "the relationship between receiving visitors and the patient's present age, age at first admission, length of hospitalization, sex, and distance of home residence from the hospital."<sup>20</sup> Sommer found no relationship between visitation and present age of the patient, and none between distance from the hospital and visitation. He did find a positive relationship between number of visits and age at admission, and a negative relationship between visits and length of hospitalization. Also, females received more visits than males. According to Sommer, "Of the variables examined in the study, the length of the patient's hospitalization is most closely related to whether or not the patient has visitors. The longer the patient is in the hospital, the less likely he is to have visitors. . . ."<sup>21</sup>

Whereas Sommer examined characteristics of the visited mental patient, Groth, Gordon, and Dietrich focused upon the characteristics of the unvisited mental patient.<sup>22</sup> Their sample was drawn from an isolated V. A. hospital in Fort Lyon, Colorado. They found that forty-one percent of the mental

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<sup>20</sup>Robert Sommer, "Visitors to Mental Hospitals: A Fertile Field for Research," Mental Hygiene, XLIII (January, 1959), p. 9.

<sup>21</sup>Ibid, p. 13.

<sup>22</sup>Groth, Gordon, and Dietrich, op. cit., pp. 210-217.

patients had not had a visit in a year.<sup>23</sup> They summarized their conclusions as follows:

Unvisited patients as compared to the real hospital population tended to be characterized by the following indices: older, hospitalized longer, never married, no service connected compensation, parents not living, no relatives residing within 500 miles of the hospital, classified as chronically ill, and displaying more atypical behavior.<sup>24</sup>

These studies by Sommer, and Groth, Gordon and Dietrich are of limited value to the proposed investigation inasmuch as they were conducted on mentally ill populations. A second shortcoming is the age range included in the populations investigated. Populations in mental institutions exhibit a wide variation in age and generally consist of adults, whereas the present study is concerned essentially with children. These studies, nevertheless, succeed in pointing up the fact that some personal, family, and institutional variables appear to be significantly involved in determining the patterns of social contacts that institutionalized persons may have.

The study most directly related to the present investigation is one by Kenneth Downey focusing upon parental interest in institutionalized mentally retarded children.<sup>25</sup>

Downey devised a "parental interest index" which measured four "acts" by parents that relate to interest. These

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<sup>23</sup>Ibid, p. 210.    <sup>24</sup>Ibid, p. 217.

<sup>25</sup>Downey, op. cit.

acts are (1) parents' visits to the child, (2) child's home visits, (3) letters from parents asking about the child's health and welfare, and (4) participation in the school's parental association.<sup>26</sup>

After analyzing parental interest in relation to thirty-eight independent variables Downey concluded that education and age were the most important factors influencing interest.<sup>27</sup> He found that interest was lower in the more highly educated families.<sup>28</sup> Several age and time variables were related to interest. These included " . . . age of parents, length of marriage, age of oldest child, age of retarded child, length of institutionalization, and life status of the grandparents. . . ." <sup>29</sup> The most important age factor, however, was the age of the child when placed in the institution.<sup>30</sup>

Downey's study leaves at least two important questions unanswered. First, he was concerned only with the severely retarded child and did not take into account degrees of

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<sup>26</sup>Ibid, pp. 187-189.

<sup>27</sup>Ibid, p. 190. "Some of the important variables which did not yield significant Chi square values are husband's occupation (white collar-blue collar), family income, sex of the retarded child, degree of marital integration, family social mobility, friendships and neighborliness of the family, church attendance, religious preference, organizational membership and activeness, and nativity of parents."

<sup>28</sup>Ibid. <sup>29</sup>Ibid, p. 191. <sup>30</sup>Ibid.

handicap. The question may be asked, how is degree of retardation related to parental interest? Second, a description of parental visitation is not attempted. There are different lengths and types of visitation. Parents may visit the child in his dormitory, on campus, or off campus, for one day, or they may take the child home for an extended period of time. The question may be asked, are there differences with respect to length and type of parental visitation?

The present study, while not unlike Downey's, will differ in some significant ways. First, the above-mentioned variables--degree of handicap and length and type of visits--will be taken into account. Other variables of concern to Downey will not be investigated. Indeed, the major difference is that where he focused attention chiefly upon parental characteristics as related to visitation (and other criteria of interest), this study focuses upon the child's characteristics as indicators of parental interest, as measured by number and length of visits.



## CHAPTER II

### METHODS AND PROCEDURES

#### The Setting

Denton State School is one of six state-supported institutions for the mentally retarded in Texas, serving thirty-seven counties in the northeastern part of the state.<sup>1</sup> It began operation in 1960 and attempts to fulfill three major purposes: "First, to provide care and training for the mentally retarded children; second, to further research in the area of mental retardation; third, to train workers in the area of retardation."<sup>2</sup>

The school is a modern institution, comprised of sixty-one new buildings, including forty-four dormitories and seventeen other buildings. The institution serves approximately 1700 students and has a staff in excess of eight hundred employees.<sup>3</sup>

#### Definition of the Population

The study population is comprised of all ambulatory residents of Denton State School as of April 15, 1969, who

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<sup>1</sup>Mental Health and Mental Retardation, (Austin, 1966-67), p. 71.

<sup>2</sup>Russell G. Thornton, "Employment of Older Persons as Foster Grandparents," unpublished Masters' thesis, School of Arts and Sciences, North Texas State University, Denton, Texas, 1966, p. 8.

<sup>3</sup>Ibid, p. 9.

had been in residence during the calendar year 1968, and the first six weeks of 1969--from January 1, 1968, to February 15, 1969.

Residents at Denton State School are classified in various ways which determine where they are placed in the institutional structure. The broadest classifications are ambulatory (cottage life division) and nursing service. Ambulatory residents are further differentiated in terms of degree of retardation. On this basis the ambulatory residents are placed under the supervision of teams. A team, consisting of a supervisor, social worker, psychologist, and secretary, in part, supervises each resident's training program and also performs certain administrative functions. There are four such teams at the school and each works with one level of retardation. Thus Team I performs these functions for the dormitories housing the profoundly retarded residents. Similarly, Teams II, III, and IV perform these functions for the dormitories housing severely and moderately and mildly retarded residents, respectively.

Children are generally assigned to teams on the basis of degree of retardation. They are then assigned to each team's several dormitories on the basis of age and sex. Each team office keeps records on the children residing in its dormitories, including the child's name, birthdate, admission date, dormitory residence, and psychological and medical reports. These records also contain information concerning

parents' characteristics, correspondence about the child, and record of visits.

The second broad classification of residents at Denton State School is the nursing service division. This division cares for those children who are bedfast or semi-ambulatory, and multiple-handicapped. These children are generally younger than the ambulatory population.

Nursing service operation is different from that in the ambulatory division. There are two teams in nursing service who supervise eleven dormitories and 572 residents. The emphasis is heavily weighted on custodial care.

As stated above, the population of this study is restricted to the ambulatory group and does not include residents in the nursing service. The latter were excluded to establish homogeneity of the population, since inclusion of these children would have introduced important variables not present in the ambulatory group.

#### Selection of the Sample

A sample of 176 children was drawn from the above defined population by a combination of purposive and probability methods.<sup>4</sup> Although the sampling procedure was not based strictly upon probability theory, it did involve some significant features of randomness. Specifically, sixteen

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<sup>4</sup>For a discussion of purposive as well as probability sampling methods see Claire Selltitz, Marie Jahoda, Morton Deutsch, and Stewart W. Cook, Research Methods in Social Relations (New York, 1959), appendix B.

dormitories were purposively selected by various criteria and individual cases were randomly chosen from these dormitories in a manner to be described below.

The rationale for selecting certain dormitories to sample was twofold. First, due to the nature of the records, this method afforded relatively easy access to data. Second, selecting dormitories provided initial assurance of the representation of specific variables in the sample. Dormitories were segregated on the basis of sex and are relatively homogeneous in terms of degree of retardation. There is considerable heterogeneity with regard to age and length of institutionalization, however. Following is a listing of the thirty dormitories housing ambulatory children, with those dormitories selected for this study indicated by use of an asterisk:

	<u>Dormitory</u>	<u>Sex</u>	<u>Age</u>	<u>I. Q. Range</u>
<b>Profound</b>				
	* 4a	F	6-14	0-20
	* 4c	F	12-up	0-20
	25a	M	8-15	20-40
	25c	M	8-15	15-30
	*26a	M	6-14	0-20
	*26c	M	12-up	0-20
<b>Severe</b>				
	* 5a	M	6-14	20-35
	* 5c	F	6-17	20-35

	<u>Dormitory</u>	<u>Sex</u>	<u>Age</u>	<u>I. Q. Range</u>
<b>Severe</b>				
	6a	F	6-18	25-35
	6c	F	14-up	20-35
	8c	M&F	4- 9	15-70
	*23c	M	16-34	20-35
	*28a	F	14-23	25-40
	28c	F	14-35	25-40
<b>Moderate</b>				
	* 8a	M	6-14	35-50
	7c	M	12-16	35-50
	23a	M	14-18	35-50
	*22a	M	16-up	35-50
	22c	M	14-up	30-40
	* 9a	F	6-14	35-50
	9c	F	12-16	35-50
	*27c	F	14-up	35-50
	24a	M	12-30	0-35
<b>Mild</b>				
	* 7a	M	6-14	50-70
	20c	M	12-18	50-70
	19a	M	16-up	50-70
	*20a	M	16-up	40-60
	*11a	F	6-16	50-70
	*11c	F	14-up	50-70
	27a	F	18-up	40-70

Dormitories were selected by the following procedure. Four dormitories were selected from each classification of retardation. The specific dormitories in each group were selected on the basis of age and sex, with a relatively "younger" and "older" dormitory being selected for each sex.

Lists of each dormitory's residents were compiled, and each child's length of institutionalization was computed. Twenty-one residents were deleted from these lists for the following reasons: one child had been discharged in 1968, one had been transferred to another institution, and nineteen had been institutionalized for less than one year.

As has already been mentioned, dormitories were rather heterogeneous with regard to age of residents. In addition, there was some degree of overlap between the dormitories with regard to age of residents. Therefore, for each retarded group the two lists of males were combined, as were the female lists, and each group was ranked by age. From these lists a systematic sample of every third case was drawn. This resulted in a sample of 180 cases. However, four had to be deleted subsequently because of lack of information concerning visitation.

Of the 176 residents in the sample, ninety-six were male and eighty were female, representing fifty-five and forty-five percent of the sample, respectively (see Table I).

The differences between percentages of children in the various categories of retardation were small, although the

TABLE I  
DEGREE OF RETARDATION, BY SEX

Degree of Retardation	Total		Male		Female	
	N	%	N	%	N	%
Profound	43	24.4	24	25.0	19	23.8
Severe	46	26.1	23	24.0	23	28.8
Moderate	47	26.7	25	26.0	22	27.5
Mild	40	22.7	24	25.0 <sup>v</sup>	16	20.0
Total	176	99.9	96	100.0	80	100.1

severe and moderate groups (26.1 and 26.7 percent) were represented slightly more than the profound and the mild

TABLE II  
MEAN AND MEDIAN PRESENT AGE, AGE AT TIME OF INSTITUTIONALIZATION, AND YEARS INSTITUTIONALIZED, BY SEX

Characteristic	Total		Male		Female	
	Mean	Median	Mean	Median	Mean	Median
Present age	17.7	16.6	18.0	17.7	17.4	15.0
Age at time of Institutionalization	5.4	3.8	5.2	3.6	5.8	3.9
Years Institutionalized	12.3	10.2	12.9	10.7	11.5	10.1

(24.4 and 22.7 percent). Sex differences with regard to these categories were negligible.

As indicated in Table II, the mean and median present ages of the sample were 17.7 and 16.6, respectively. The male group was older than the female, as evidenced by a mean of 18.0 and a median of 17.7 for the boys, as against 17.4 and 15.0 for the girls. The average length of institutionalization for the sample was about four to five years (mean 5.4 and median 3.8). Females had been institutionalized somewhat longer than the males. This is reflected by an earlier age at first placement among girls (11.5 and 10.1) as compared to boys (12.9 and 10.7).

#### Definition of Variables

The dependent variables in this study included number and length of visits.<sup>5</sup> In order to define these variables operationally it is essential to describe the visiting procedure at Denton State School in some detail.

Denton State School differentiates between five types of visits of varying lengths. On-dormitory, on-campus, and off-campus refer to visits of less than one day. A leave is a visit in which the resident spends from one to eight days off campus, generally at home. A furlough refers to any home visit of nine days or more, and these visits may extend for several weeks or even months.

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<sup>5</sup>Obviously, different lengths of visits may imply different types also. While the emphasis in this study is more directly upon length than type, both terms will be used as appropriate.



Normally, the visitor is required to make a request for a student pass prior to the intended visit. Usually this request is telephoned to the main switchboard or the team social worker. The request provides information pertaining to the date of the visit, type of visit, the name of the visitor, and his relationship to the child.

The team social worker checks the child's information card for possible restrictions on visits and visitors. Generally, there are two types of restrictions that would either modify the pass or cause the request to be rejected. One is medical restrictions. For example, the child may have contracted an infectious disease and be quarantined to the school. Or, in some cases, the child may need injections or medicine that cannot be administered if he is taken from the school for an extended period of time. The second restriction is social in nature, whereby certain individuals are denied visiting privileges. These restrictions may be by request of the legal guardian, as in divorce cases where the ex-spouse is denied visitation rights. The institution may restrict certain people, for reasons such as visits having deleterious effects on the child, or for chronic non-compliance with visiting rules.

If no restrictions apply, the team social worker issues the pass. This is recorded in the team files, and a copy of the pass is sent to the visitor. Another is sent to the resident's dormitory.

On the approved day the visitor takes the pass to the switchboard at the central office and signs the child's visitors' card. He then picks up the child at the dormitory (or visits him in the dormitory) and keeps him for the approved length of time. When the visit is completed, the child is returned to the dormitory and the visitor signs out at the central switchboard.

Records of the residents' visits are located in two places. One, relatively recent records are kept in the team files, but these are generally discarded after the child's visit card is filled up. Two, a permanent record of the child's visits is kept on the child's visitors' card at the central office switchboard. When the child's visitors' card is filled up it is put in his case folder in the master files of the institution.

This study examines two aspects of visitation: first, the number of visits received by the residents during the time period analyzed; second, the type of visit received. Although the school differentiates between the five types mentioned previously, the records provided information concerning only length of visit. Thus, only three types of visits were distinguishable. These were visits of less than one day (the records did not differentiate between in-dormitory, on-campus, or off-campus visits), more than one day but less than nine days (leave), and nine days or more (furlough). In later analysis four categories of visit were used, as the

leave category was dichotomized into visits of two to three days and four to eight days.

Two points need to be made concerning the nature of the records concerning visitation. First, the team office generally kept more accurate records concerning number and length of visits than the administrative office, but the latter kept a more accurate record of who visited. Therefore, data concerning the number and length of visits for the residents included in the sample were first collected in the team offices. These data were then checked against the record of the visits kept at the switchboard to ascertain the relationship of the visitor. Occasionally team records showed visits that were not recorded on the child's visitors' card. In most instances, these reflected visits that were applied for but never carried out. In some cases actual visits occurred, but the parent neglected to sign in and out at the switchboard.

Second, there was incomplete information as to who was included in the visiting party. The child's visitors' card indicated only the signature of the person responsible for the child during the visit. Because of this, it was impossible to differentiate between visits involving one parent, both parents, family visits, or for that matter, visits including any person other than the one who signed for the child.

Examination of visitation data showed that of the 1273 visits paid to the sample, 1094 were distinguishable (within

the limits described above) as parental visits. Although the focus of this study was primarily on parental visitation, the remaining 179 visits were also included. This was done for several reasons. Many non-parent visits were by other close family members such as brothers, sisters, or other close relatives, and as indicated in Chapter I, this study was interested, broadly speaking, in family as well as parental visitation. Also, in some cases relatives signed for the child, but visits were actually in the home of the parents. The precise number of non-family visits could not be ascertained but can be safely assumed to be very small, and for purposes of this study considered to be negligible.

It was noted above that the population was made up of children who had been in residence throughout 1968 and a part of 1969. Since children are generally not allowed visitors for the first six weeks of institutionalization, visitation data were collected, in actuality, for the twelve-month period between February 15, 1968 and February 15, 1969.

As indicated in Chapter I, the independent variables pertained to certain social characteristics of the retarded child, and included present age, sex, degree of retardation, and length of institutionalization. No special problems were involved in operationalizing these variables. Present age, technically, has reference to "age last birthday as of January 1, 1969." The true present age, of course, is in excess of these values. In those few cases where children

had transferred from another institution (generally Austin or Mexia) to Denton State School, the institutionalized period of time prior to transfer was included in determining "length of institutionalization." For this study degree of retardation was determined on the basis of dormitory placement. There were, however, some variations in I. Q. ranges within and between dormitories in each classification of retardation, as well as some overlap between the various classifications (see pp. 16-17).

#### Statistical Procedures

This research was descriptive and exploratory in nature and no hypotheses were advanced for testing. Accordingly, relatively simple descriptive statistical procedures were used, including frequencies, percentages, proportions, means, and medians. Where appropriate, Goodman and Kruskal's gamma was employed as a measure of degree of association between variables.<sup>6</sup> Statistical tests of significance were considered inappropriate in view of the non-random nature of the sampling procedure.<sup>7</sup>

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<sup>6</sup>See Theodore R. Anderson and Morris Zelditch, Jr., A Basic Course in Statistics, 2nd Edition, (New York, 1968), pp. 152-153.

<sup>7</sup>For a recent comprehensive discussion of the appropriateness of tests of significance together with an extensive bibliography, see Denton E. Morrison and Ramon E. Henkel, "Significance Tests Reconsidered," The American Sociologist, IV (May, 1969), pp. 131-140.

## CHAPTER III

### FINDINGS I: NUMBER OF VISITS

This chapter is concerned with the relationship between number of visits and degree of retardation, sex, present age, and length of institutionalization.

The 176 children in the sample received a total of 1273 visits between February 15, 1968 and February 15, 1969. The range of visits was zero to twenty-seven, with a mean of 7.3 visits per child and a median of 5.4.

Examination of the frequency of visits disclosed that the greater proportion were concentrated at the lower end of the range (see Table III). Twenty-four residents, or 13.6 percent of the sample, had no visits, and ninety-eight (55.7 percent) received six visits or less. Conversely, only ten residents (5.7 percent) received twenty or more visits. This skewness is reflected by a lower median than mean.

#### Degree of Retardation

There was a marked negative relationship between number of visits and degree of retardation. The correlation value (gamma) was  $-.48$ . This relationship was shown in several ways, as indicated in Table IV.

An examination of the mean and the median number of visits for children in the various categories of retardation

TABLE III

## FREQUENCY OF VISITS

Number of Visits	Frequency	%	Cumulative %	Number of Visits	Frequency	%	Cumulative %
0	24	13.6	13.6	14	5	2.8	86.9
1	9	5.1	18.8	15	2	1.1	88.1
2	15	8.5	27.3	16	2	1.1	89.2
3	11	6.2	33.5	17	2	1.1	91.5
4	14	7.9	41.5	18	5	2.8	93.2
5	9	5.1	46.6	19	2	1.1	94.3
6	16	9.1	55.7	20	2	1.1	95.4
7	9	5.1	60.8	21	0	.0	95.4
8	10	5.7	66.5	22	3	1.7	97.2
9	7	4.0	70.4	23	2	1.1	98.3
10	6	3.4	73.9	24	1	.6	98.9
11	6	3.4	77.3	25	0	.0	98.9
12	7	4.0	81.2	26	1	.6	99.4
13	5	2.8	84.1	27	1	.6	100.0

reflected the negative relationship. The profoundly and severely retarded children were generally visited less frequently than the moderately and mildly retarded children. For the profound group the mean number of visits was 3.9, for the severe group 6.6, and for the moderate group 9.4.

TABLE IV

## NUMBER OF VISITS, BY DEGREE OF RETARDATION

Number of Visits	Degree of Retardation									
	Profound		Severe		Moderate		Mild		Total	
	N	%	N	%	N	%	N	%	N	%
0	14	32.5	9	19.6	0	0	1	2.5	24	13.6
1-5	19	41.9	17	37.0	14	29.8	8	20.0	57	32.4
6-11	6	14.0	12	26.1	17	36.2	19	47.5	54	30.7
12-up	4	11.6	8	17.4	16	34.0	12	30.0	41	23.3
Total	43	100.0	46	100.1	47	100.0	40	100.0	176	100.0
Mean*	3.9		6.6		9.4		9.0		7.3	
Median	2.1		4.1		8.4		8.5		5.4	
Range	0-23		0-27		1-24		0-26		0-27	

\*Mean computed on ungrouped data.

However, the mean of the mildly retarded group, 9.0, was slightly lower than that of the moderate group. Because of the skewness of the data the median values are more meaningful measures of these group differences. The median number of visits for the profound, severe, moderate, and mild groups were 2.1, 4.1, 8.4, and 8.5, respectively.

Further evidence of this relationship lies in the fact that there was a positive relationship between number



of children with no visits and degree of retardation. About a third (32.5 percent) of the profoundly retarded group received no visits, as against one-fifth (19.6 percent) of the severely retarded group. By contrast, all moderately retarded children in the sample received visits and all but one child (2.5 percent) of the mild group received visits during the period in question.

In terms of actual number of visits, Table IV indicates a similarly consistent pattern. For example, whereas 41.9 percent of the profound group had five or fewer visits, 20.0 percent of the mild category had as few as five. At the other extreme, only 11.6 percent of the former had as many as twelve visits whereas 30.0 percent of the latter had at least twelve.

Sight should not be lost of the fact that an appreciable number of both the profound and severe types of retardates did have "frequent" visits. Clearly many of them were visited more often than some of the moderately and mildly retarded. This is evident also in the fact that the ranges of number of visits were remarkably similar for all four subgroups.

It is not surprising to find a negative relationship between visitation and the classification of retardation. The birth of a retarded child into a family is a traumatic occurrence which is probably accentuated in cases of profound and severe retardation. Due to their degree of handicap,

these children have little chance of approximating normal, mutually rewarding social interaction with the parents. Moderately and mildly retarded children are better able to act out appropriate behavior in the family. This may be reflected in visitation patterns also. Profoundly and severely retarded children may show less adaptive behavior and be more difficult to handle when compared with moderately and mildly retarded children. Hence, parents of the former likely find these visits less pleasant, less inspiring, and more demoralizing than parents of the latter.

#### Sex

Females were visited more often than males. The mean number of visits for the girls was 7.7, as compared to a mean of 7.0 visits for the male group. This same relationship is shown in medians of 6.3 and 4.3 visits for the two groups, respectively.

As Table V indicates, fewer females (7.5 percent) received no visits than was the case for the males (18.8 percent). Thirty-five percent of the females received from one to five visits, 33.8 percent received between six and eleven visits, and 23.8 percent received twelve or more visits. Comparable figures for the males were 30.2, 28.1, and 22.9.

Again, it should be noted that there was much overlapping between the two groups. Indeed, the range of number of visits for the boys was 0-27 as against 0-22 for the girls. Although it is not shown in Table IV, the percentage of

children visited twenty or more times was 8.3 for the males and only 3.8 for the females.

TABLE V  
NUMBER OF VISITS, BY SEX

Number of Visits	Sex				Total	
	Male		Female		N	%
	N	%	N	%		
0	18	18.8	6	7.5	24	13.6
1-5	29	30.2	28	35.0	57	32.4
6-11	27	28.1	27	33.8	54	30.7
12-up	22	22.9	19	23.8	41	23.3
Total	96	100.1	80	100.1	176	100.0
Mean*	7.0		7.7		7.3	
Median	4.3		6.3		5.4	
Range	0-27		0-22		0-27	

\*Mean computed on ungrouped data.

The observed difference in visitation may be partially explained in terms of variation in the parental role in relation to sex of the child. Parents may, for example, feel more protective towards females, and manifest this feeling by visiting them more than males. Possibly the parents may

view the male more instrumentally and the female more expressively. That is, the worth of the boy may be measured in terms of his educational and occupational limitations, whereas the female may be viewed more in terms of ability to give and receive affection.<sup>1</sup> If such is the case, then the male may represent a greater failure to the parents which might make visits more a painful experience.

#### Present Age

Analysis of Table VI shows a moderate positive relationship between number of visits and present age, the gamma correlation value being .14. This relationship was curvilinear in nature, however. The median number of visits for those children eleven years of age and under was 4.5, whereas the number for the twelve to seventeen and the eighteen to twenty-two groups increased markedly to 6.8 and 6.9, respectively. The median for the twenty-three to thirty-six years group, 4.6, was substantially lower than the two middle groups.

A negative relationship existed between present age and number of children receiving no visits. The largest percentage, 17.1, occurred in the eleven-and-under bracket. The percentages decreased through the other age categories to 15.7, 13.5, and 6.2, respectively.

The pattern which emerged, then, was one of fewer visits in the two extreme categories, with more visits in the middle

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<sup>1</sup>For a discussion of instrumental and expressive roles see Talcott Parsons and Robert F. Bales, Family, Socialization, and Interaction Process, (Glencoe, 1955), pp. 45-48.

categories. Over one-third (36.6 percent) of the youngest and almost half (46.9 percent) of the oldest age groups had less than five visits. In both of these groups only about one-seventh (14.6 and 15.6 percent) of the children had twelve or more visits. By comparison, in the second and third age groups 25.5 and 26.9 percent had less than five visits, and for the children with twelve or more visits the percentages were 29.4 and 28.8, respectively.

TABLE VI  
NUMBER OF VISITS, BY PRESENT AGE

Number of Visits	Present Age								Total	
	11 and Below		12-17		18-22		23-36		N	%
	N	%	N	%	N	%	N	%		
0	7	17.1	8	15.7	7	13.5	2	6.2	24	13.6
1-5	15	36.6	13	25.5	14	26.9	15	46.9	57	32.4
6-11	13	31.7	15	29.4	16	30.8	10	31.2	54	30.7
12-up	6	14.6	15	29.4	15	28.8	5	15.6	41	23.3
Total	41	100.0	51	100.0	52	100.0	32	99.9	176	100.0
Median	4.5		6.8		6.9		4.6		5.4	

A somewhat similar pattern for present age was described by Downey. He found that "The older the retarded child, the

greater the interest."<sup>2</sup> This pattern can be explained in terms of the life cycle of the family which, according to Downey, is "intrinsically" related to visitation.<sup>3</sup> Younger children are generally placed by younger families. Although there may be interest in the child, other concerns and responsibilities may take priority over frequent visitation. This is a period in which there are many demands upon the family. It is, in a sense, engaged in an effort to assert its financial independence, establish status in the community, and rear other children, and at the same time provide emotional and affectional support for all of its members. Visiting the retarded child may take a position of secondary importance to some of these demands.

The family in the middle stages (with a retarded child between the ages of twelve and twenty-two) may be better able to show interest in the child, and as a result the child may receive a greater number of visits.

As indicated earlier, there was a decrease in visits for retardates over the age of twenty-three (even though nearly all received at least one visit). In some cases this decline may be attributed to mobility of the parents, inasmuch as they may have moved some distance from the institution after first placement. In other cases decline of visits may be a function of adjustment of the retarded child to institutional life after a several-year period. As a consequence, the parents may feel less need to visit him.

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<sup>2</sup>Downey, op. cit., p. 190.    <sup>3</sup>Ibid, p. 191.

## Length of Institutionalization

Viewed overall, there was no relationship between number of visits and length of institutionalization (gamma .01). However, despite certain inconsistencies some meaningful patterns emerged, as indicated in Table VII.

TABLE VII

## NUMBER OF VISIT, BY LENGTH OF INSTITUTIONALIZATION

Number of Visits	Years Institutionalized								Total	
	1		2-3		4-5		6+		N	%
	N	%	N	%	N	%	N	%		
0	0	0.0	6	25.0	9	12.3	9	13.4	24	13.6
1-5	3	25.0	10	41.7	22	30.1	22	32.8	57	32.4
6-11	6	50.0	7	29.2	16	21.9	25	37.3	54	30.7
12-up	3	25.0	1	4.2	26	35.6	11	16.4	41	23.3
Total	12	100.0	24	100.1	73	99.9	67	99.9	176	100.0
Median	8.0		3.0		7.0		5.6		5.4	

The median number of visits for children institutionalized one year (8.0) was higher than the two-to-three-year category (3.0). Also, children in the four-to-five-year group had a higher median (7.0) than those children institutionalized six years and over (5.6).

The smallest number of children who received no visits occurred in the one-year category (0 percent). The largest (25.0 percent) occurred in the two-to-three-year category. For those children institutionalized four to five years and six years and over the percentages were 12.3 and 13.4 percent, respectively.

As indicated by median visits and actual number of visits, the pattern which emerged was one of relatively high interest for those children in the first year of residence, and a decline in visitation for those in the two-to-three-year category. This is further evidenced by the fact that half (50.0 percent) of the children in the former category received between six and eleven visits, whereas a preponderance of the latter category (41.7 percent) had only one to five visits. Residents institutionalized for four or five years had a relatively high proportion (35.6 percent) who received twelve or more visits. However, with 37.3 percent receiving between six and eleven visits, children institutionalized six or more years had relatively fewer visits than the previous category.

These results do not coincide with the findings of Sommer, and of Groth, Gordon, and Dietrich, noted in Chapter I. These studies of mental patients revealed a direct negative relationship between number of visits and length of institutionalization. The differences between the results may be attributed to two factors. One, as indicated, the prior



studies were conducted on mentally ill populations. According to Downey, parents may perceive mental illness as a temporary situation, whereas mental retardation may be more often viewed as permanent.<sup>4</sup> Thus, if the mentally ill person is institutionalized for a number of years with little or no improvement, relatives might experience disillusionment, the result of which could be less frequent visits. This may not be the case with the retarded child, at least during the intermediate years. Second, the populations in these studies were composed of adults and had a wider range in age than the subjects of the present study.<sup>5</sup> There may be characteristic differences in the visitation of predominately younger individuals as compared to visitation of adult residents.

The result of this study more closely resemble Downey's findings in this regard. He found that for "the first three years of institutionalization interest is low and a sharp increase occurs for the three-to-six-year period."<sup>6</sup> Downey's generalizations, however, concerned two categories, one to three and three to six years, whereas this study used four categories, with first year of institutionalization treated separately from the second and third years. Therefore, the interest found in the first year would not be reflected in Downey's broader view. Also, Downey generalized only through the sixth year of institutionalization, whereas this study included longer periods of residence. Differences in results

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<sup>4</sup>Downey, op. cit., p. 190.   <sup>5</sup>Ibid.   <sup>6</sup>Ibid.

may be largely a function of decreased visits after the sixth year.

#### Interrelationships between Independent Variables

Of the four independent variables, degree of retardation, sex, and present age demonstrated meaningful relationships with visitation, with degree of retardation showing the strongest relationship. As a further analysis of the relative strength of these variables, first sex and then age were combined with degree of retardation and cross-tabulated with number of visits. The results are discussed below.

#### Degree of Retardation and Sex

Females received more visits than males in each retarded group. Among the profound children, the median number of visits for males was 1.2 as compared to 2.7 for females. Similarly, for the severe, moderate, and mild groups the respective medians were 3.2 and 4.7, 7.2 and 8.6 and 8.0 and 9.2 (see Table VIII).

Also, for both sexes there was a positive relationship between number of children with no visits and degree of retardation. But, again, in the profound and severe categories fewer females than males had no visits (only one child, a male, in the moderate and mild groups had no visits). It should be noted, however, that moderate and mild boys included fewer instances of no visits than was the case among the profound and severe girls.

TABLE VIII

NUMBER OF VISITS, BY DEGREE OF RETARDATION AND SEX

Number of Visits	Degree of Retardation							
	Profound				Severe			
	Male		Female		Male		Female	
	N	%	N	%	N	%	N	%
0	10	41.7	4	21.0	7	30.4	2	8.7
1-5	8	33.3	10	52.6	7	30.4	10	43.5
6-11	3	12.5	3	15.8	5	21.7	7	30.4
12-up	3	12.5	2	10.5	4	17.4	4	17.4
Total	24	100.0	10	99.9	23	99.9	23	100.0
Median	1.2		2.7		3.2		4.7	

TABLE VIII -- Continued

Degree of Retardation									
Moderate				Mild				Total	
Male		Female		Male		Female			
N	%	N	%	N	%	N	%	N	%
0	0.0	0	0.0	1	4.2	0	0.0	24	13.6
9	36.0	5	22.7	5	20.8	3	18.8	57	32.4
7	28.0	10	45.5	12	50.0	7	43.8	54	30.7
9	36.0	7	31.8	6	25.0	6	37.5	51	23.3
25	100.0	22	100.0	24	100.0	16	100.1	176	100.0
7.2		8.6		8.0		9.2		5.4	

Analysis by sex of the children who were actually visited again shows the strong influence of the retardation variable. Irrespective of sex, the mild and moderate groups showed the largest number of visits. For males with twelve or more visits the percentages were 36.0 and 25.0. Females had corresponding percentages of 31.8 and 37.5. In contrast, for profound and severe children with twelve or more visits, the percentages were 12.5, 17.4, 10.5, and 17.4, respectively.

Although sex did not affect the negative relationship between degree of retardation and number of visits, sex differences with regard to visitation increased in direct relation to the degree of retardation. This relationship is revealed by a comparison of the relative differences between males and females in median number of visits for each degree of retardation. The largest difference between the sexes occurred in the profound group, in which females received over twice as many visits on the average as males. That is, the median number of visits for females, 2.7, was 125 percent greater than the median for males, 1.2 (see Table VIII).

Relative differences were conspicuously less for the other degree of retardation groups. For the severe group the difference was rather high, 46.9 percent. In comparison, the moderately and mildly retarded groups showed smaller differences of 19 percent and 15 percent, respectively.

It is evident, then, that sex differences in visitation are greater for the more retarded groups. This may, in part, be attributed to the point made earlier that females may be viewed expressively whereas males may be viewed instrumentally. In the moderate and mild classifications males and females may be perceived as relatively equal in their ability to act out their respective roles. Hence, there is a smaller relative difference in visits. However, in the severe and especially in the profound category the differences in abilities of the sexes to act out their roles may be accentuated. The female possibly is somewhat better able to enact her expressive role, whereas the male may fall comparatively short in his ability to accomplish instrumental goals. Again, as indicated earlier, the male may thus be viewed as a greater failure by the parents than the female. In any event, these findings suggest the sex differential in visitation is at least partly a function of severity of mental handicap.

#### Degree of Retardation and Present Age

As stated previously, a curvilinear relationship existed between number of visits and present age and a pronounced negative relationship existed between number of visits and degree of retardation. To determine how the curvilinear relationship was related to degree of retardation these variables were combined and analyzed in relation to number of visits. The results are summarized in Table IX.

TABLE IX

NUMBER AND PERCENT OF RESIDENTS WITH SIX OR MORE VISITS,  
BY PRESENT AGE AND DEGREE OF RETARDATION

Degree of Retardation	Present Age			
	11 and Below  (N=41)	12-17  (N=51)	18-22  (N=52)	23-36  (N=32)
Profound	30.8 (13)	10.0 (10)	33.3 (12)	25.0 (8)
Severe	46.2 (13)	36.4 (11)	50.0 (18)	25.0 (4)
Moderate	45.5 (11)	84.6 (13)	91.7 (12)	54.6 (14)
Mild	100.0 (4)	76.5 (17)	80.0 (10)	66.7 (9)

Table IX shows each age group broken down by number of children in the various retardation categories and percentages of the subcategories receiving "frequent" (six or more) visits. For illustration, of the forty-one children in the eleven and below category thirteen were profound, thirteen were severe, eleven were moderate, and four were mild retardates. Of these children 30.8 percent of the profound group received frequent visits. For the severe and moderate and mild groups the percentages were 46.2, 45.5, and 100.0, respectively.

As indicated by the above table, each age category showed a larger percentage of frequently visited children in the less pronounced classifications of retardation than in the more pronounced classifications. That is, there was a direct increase in the percentages with "frequent" visits, from the profound to the mild groups, for each age category with minor exceptions.

This may partially explain the curvilinear relationship between number of visits and present age. This is especially evident in the eleven-and-under category. Whereas the family life cycle discussed earlier may help to explain fewer visits for those children in this age group, the pattern may also be attributable in part to the presence of a proportionately larger number of severe and profound children (63.4 percent) as compared to moderate and mild types of children (36.6 percent) in this particular age group. At the other age extreme, in the twenty-three to thirty-six year group there were more moderate and mild (62.5 percent) than profound and severe children (37.5 percent). Therefore, degree of retardation was probably not as important a factor in low visitation in this young adult group as was the case with the eleven and under group. Infrequent visitation for this group may be due in part, as suggested earlier, to geographic mobility of the parents and relative adjustment of the resident to institutional life.



## CHAPTER IV

### FINDINGS II: LENGTH OF VISITS

In this chapter length of visit will be considered from the standpoint of number of visits, degree of retardation, sex, present age, and length of institutionalization.

Four categories were constructed to delineate various lengths of visitation, which may also be regarded as different types of visits. As indicated in Chapter II, one-day visits refer to those in which the parents spend all or part of a day with their child, either in his dormitory, on campus, or off campus. The other categories employed in this research are two-to-three, four-to-eight, and nine-or-more-day visits. All of these imply home visits, and are designated by the institution as "leaves" or, if more than eight days, as "furloughs."

In comparing lengths with number of visits it was found that the number of children decreased in proportion to the increase in length of visitation. These data are summarized in Table X.

Whereas only about a third (31.8 percent) of the children received no one-day visits, over one-half received no two-to-three-day visits (50.6 percent) and four-to-eight-day

(53.4 percent) leaves. Characteristically, even a larger number of children (55.1 percent) received no furloughs.

TABLE X

NUMBER AND PERCENT OF RESIDENTS WHO RECEIVED  
VISITS OF VARIOUS LENGTHS,  
BY NUMBER OF VISITS

Number of Visits	Length of Visit							
	1 day		2-3 days		4-8 days		9+	
	N	%	N	%	N	%	N	%
0	56	31.8	89	50.6	94	53.4	97	55.1
1-5	94	53.4	58	33.0	77	43.8	76	43.2
6-11	20	11.4	22	12.5	4	2.3	3	1.7
12-up	6	3.4	7	4.0	1	.6	0	0.0
Total	176	100.0	176	100.1	176	100.1	176	100.0

Further evidence of this pattern is seen in analysis of the number of children visited several times in each length of visitation. In the one-day category about one child in seven (14.8 percent) received in excess of six visits, whereas less than one child in fifty (1.7 percent) received six or more furloughs of nine days or longer.

#### Degree of Retardation

As one might expect, length of visits was strongly influenced by the retarded status of the child. Comparatively

more mildly retarded residents received visits in all lengths of visitation, but especially those of longer duration. Conversely, with only one minor exception, fewer profoundly retarded children received visits in all categories, with differences being more appreciable for visits of longer than one day. These data are summarized in Table XI.

TABLE XI

NUMBER AND PERCENT OF RESIDENTS WHO RECEIVED VISITS OF VARIOUS LENGTHS, BY DEGREE OF RETARDATION

Length of Visit	Degree of Retardation							
	Profound (N=43)		Severe (N=46)		Moderate (N=47)		Mild (N=40)	
	N	%	N	%	N	%	N	%
1 day	26	60.5	27	58.7	34	72.4	33	82.5
2-3	6	14.0	20	43.5	32	68.1	29	72.5
4-8	8	18.6	21	45.6	29	61.7	24	60.0
9+	5	11.6	12	26.1	33	70.2	29	72.5

Whereas about three out of five (60.5 percent) of the profound group received one-day visits, only about one in nine (11.6 percent) received a furlough. This contrasts with the mild category, in which four out of five (82.5 percent) had one-day visits and almost three out of four (72.5 percent) received furloughs.

Although the number of children visited for longer periods of time is substantially larger for the moderate and mild groups, it should be noted that some of the profoundly and severely retarded did receive extended leaves and furloughs, whereas some of the moderately and mildly retarded children did not.

Profoundly and severely retarded children generally lack essential self-help and communicative skills which may be necessary to make a home visit convenient and mutually rewarding. Home visits by moderately and mildly retarded children are possibly less problematic and more rewarding and pleasant for both the parents and the child. Parents who may be willing to visit a profound or severely retarded child at the institution may be less willing or able to cope with the problems engendered in an extended home visit.

#### Sex

Sex differences were not large, but as was the case with number of visits, generally a larger proportion of females than males received visits of the various types. (See Table XIII).

Considerably more females than males had one-day visits (76.0 percent as against 61.4 percent), and they also had more visits of nine or more days (50.0 percent compared to 40.6 percent) than males. However, there were only minor differences in the two-to-three and four-to-eight-day categories. The girls' percentages were 47.5 and 47.5, while the

boys had 51.0 and 45.8 percent for the two categories, respectively. Thus a slightly larger proportion of males received two-to-three day leaves, but the proportion of females was higher in all other categories of visits.

TABLE XII

NUMBER AND PERCENT OF RESIDENTS WHO RECEIVED VISITS OF VARIOUS LENGTHS, BY SEX

Length of Visit	Sex			
	Male (N=96)		Female (N=80)	
	N	%	N	%
1 day	59	61.4	61	76.0
2-3	49	51.0	38	47.5
4-8	44	45.8	38	47.5
9+	39	40.6	40	50.0

This relationship may too be partially attributable to males being more problematic for the parents than females in the sense that they may be physically stronger and more difficult to cope with. They may, also, represent a greater sense of failure to the parents (see Chapter III). Thus, parents of a male retarded child may more often prefer a two-to-three day home visit, whereas the parents of a female retarded child more frequently may prefer a relatively longer visit.

## Present Age

As shown in Table XIII, the main difference in visitation patterns by present age was between the eleven-and-under category and the remaining "older" categories. In the eleven-and-under category thirty-nine percent of the children were visited in the two-to-three-day category, 26.8 percent in the four-to-eight-day category, and 29.3 percent received furloughs. This contrasts with the findings that over fifty percent of the children aged twelve to seventeen went home on leave or furlough, and that residents over age eighteen also received more extended visits than did the young children.

TABLE XIII

NUMBER AND PERCENT OF RESIDENTS WHO RECEIVED VISITS OF VARIOUS LENGTHS, BY PRESENT AGE

Length of Visit	Present Age							
	11 & Below (N=41)		12-17 (N=51)		18-22 (N=52)		23-36 (N=32)	
	N	%	N	%	N	%	N	%
1 day	30	73.2	33	64.7	32	61.5	25	78.1
2-3	16	39.0	28	54.9	28	53.8	14	43.8
4-8	11	26.8	27	52.9	27	51.9	17	53.1
9+	12	29.3	28	54.9	25	48.1	14	43.8

As is also evident in Table XIII and the discussion above, a curvilinear relationship existed for visits over one day that is somewhat comparable to the findings described in Chapter III. The youngest children showed the lowest percentage receiving leaves and furloughs. By comparison, a higher percentage of the young adults (age 23-36) received such visits, but except for the four to eight day type of leave these percentages were lower than those for the two "middle" age groups.

The argument advanced in Chapter III concerning the family life cycle may also help to explain the existence of this visitation pattern. A relatively large percentage of younger children may have one-day visits because the family is too involved with other immediate concerns to allow the time necessary for extended visitation. Families of children between the ages of twelve and thirty-six may have resolved many of the problems that previously faced them and be better able to care for their child for longer periods of time. Families with retarded children over the age of twenty-three, however, may find that the child had to a great extent "adjusted" to the institution and thus see relatively less need for extended home visitation.

#### Length of Institutionalization

No consistent linear relationship was found between years institutionalized and length of visit, but patterns

emerged similar to those described in Chapter III concerning number of visits. The highest percentages of children visited for the various lengths of time generally were those institutionalized for one year (see Table XIV). The only exception to this pattern occurred for visits of nine days or more where those institutionalized six or more years had a slightly higher percentage of children visited than those in residence only one year (43.3 percent as compared to 41.7

TABLE XIV

NUMBER AND PERCENT OF RESIDENTS WHO RECEIVED  
VISITS OF VARIOUS LENGTHS, BY LENGTH  
OF INSTITUTIONALIZATION

Length of Visit	Years Institutionalized							
	1 (N=12)		2-3 (N=24)		4-5 (N=73)		6+ (N=67)	
	N	%	N	%	N	%	N	%
1 day	9	75.0	16	66.7	47	64.4	48	71.6
2-3	9	75.0	8	33.3	38	52.0	32	47.8
4-8	6	50.0	9	37.5	39	53.4	28	41.8
9+	5	41.7	8	33.3	27	37.0	29	43.3

percent). The lowest percentage of children visited in each category occurred among those institutionalized two to three years. Children institutionalized four to five years and six



years or more had a relatively higher percentage who received extended visits. Except in the nine-day-or-over category mentioned above, the former had relatively higher percentages of persons visited than the latter.

Although no evidence was gathered to support an explanation, it is suggested that fluctuations in visitation may be viewed as transitional stages in family adjustment to the placement of the retarded child in an institution. The comparatively high percentage of children visited during the first year of institutionalization may be a function of relatively low adjustment. Ordinarily the child has spent at least six years in the family, during which time there was some modification of behavior to care for him. During the pre-institutionalization period, strong primary relations between the family and the child have presumably emerged. The initial period of institutionalization, then, may disrupt the established accommodative pattern as well as the primary relationship between the parents and the child. Additionally, parents may experience a sense of guilt about placing the child, especially if this placement is viewed as an evasion of responsibility. Frequent visitation may serve to ameliorate these disruptions and assuage the feelings of guilt.

After the initial period--during the second and third year--the percentage of children visited was at its lowest point. Several factors may explain this. The crisis involved

in placing the child, coupled with relatively high visitation during the first year, may have so emotionally drained the family that previous visitation patterns cannot be maintained. Also, the family may have developed behavioral patterns no longer consistent with the presence of a retarded child. Home visits, especially, would then be more problematic to the family than previously. Finally, the family may have harbored unrealistic expectations of the institution's ability to develop the child. When little development is observed after the first year the family may realize that there are lasting limitations on the child.

However, as we have seen, beginning with the fourth year, visitation patterns assume a somewhat intermediary position between those patterns seen in the first year and the second and third years. This may represent an accommodation of the parents and of the child to institutionalization. Parents, by the fourth year, may effectively rationalize previous reservations about institutionalizing the child, especially guilt feelings that might have arisen from placing him. Parents may also have developed more realistic expectations about what the child can and cannot accomplish through institutional training. The child, on the other hand, may have adjusted favorably to the institutional setting, and may also have learned various skills that would tend to facilitate home visits.

## CHAPTER V

### SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

#### Summary

This study was concerned with a description of visiting patterns by parents of ambulatory mentally retarded children at Denton State School, who had been institutionalized no later than January 1, 1968. The number and types of parental visitation were analyzed in light of four characteristics of the child: his degree of retardation, sex, present age, and length of institutionalization.

The sampling procedure entailed aspects of both purposive and probability sampling. Sixteen dormitories were selected on the basis of the variables of interest. Thus, four dormitories were selected for each classification of retardation, which included a relatively "older" and "younger" resident dormitory for each sex. After deleting twenty-one residents for reasons of transfer, discharge, and institutionalization for less than one year, the remaining residents of the two dormitories for each sex were combined into a list and ranked according to age. A systematic sampling of every third case was drawn from these lists. The sample size originally numbered 180 residents. Four were later dropped because of inadequate information concerning visitation.

In analyzing relationships between variables descriptive statistics such as frequencies, percentages, proportions, means, and medians, were employed. As a measure of degree of association Goodman and Kruskal's gamma was used where appropriate.

### Conclusions

The most significant findings of this thesis may be summarized as follows:

1. A negative relationship existed between number of visits and degree of retardation and a positive relationship existed between number of children with no visits and degree of retardation.
2. Although the range of visitation was zero to twenty-seven, the greater proportion of residents were visited fewer than six times.
3. Females were visited more than males and fewer females than males received no visits.
4. A moderate positive relationship existed between number of children who received no visits and present age. The positive relationship was curvilinear with fewer visits in the "young" and "old" age categories and relatively more visits in the two middle categories.
5. Although no overall relationship existed between number of visits and length of institutionalization, relatively high visitation was paid to those children institutionalized one year and relatively low visitation to those

in the second and third years. Those institutionalized longer than four years received an intermediate number of visits.

6. Comparison of number of visits with degree of retardation and sex showed that irrespective of sex mild and moderate children were visited more than profound and severe children, but the relative differences in percentages were greater among the latter than former.

7. When number of visits was compared with degree of retardation and present age, mild and moderate children in each age group were visited more than profound and severe children.

8. The percentage of children who received several visits decreased relative to increased length of visit.

9. More mildly retarded children received visits of all types than the more severely handicapped children. These differences were more apparent for the longer visit.

10. More females were visited than males, especially for home visits of four days or more.

11. Although a curvilinear pattern existed between length of visit and present age, the primary differences were between relatively low visitation in the eleven and under category and higher visitation in the other categories.

12. The percentage of children visited for each type of visit was highest in the first year of institutionalization

and lowest in the second and third years. Although not as high as the first year, more children were visited after the fourth year than in the second and third years. However, after six years the percentages were lower than those for the fourth or fifth years.

The main purpose of the study was to contribute to existing knowledge surrounding the retarded child-family-institution social system by analyzing parental and to a lesser extent family interest, as evidenced by number and length of visits, relative to selected characteristics of the child.

The findings set forth above suggest marked differences in parental interest (visitation). Although direct causal relationships cannot be inferred, the number and length of visits received are strongly related to certain characteristics of the child. Degree of retardation may be considered the most decisive factor among those studied.

The notion that visitation may at least temporarily increase the child's morale and well-being has been discussed previously and is accepted with some reservations in this study. However, many children receive neither an appreciable number of visits nor for an extended period of time, and such benefits as visitation may bring obviously are not equitably distributed among the residents.

The interpretations of the findings of this study have been advanced tentatively and require further substantiation. But, if these interpretations contain any validity, certain

procedures already in operation in the institutional setting might be utilized to increase visitation for these children. Present efforts at habilitation of the residents is one example. No amount of training can develop profoundly and severely retarded children to the capabilities of the moderately and mildly retarded, but with increased success in programs designed to develop self-help and communicative skills in these more retarded groups one result might be an increase in the number and lengths of visitation. Also, parents already receive some counselling when placing the child in the institution, but the sex differences in visitation suggest that parents of male children may require more extended counselling or counselling of a different nature than parents of female children, especially in the profound and severe categories of retardation. Finally, it should be noted that institutions maintain periodic correspondence with parents. Possibly decline in interest could be partially abated by increased correspondence concerning the child's progress and offering encouragement for parents to visit during periods of low visitation.

#### Recommendations

Several limitations are imposed on this research by its exploratory nature. Two can be mentioned with reference to methodology and two with respect to scope.

As indicated in Chapter II, sampling by dormitories did not produce classifications of degrees of retardation that

were completely homogeneous. Since the results of this study indicate that the retardation variable is extremely important in parental visitation patterns, subsequent research should endeavor to categorize residents more accurately. Furthermore, if degree of retardation is viewed as a measure of adaptive behavior, then attention should be paid to different levels of proficiency within these classifications.

Second, although the number of visits for each length of visit was analyzed in a general sense, the percentages used in the analysis referred to those children who received at least one visit for the category under consideration. Further research might analyze length of visit in relation to the number of each type of visit rather than only to the number of children receiving the visits.

A third limitation of this study is that it focused primarily on parental visitation. Since differentiation between parental visits and visits by other people by means of institutional records was quite problematic, the result was less clearly defined categories than desired. Subsequent studies should insure more adequate methods of ascertaining who visited. In the same vein, questions may be raised about visitation patterns of persons other than parents. Do other relatives or friends visit the retarded child, and if so, how frequently do they visit? Also, are these visits paid only at the institution, or are extended visits also involved?



Finally, this study was sharply limited in the number of variables studied. The focus was on four characteristics of the child. Obviously there are other important characteristics that need to be analyzed, such as the child's race and ethnicity, his age at first placement, and his family structure. Even then visitation patterns cannot be fully understood when divorced from social and psychological characteristics of the parents themselves. Research on both parental and child characteristics is needed to analyze visitation patterns effectively.

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