THE UNIVERSITY OF MANITOBA

SCHOOL OF SOCIAL WORK

A STUDY OF THE RELATIONSHIP BETWEEN MOTHERS' ACCEPTANCE AND THE LEVEL OF SOCIAL MATURITY OF TRAINABLE MENTALLY RETARDED CHILDREN

Being a report of a study submitted in partial fulfillment of the requirements for the Degree of Master of Social Work

by

Arlene Fleisher

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ABSTRACT

Within the broad area of study, mental retardation, this particular study was concerned with factors, other than intelligence that affected the level of social maturity of trainable mentally retarded children. The mother's acceptance of the child was selected as the main variable affecting social maturity and as the specific focus of the study. The study attempted to determine whether there was a direct relationship between a mother's acceptance of her trainable mentally retarded child and the child's level of social maturity. Two possible factors underlying acceptance, the sex of the child and the mother's level of academic education were studied and, further, related to the child's social maturity. It was hypothesized that the girls were more accepted than the boys and that the mother's acceptance was directly related to her level of academic education.

Information was obtained from a randomly-selected sample of 42 mothers, each having a trainable mentally retarded child between the ages of 6 and 12 years inclusive who was enrolled at the Kinsmen School for Retarded Children. Personal interviews with the mothers were used to administer two instruments: The Vineland Social Maturity Scale, to determine the child's level of social maturity and the Rating Scale, to determine the mother's level of acceptance.

The findings indicated that a direct relationship between

maternal acceptance and social maturity existed; the more accepting mothers had children who were more socially mature than the children of the less accepting mothers. However, the coefficient of correlation was not statistically significant.

With regard to the first variable underlying acceptance, the sex of the child, it was found that the mothers were more accepting of the girls than they were of the boys. However, when the sex of the child was related directly to social maturity, it was found that the boys were more socially mature than the girls although they were less accepted than the girls.

With regard to the second variable underlying acceptance, the mother's level of academic education, the findings did not indicate a direct relationship between these variables; mothers at both extremes of educational achievement were the least accepting of their children, with no distinctive acceptance-rejection pattern in the middle range of educational achievement. In relating the mothers' level of academic education to the child's level of social maturity, the findings were inconclusive. It was noted that the greatest differences in social quotient scores occurred between the two highest levels of academic education, Grade 12 having the highest social quotient scores, and "Above Grade 12" having the lowest social quotient scores in the sample. Mothers in both these classes were similarly rejecting of their children, which indicated a contradiction of the general finding

that, with regard to the mothers' level of academic education, the lowest levels of maternal acceptance and the lowest levels of social maturity corresponded.

Because of the low correlation between maternal acceptance and the child's level of social maturity, and the inconclusive nature of other findings, this study has value of a speculative nature. Over-all findings indicated the relevance of variables other than those studied in determining the relationship between acceptance and social maturity and the need for further research in this area.

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CHAPTER I

INTRODUCTION

There is a growing awareness of mental retardation as a 20th Century problem, requiring 20th Century methods of prevention, treatment and amelioration. It is a 20th Century problem in that modern advances in medicine have increased the life span, and therefore, the size of the retarded population, at the same time that automation, urbanization and other social forces have placed additional stresses on the mutual adjustment of the retarded and society.

Mental retardation is a major national health, economic and social problem in terms of its incidence and impact on the individual, family and community life and society in general. "The health of a society depends upon the emotional satisfaction and social usefulness of its members."[1] Mental retardation satisfies Bernard's criteria of a social problem: Humanitarian, utilitarian and dysfunctionality referring to human suffering, economic costs and loss of human resources.[2] According to Goldberg's survey, the estimated rate of prevalence of mental retardation in the United States is 3% of the general population, one tenth of

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[1] M.J. Begab, "Mental Retardation as a Social Problem," Mental Retardation and Social Work Education, ed. A.H. Katz (Detroit: Wayne University Press, 1961), p. 6.

[2] J. Bernard, Social Problems at Mid-Century (N.Y.: Holt, Rinehart & Windston, 1957), pp. 104 - 107.

of whom are severly retarded.[3] In Canada, there are 400,000 mentally retarded children.[4] The mentally retarded are found in every strata of society and in the clientele of every type of social agency. Two-thirds of retarded children live in the community with their parents. Therefore, there is a need for a continuism of community services, including casework help to parents.

The purpose of this study is to provide a better understanding of mental retardation; in particular, the relationship between maternal acceptance of the retarded child and the child's level of social maturity and further, variables which may underly maternal acceptance. The importance of this relationship is indicated in the definition of mental retardation as a symptom of biological, psychological and social malfunctioning. Although intellectual capacity may be biologically fixed, psychological and social malfunctioning are amenable to change. Social work is committed to the belief in the growth potential of all individuals, including the retarded. It is social work's function to alleviate additional handicapping elements in the environment, including unfavorable family conditions and attitudes which may

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[3] H.M. Stoddard, "The Relation of Parental Attitudes and Achievements of Severely Mentally Retarded Children," American Journal of mental Deficiency, LXIII, (1958-1959), p 576.

[4] Questions and Answers, Canadian Association for Retarded Children, p. 20.

contribute to impaired or inadequate social functioning. The full utilization of existing capacities in a favorable environment bring the retarded as close as possible to the main stream of independence in leading useful, happy lives. Knowledge of the relationship between maternal acceptance of the retarded child and his level of social maturity supplies a basis for effective social work intervention in helping families understand and accept their child and their feelings about him. The application of this knowledge has ramifications in preventing the development of secondary deviations, such as emotional disturbance, which would compound retardation, producing a double handicap.

This study was set in Metropolitan Winnipeg, the capital city of Manitoba, a Western Canadian city with population of approximately 500,000 people. It covered the period from September, 1966 to April, 1967, with interviewing conducted in January, 1967. It was conducted by a group of fourteen students enrolled in the Masters Program at the School of Social Work, University of Manitoba. It was one part of a total research project involving four groups and four related areas of concern within the broader area of mental retardation and within the theoretical context of variables affecting social maturity.

The focus of this particular study was the relationship between maternal acceptance of the mentally retarded child and his level of social maturity. The relationships between sex of

the child and mother's level of academic education, both with regard to mother's acceptance of the child were studied. The population studied consisted of a randomly-selected sample of 42 mothers of trainable mentally retarded children. The children were between the ages of six to twelve years inclusive, were classified as severely retarded and attended the Kinsmen School for Retarded Children. The family units from which the children came consisted of two natural parents, with only one retarded child.

The study was limited in its scope by the following factors which might have influenced the family's realistic acceptance of the child. Only the mother was interviewed, as it was felt that she was the more important parent in that she played the major role in coping with the child and would therefore be able to respond more accurately to the items on the schedule. The attitude of the father, possible disharmony between the parents' attitudes, emotional and marital stability of the parents and the ages of the parents were not taken into account. Nor were the attitudes of siblings, the child's ordinal position in the family and family composition considered. The study did not include variables such as socio-economic class, education and occupation of the father, religion, ethnicity, parents' expectations, peer association, opportunity for socializing experiences in the community, the community's attitude toward the retarded child, and children with gross physical handicaps, all of which

might have contributed to parental attitudes and child-rearing practices. The extent and effect of previous professional contact by the parents was not considered to influence the findings. The applicability of the findings may have been further limited by the fact that the study referred to an urban population in an urban setting with local characteristics which may not be found in other urban or rural settings. Since social competence is relative to the demands of the personal and impersonal environment, the difference between rural and urban settings may be significant. The small size of the sample somewhat limited generalization and the time span, that is, the assessment of the child at one particular point in time, must be considered in interpreting the data.

From observation and theoretical knowledge of individual differences, it was reasoned that mentally retarded children within similar chronological and mental age range, i.e. I.Q., function at different levels of social maturity, those with higher level of social maturity functioning more adequately in their environment than those with lower levels of social maturity. What variables, other than intelligence, then, contribute to this difference? A child's social maturity depends not only on intellectual ability, but on the development of a healthy personality. Recognizing that the same principles of human behaviour theory apply to the retarded and normal child, the parent-child relationship was seen

to be a crucial influence in the development of the child's healthy personality and therefore, social maturity. In the socializing process of a child's early years, his self-concept and motivation are derived largely from the reactions of "significant others," especially his mother, the first love object. A child reflects the emotional attitudes of his parents. The parent-child relationship is based on the parents' acceptance of the child. Acceptance is the principal key to mental health and social adjustment of all children, but especially for the retarded child, whose needs are greater and defenses against rejection, weaker. All children need nurturing and acceptance, the support and incentive to develop and grow, but because the retarded child faces greater risk of failure, his need for the security and support of acceptance is greater.

Basic attitudes of acceptance or rejection reflect on all aspects of child care. Acceptance creates a favorable emotional climate in the home which allows the child to utilize and develop his capacities for self-help, independence or social maturity. Acceptance is essential if the parents are to be effective in helping the child profit from training experiences. It is destructive for all children, and especially frustrating for the retarded child, to be pressured beyond their abilities or overprotected and denied the opportunity to develop to their fullest

capacities. Parents who cannot realistically accept their children and their limitations, tend to react to them in these maladaptive ways. "The more retarded the child, the more important his emotional adjustment in his general level of social functioning. The emotional adjustment of a retarded child, more than for a normal child, depends on the parents' acceptance of his condition and their security in their relationship with him."[5]

This thinking led to formulation of the major hypothesis of this study:

> In a group of trainable mentally retarded children between the ages of 6 and 12 years inclusive, who are enrolled in the Kinsmen School for Retarded Children, there is a direct relationship between the child's level of social maturity and the mother's acceptance of the child in the family.

In deriving the second hypothesis of the study, specific factors which affected maternal acceptance were sought. It stated:

> There are variations in the level of the mothers' acceptance of their trainable mentally retarded children which are related to the sex of the child

[5]Canadian Association for Retarded Children: Third Conference on Mental Retardation, "Purpose and Method in Home Care," (1960), p. 30.

and the mother's level of academic education.

The first sub-hypothesis stated that: "The mothers' acceptance of the trainable mentally retarded girls is greater than their acceptance of the trainable mentally retarded boys."

It was thought that different cultural expectations of males and females would lead to greater acceptance of females. In our culture, males are expected to be independent, ambitious and aggressive in their roles as providors and heads of families. Females are perceived as more passive and dependent in their traditional roles of homemakers. Because of intellectual and social disabilities of retardation, males are unable to achieve the cultural expectations to a greater extent than females, and, therefore, are perceived as less adequate than females and devalued more than females.[6]

The second sub-hypothesis states: "There is a direct relationship between the mother's acceptance of her trainable mentally retarded child and her level of academic education."

Literature on the subject indicates that there is some controversy concerning the relationship between educational achievement of parents and their acceptance of their retarded

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[6]V. Levine, "Sex-Role Identification and Parental Perceptions of Social Competency," American Journal of mental Deficiency, LXX, (May, 1966), p. 822.

child. There is some evidence that poorly educated parents are better able to accept and more successful in helping their mentally retarded child than well-educated parents. Well-educated parents have higher expectations of their children and tend to look upon the retarded child as a threat; consequently they may reject him. On the other hand, it would be expected that education and knowledge would lead to greater understanding and acceptance of a retarded child's condition and limitations by his parents. Enlightened parents would be more realistic in their expectations, more flexible in changing their attitudes and more aware of the importance of their roles in influencing the child's development. Some studies have found that parents' education seemed most significantly related to the retarded child's well being.[7] Thus, there are two disparate points of view on this issue.

For purposes of consistency and clarity, the following terms were defined:

"Trainable mental retardates" -- children who have been assessed through psychological testing as capable of training in the Kinsmen School for Retarded Children but are unable to benefit from participation in the Greater Winnipeg Public School System.

"Social Maturity" -- the attainment of optimum realization

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[7] M.A. Green and B. Cushna, "Mental Retardation and Social Class in an Out-patient Clinic Population," American Journal of mental Deficiency, LXX (July, 1965), p. 114.

in the areas of self-help, locomation, self-direction, occupation, socialization and communication as indicated by the score obtained through application of the Vineland Social Maturity Scale.

"Acceptance" -- the degree of discrepancy between a mother's rating of her retarded child and of the ideal child as obtained by the application of the Rating Scale used in this study.

"Level of academic education" -- the highest grade successfully completed.

Several assumptions underlay and were basic to this study. First, it was assumed that the psychosocial, growth-producing needs of the trainable mentally retarded child are the same as for children who are not retarded. With regard to method, it was assumed that the responses of the mothers to the Rating Scale were valid indications of the mothers' true feelings. It was assumed that the instruments of measurements in this study were valid determinants of social maturity and acceptance and further, that the Rating Scale and Vineland Social Maturity Scale were administered objectively and uniformly.

The method employed in this study consisted of an individual interview with a mother in which both scales, the Vineland Social Maturity Scale and the Rating Scale measuring acceptance were administered. This was a modification in which the Rating Scale was conducted in a group, several days after the Vineland Social Maturity Scale had been individually administered to the mothers.

It was felt that more individual attention and interpretation were required and that a personal interview would increase flexibility, thereby obtaining more accurate and broader responses from the mother. Individually arranged interviews would eliminate group pressure for completion of the Rating Scale and would reach a larger sample.

In the analysis of data, we wished to study the relationship between the variables and, therefore, the scores on the Vineland Social Maturity Scales and Rating Scales were correlated. The data was presented narratively, statistically, and in tabular form, including the classification of findings in the variables of child's sex and mothers' level of academic education.

Chapters III and IV shall elaborate on the method and analysis of the data; Chapter V shall state conclusions, interpretations and recommendations based on the findings of this study. The next Chapter presents a review of the literature related to parental attitudes and the social maturity of retarded children, which provides a background for this study.

CHAPTER II

BACKGROUND

A review of the literature on mental retardation indicates the overall reorientation in thinking about the retarded, from social liabilities to potentially useful members of society. This more positive and constructive attitude is reflected in the redefinition of the concept of mental retardation beyond the confines of an intelligence test score to include social evaluation. Tredgold and Doll stress "social incompetence" as the ultimate criterion of mental retardation. Doll further distinguishes between "feeblemindedness," an incurable condition characterized always by social incompetence and "Intellectual retardation" which implies potential social competence.[1] The American Association of Mental Deficiency defines mental retardation as "subaverage general intellectual functioning which originates during the developmental period and is associated with impairment in one or more of the following areas: (1) maturation, (2) learning, and (3) social adjustment."[2]

This is carried into the classification system which was traditionally based on I.Q. and divided the retarded into four major categories, in ascending order: idiot, imbecile, moron and

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[1]M.T. Hutt and R.G. Gibbey, The Mentally Retarded Child: Development, Education and Treatment (Boston: Allyn and Bacon, Inc, 1965), pp. 8-9.

[2]Ibid., p. 9.

borderline. The classification of the American Association of Mental Deficiency utilizes two related dimensions: measured intelligence and adaptive behaviour of the individual. Adaptive behaviour includes personal independence and social responsibility, as measured by the Vineland Social Maturity Scale.[3] Three levels of retardation are then distinguished: mild, moderate, and severe retardation.

Hutt and Gibbey procede to discuss the behavioral characteristics of children in the mild and moderate range of retardation and some specific conditions associated with severe retardation.[4] In this discussion, they apply a dynamic approach that stresses underlying causes and interacting factors in behaviour. "The attitudes and actions of the child's family, his neighbours and schoolmates, and society generally, as well as his inferior intellectual capacities, co-determine the child's reactions."[5] In their comprehensive view, they stress that the retarded individual is a unique personality who must be understood and treated as a whole, complex human being. "The intellectual functioning of a child cannot be considered apart from his emotional and personality

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[3]Ibid., p. 51.

[4]Ibid., pp. 57-75.

[5]Ibid., p. 11.

functioning."[6] This is a marked departure from the earlier beliefs that mental retardation was determined solely by heredity; behaviour was interpreted solely as a function of intellect -- or lack of it -- and personality differences and variations in social and emotional maturity were largely overlooked.[7]

Lawrence briefly outlines the shift in treatment and interest in retardation over the past few decades. The "restrictive" period of institutionalization was followed in the 40's by a period of "social control" which advocated humanitarian attitudes at the same time it advocated sterilization. The period of "social adjustment" made rehabilitation and integration into the home and community its goal. This was extended into the period in which "emotional adjustment," as the base of social adjustment was the focal point of interest.[8]

Davies present a more detailed historical account of this movement in attitudes and treatment of retardation, as a result of evolution "From Sorcery to Science" over the centuries. Of particular significance were the development of the Sanford-Binet intelligence test in 1904 and studies in genetics and delinquency.

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[6]Ibid., p. 56.

[7]Begab, op. cit., p. 7

[8]E.S. Lawrence, "Social Adjustment: An Area for Psychological Research in Mental Deficiency," American Journal of mental Deficiency, LVIII (1953-54).

Application of the Sanford-Binet test led to the discovery of widespread retardation (morons) and questioning of the validity of using I.Q. alone as a criterion of retardation. Research in genetics and delinquency led to new concepts regarding the multiple causation of retardation and the interaction of bio-psychosocial factors in producing behaviour. Davies discusses socialization, that is, the development of personality in relation to the environment, as the goal of modern rehabilitation programs. The focus of the social approach to retardation is directed at developing the qualities in personality which are susceptible to change and "more decisive factors in socialization than intelligence alone."[9] Efforts should be made to change other "movable" elements such as the environment, which includes family, friends, living conditions, training, etc. The influence of the family as the major socializing agent in the environment, especially in a child's formative years, is recognized but not dealt with in depth.

Problems in the area of personality development and functioning are thoroughly considered by Hutt and Gibbey. They apply the principle of Erikson's maturational or "unfolding" process to the retarded child, noting that he develops through the same psychosexual stages as all children, but at a slower rate, and that the immaturity of the ego and super ego present

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[9] S.P. Davies, The Mentally Retarded in Society (N.Y.: Columbia University Press, 1960), p. 216.

difficulties in dealing with social situations.

The child's potentialities unfold in relationship with significant others. During the first years in life, this is the mother, on whom the child depends for satisfaction of his basic biological and affectional needs. Out of the warmth of the mother-child relationship develops, what Erikson has termed "basic trust" which provides the child with the security necessary to move out into the wider environment and the self-confidence to express, rather than curb his potentialities.[10] "The emotional reactions of the child and his level of maturity are a reflection of the degree of nurturance, care and security that he derives from his parents."[11] The primary importance of the mother-child relationship in a child's development is illustrated by Spitz's study that separation from the mother led to retarded development and even death of the child.[12] Symonds talks about separation as one of the most serious expressions of parental rejection of a child.[13] A study undertaken at the Fels Research Institution

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[10]Hutt and Gibbey, op. cit., p. 116

[11]J.R. Thurston, "A Procedure for Evaluating Parental Attitudes toward the Handicapped," American Journal of mental Deficiency, LXIV (1959-1960), p. 148.

[12]Hutt and Gibbey, op. cit., p. 114.

[13]P.M. Symonds, The Dynamics of Parent-Child Relationships (N.Y.: Bureau of Publications, Teachers College, Columbia University, 1949), p. 16.

demonstrated that "accepted children," on the other hand, ten to be more alert mentally, as well as more friendly and responsive than rejected children.[14]

Symonds develops the thesis that personality is an outgrowth of the parent-child relationship in infancy and states that this relationship is determined by the attitudes of the parents.[15] Further he hypothesizes that a definite relationship exists between parental attitudes and the way parents behave toward a child and that child's own attitudes and behaviour.[16] This applies to the retarded child also. "The handicapped child's attitude toward himself and his handicap are in major part determined by parental reactions toward the child and his disability."[17] In this study of parental adjustment to dually handicapped children, Heilman goes on to give three illustrations which relate observed parental behaviour to observed child behaviour.

The presence of a retarded child always imposes a strain on parent-child relationships.[18] Begab refers to the non-fulfilment

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[14]Hutt and Gibbey, op.cit., p. 125.

[15]Symonds, op. cit., p. 5.

[16]P.M. Symonds, The Psychology of Parent-Child Relationships (N.Y.: D. Appleton-Century Company, 1939), p. 54.

[17]A.E. Heilman, "Parental Adjustment to the Dull Handicapped Child," American Journal of mental Deficiency, LIV (1949-1950) p. 556.

[18]Thurston, op. cit., p. 148.

of parental needs as an ego-threatening situation calling forth various defense mechanisms.[19] The resulting behaviour may be adaptive, such as realistic acceptance of the child's condition or maladaptive, as in rejection. Kanner describes the three principle types of reactions he found among parents: mature acknowledgement of the child's retardation and acceptance of the child as he is, disguises of reality with the retardation being ascribed to a correctable circumstance, and complete inability to face reality and consequent denial of the child's condition.[20]

In eleven case studies, Grebber examines parental attitudes toward mentally retarded children as reactions to frustration. He categorizes these attitudes in terms of acceptance-rejection in the parent-child relationship. His findings show that parents with extrapunitive attitudes are hostile toward the environment and reject the child, those with intropunitive attitudes blame themselves for the child's condition, feel guilty and express ambivalence toward the child, while an impunitive attitude is characterized by conciliatory behaviour and parental acceptance of the child. In the one case in which the parent was found to be accepting of the child, the child was able to make a good adjustment and utilize his capacities to the fullest, whereas the

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[19] Begab, op. cit., p. 12.

[20] L. Kanner, "Parents' Feelings about Retarded Children," American Journal of mental Deficiency, LVII (1952-1953), pp. 375-383.

children of parents with unfavorable attitudes exhibited behaviour problems which prevented them from using even their limited capabilities.[21]

There is evidence that parents usually progress through a process of growth leading to acceptance of their child. Rosen's study traces the development of parental understanding of the retarded child through five phases: awareness and recognition of the problem, seeking for cause and effect, and acceptance, which he believes, is never fully attained.[22] Stone's study too shows the change in parental attitudes from various degrees of awareness of the child's limitations at the Intake interview to various degrees of acceptance in subsequent interviews.[23]

The area of parental attitudes is a recent development in social work practice and research. Most of the literature in this area are descriptive studies based on case records in clinical settings. Stoddard comments about the gaps in the nature and definition of parental attitudes and the degree to which these affect the child's functioning. Her study is an

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[21] A.M. Grebber, "Parental Attitudes toward Mentally Retarded Children," American Journal of mental Deficiency, LVI (1952), pp. 475 - 483.

[22] F. Rosen, "Selected Aspects in the Development of a Mother's Understanding of her Mentally Retarded Child," American Journal of mental Deficiency, LIX (1954-1955), pp. 522-528.

[23] M.M. Stone, "Parental Attitudes to Retardation," American Journal of mental Deficiency, LIII (1958) pp. 363-372.

attempt to help fill this gap in research. Stoddard classified parental attitudes in terms of awareness and acceptance of the child's limitations and readiness to plan realistically for his present and future needs. These attitudes were measured according to replies to key questions in interviews, and correlated with the child's level of achievement at school, as rated by teachers on a Behaviour Rating Scale. Surprisingly, no relationship was shown to exist between parental attitudes and the child's level of achievement. This finding was held to be insufficient proof because of the study's limitations: the inadequacy of the instruments used, the question of whether "in an endeavour to escape a quagmire of 'acceptance' as a concept of an emotional quality," the study dealt with the intellectual quality only, which may not have been the significant attitude affecting the child's growth; nor was the quality of the teacher-child relationship, nor the possible effects of paternal attitudes considered.[24] This study is similar to the present study in that it attempts to establish the nature of the relationship between similar variables, that is, maternal acceptance of the retarded child and his level of social maturity.

Another study on which the present one is partly modelled is that of Worschel and Worschel which assesses the acceptance - rejection pattern held by parents toward their mentally retarded child. Parents from twenty-two families with at least one retarded

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[24] Stoddard, op. cit., pp. 575-598.

child were asked to evaluate their retarded child and a normal child on forty personality traits, selected from Allport and Odbert and from literature on mental retardation. These traits were alphabetically listed, each word being followed by three columns:

Column I -- My child is . . .

Column II - I wish my child were . . .

Column III- Most children are . . .

with a seven-point continuum rating. The self-ideal Discrepancy Index provided three indirect measures of parental acceptance of the child. It was assumed that the more negatively the parent rated the child, the greater the rejection. Also, the more the parent perceived the child as deviating from the "ideal" (Column I -- Column II) and from "most other children" (Column I -- Column III), the less his acceptance. The findings support the hypotheses. The retarded child was rated less favorably on the personality traits than the normal child. The parents perceived the normal child in a more positive way than "most other children" but saw the personalities of the retarded children more negatively than "most other children". The retarded child was seen as deviating more from the concept of the "ideal" child than the normal child. It was interpreted, then, that there was a greater degree of parental rejection of retarded children as compared with normal children. It was suggested, however, that the great variability

in parental attitudes toward the retarded children indicates that some parents were basically accepting of the retarded children. The relatively negative attitudes toward other children, compared with their normal children, was possibly due to projection, as compensation for their disappointment in their retarded children. The study predicts that parents having more positive attitudes would have better adjusted children.[25]

Another study of interest attempts to test this prediction. Peck and Stephens relate the attitudes and behaviour of parents toward their retarded child and the attitudes and behaviour of the child. Using case studies of ten adolescent retardates and their parents, they rated parental attitudes and behaviour with the Fels Parent Behaviour Scales and the Worschel Rating Scale for Child-Concept. The children were rated with the Fels Child Behaviour Scales and the Vineland Social Maturity Scale. The findings were in accordance with Worschel's findings that the retarded child was less favorably rated than was the normal or "ideal" child on personality traits. However, parents rated "other children" more negatively than both their normal <u>and</u> retarded child. A most significant factor was the finding that the father's acceptance or rejection, and not the mother's, as rated on the Worschel scale, coincided with the amount of rejection observed in the home on

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25T.F. Worschel and P. Worschel, "The Parental Concept of the Mentally Retarded Child," <u>American Journal of mental Deficiency</u>, LXV (1960-1961), pp. 782-788.

Fels Scales. Two possible explanations were that the father's acceptance or rejection set the pattern for the acceptance or rejection in the home, or that the mother tended to conceal her feelings of rejection more than the father. Another finding was that the needs and capacities of these mentally retarded children were frequently not met and understood. It was concluded that this kind of study was of value on planning counselling, therapy and education.[26]

Murray, herself a mother of a retarded child, believes that parents' greatest need is for constructive, professional counselling at various stages in the child's life. "In the early stages of parental adjustment, we need someone to help us understand our own attitudes and feelings about the child."[27] In discussing social work's responsibility in the field of mental retardation, Begab notes that our changed philosophy, emphasizing the retarded individual's capacity for community living rather than institutional care requires expanded casework services to parents in helping them understand and accept their child's limitations and thus in helping him to utilize his potentialities for optimal social functioning and satisfaction.[28]

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[26] J.R. Peck and W.B. Stephens, "A Study of the Relationship between the Attitudes and Behaviour of Parents and that of their Mentally Deficient Child," American Journal of mental Deficiency, LXIV (1960), pp. 839 - 844.

[27] M.A. Murray, "Needs of Parents of Mentally Retarded Children," American Journal of mental Deficiency, LXIII (1959), p. 1084.

[28] Begab, op. cit., p. 20.

CHAPTER III

METHOD

This is a descriptive-diagnostic study which attempts to describe the relationship between the variables of social maturity and maternal acceptance, and in turn, the relationship between maternal acceptance and the variables of mother's level of academic education and the sex of the child. In order to obtain the information necessary to answer questions with regard to these variables, interviews with mothers of retarded children were conducted, in which two instruments were administered, the Vineland Social Maturity Scale and the Rating Scale. From these, scores were obtained, correlated and analyzed.

The general area of study was designated by the Research Committee of the School of Social Work. With the cooperation of the Association for Retarded Children in Greater Winnipeg, it was decided to centre the study around children currently and previously enrolled in the Kinsmen School for Retarded Children, which is operated by the Association. This enabled us to select a group of trainable mental retardates who were comparable in terms of I.Q. range (25 - 50), with an awareness that individuals within a similar intelligence range have varying capacities for levels of social functioning. The broad group of children was classified in terms of age into three sub-groups: 6 - 12 years, 13 - 17 years,

18 years and over, inclusive. The four research groups of students in the total project were each assigned a particular age range. This study focused on the 6 - 12 year old group of retarded children. Primary interest concerned the social functioning of children in this group; through perusal of the literature and group discussions, the particular focus was determined, that is, maternal acceptance.

General orientation to the field of mental retardation was obtained through lectures by two guest speakers: Dr. G.H. Lowther, Medical Superintendent of the Manitoba School and Mr. A.H. Hoole, Executive Director of the Canadian Association for Retarded Children, Manitoba Division. The research group also had the opportunity for direct observation of the children and discussions with teachers durings its visit to the Kinsmen School.

The sample was selected with the cooperation of the Board of Directors of the Association for Retarded Children in Greater Winnipeg, who provided the School of Social Work with a complete list of children enrolled in the Kinsmen School and names and addresses of parents who were members of the Association. The number of children in the 6 to 12 years age range was identified and in consultation with the Association for Retarded Children, the children who did not meet the criteria we established (outlined in Chapter I), were eliminated from the study population. Letters were sent by the School of Social Work to parents of children in

the total age range (6 - 18 plus years), advising them of the study and requesting their participation. Those parents who were not willing to cooperate were also eliminated from the study population. The original total population contained 208 subjects, 38 of whom were eliminated for the above reasons. For our purposes, then, there were 170 children available in the 6 to 12 age range, inclusive. Two random samples were selected from this group because two research groups were studying children in this age range. Our sample consisted of 56 subjects; 14 of these were interviewed in the pre-test, leaving a sample of 42 mothers of retarded children for the actual research project. A sample of this size was felt to be large enough to test the hypotheses and manageable for the student time available.

From a search of available material in a review of the literature, two instruments were chosen to measure the degree of maternal acceptance and the child's level of social maturity. These were respectively, the Worschel Rating Scale, a modified version of the Bills, Vance, McLean Index of Adjustment and Values (1951) and the Vineland Social Maturity Scale, which is a reliable and widely-used instrument developed by Dr. Edgar A. Doll.

The Worschel Scale (described briefly in Chapter II) is an indirect method of measuring acceptance-rejection patterns by three indices: the discrepancy between a parent's evaluation of

his retarded child and his concept of the ideal child, the discrepancy between his evaluation of the retarded child and "most children" and ratings on the retarded child for the 40 positive and negative personality traits, as compared with ratings for a normal child in the family.[1]

The Vineland Social Maturity Scale is a unique instrument in that it has all the virtues of a standard measurement device and the unusual advantage of not requiring the physical presence of the subject being examined.[2] The Scale consists of 117 items representing some particular aspect of the ability to look after one's own practical needs. There are eight categories of social maturity: self-help in general, self-help in eating, self-help in dressing, locomotion, communication, self-direction, socialization and occupation. Items from these categories are arranged according to age periods of one year intervals, from birth to 25 plus years, to reflect progressive social maturity. The items are scored by the interviewer on the basis of information obtained from a parent. The total score obtained on the Scale is converted into a social age equivalent; this is divded by the chronological age of the

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[1]Worschel and Worschel, op. cit., pp. 783-784.

[2]D.J. Mase, "Book Review: Measurement of Social Competence: A Manual for the Vineland Social Maturity Scale," American Journal of mental Deficiency, LX (1955), pp. 193-194.

child to arrive at a social quotient, which represents a level of social maturity. On the face sheet of the Vineland Social Maturity Scale, information necessary for testing the sub-hypotheses was obtained, that is, the mother's level of academic education and the sex of the child. Miss Lois Fry, a psychologist at the Society for Crippled Children and Adults of Manitoba, addressed the research group on the method of administering the Vineland Social Maturity Scale. The group also received "Excerpts from Vineland Social Maturity Scale Manual of Directions," to standardize its administration.

The pre-test occurred on December 21, 1966. Each student contacted a parent directly to arrange an interview and presented an identifying letter of introduction. The pre-test was carried out in two parts, on an experimental basis. The Vineland Social Maturity Scale was administered in personal interviews with the mothers and the Worschel Rating Scale was administered to the whole group of mothers in the pre-test sample at the Kinsmen School.

Following analysis of the data thus obtained, the method of administering the schedules and the Worschel Rating Scale itself were modified. For reasons indicated in Chapter I, it was felt that individual interviews were more advantageous than the group method in securing more accurate responses. Because of the questions raised by mothers concerning the meanings of traits on

the Worschel Scale, a list of definitions was compiled by the research group to clarify and standardize interpretation, if requested. Following discussions, it was decided that for the purposes of our study, it was not necessary to obtain three indices of the acceptance-rejection pattern, because maternal acceptance was only one of the variables being studied. Therefore, we eliminated the measurement of discrepancy scores between the retarded child and the normal child in the family, and between the retarded child and "most children." Neither were the 40 personality traits on the Worschel Scale given positive or negative ratings. Instead, acceptance was measured in terms of the discrepancy between the mother's evaluation of her retarded child and her conception of the ideal child, with low discrepancy indicating a high degree of acceptance. This revision of the Worschel Scale was referred to simply as the Rating Scale. The Appendices contain the Rating Scale in its final form, as well as the "Definitions of Traits on the Rating Scale", and a copy of the Vineland Social Maturity Scale.

Actual testing took place in January 1967. A standard approach was taken in contacting the 42 mothers to arrange personal interviews. Each student interviewed three mothers in their homes. A general explanation of the purpose of the study, that is, as an aid in gaining a better understanding of what

retarded children are like, was given. The Vineland Social Maturity Scale was administered first, because it evoked less emotional responses from the mothers than the Rating Scale and required more active participation with the interviewer. Instructions for completing the Rating Scale were given, with the interviewer available to help with any interpretation of traits. Following the interviews, letters of thanks were sent, by the students, to the 56 mothers who participated in the study.

Before analyzing the data, the scores on the Rating Scale were calculated for each subject by totalling the discrepancy score, i.e. between the mothers' evaluation of the retarded child and the "ideal" child, for each trait. The social quotient scores were also calculated by the method described earlier in this chapter. The "Tabulation of Results" appears in Appendix A. Using a formula for computing the coefficient of correlation between these two scores, we determined the degree of the relationship that existed between maternal acceptance and social maturity of the child as stated in the first hypothesis.

In order to determine the relationship between the variables of maternal acceptance and the differences in the sex of the child, the ranges, means and medians of the discrepancy scores obtained for boys and girls on the Rating Scale were calculated and compared. The data was also organized in tabular form to indicate

the distribution of discrepancy scores. A further step in the analysis showed the relationship between the sex of the child and the level of social maturity by a similar method of calculating and comparing the ranges, means and medians of the social quotient scores for both sexes and organizing the distribution of the social quotient scores in tabular form. The two sets of data -- discrepancy scores and social quotient scores -- were then analyzed in relation to the sex of the child.

In order to determine the relationship between the variables of maternal acceptance and the mother's level of academic education, the mean discrepancy score was determined for each level of academic education. This data was organized and analyzed in tabular form. Again a further step was taken to determine the relationship between the mother's level of academic education and the child's level of social maturity. The mean social quotient score of the children was determined for each level of academic education, presented and analyzed in tabular form. The mean discrepancy scores and the mean social quotient scores were then compared in relation to the mothers' level of academic education. The above steps were taken to confirm or dispute the second hypothesis and, indirectly, further confirm or dispute the first hypothesis.

The presentation of findings and a fuller analysis of the data are discussed in Chapter IV.

CHAPTER IV

ANALYSIS OF DATA

From the original study population of 208 mothers, 38 were unwilling to cooperate in the study and were, therefore, eliminated. Of the remaining 170 in the population, 42 mothers were selected at random, to be interviewed for the purposes of our study. The data obtained from the mothers by administering the Vineland Social Maturity Scale and the Rating Scale was tabulated in the following categories: social quotient scores, discrepancy scores, sex of the child, the mother's level of academic education and age of the child. Please refer to Appendix A for these results. The first 4 categories referred to the variables being studied in the hypotheses; the last category indicated the representativeness of the 6 - 12 years age range being studied.

The first major step in the analysis of data was to compute the coefficient of correlation (r), stating the degree of relationship between social maturity and maternal acceptance. The formula used was:

$$r = \frac{\Sigma xy - \frac{(\Sigma x)(\Sigma y)}{n}}{\sqrt{\left(\Sigma x^2 - \frac{(\Sigma x)^2}{n}\right)\left(\Sigma y^2 - \frac{(\Sigma y)^2}{n}\right)}}$$

$$r = \frac{165{,}963 - \frac{(2783)(2585)}{42}}{\sqrt{\left(203{,}114 - \frac{(2783)^2}{42}\right)\left(183{,}217 - \frac{(2585)^2}{42}\right)}}$$

X = SOCIAL QUOTIENT SCORES
Y = DISCREPANCY SCORES
Σ = SUM

The correlation found was -.25, a low negative correlation which was not statistically significant but did indicate an inverse relationship between maternal rejection (i.e. lack of acceptance) and social maturity, and therefore, a direct relationship between maternal acceptance and social maturity.

Relating further to social maturity, we analyzed the distribution of social quotient scores on an interval scale in relation to the sex of the child. The findings are presented in Table 1.

TABLE 1

DISTRIBUTION OF SOCIAL QUOTIENT SCORES
FOR BOYS AND GIRLS

S.Q. Scores	No. of Cases	Boys	Girls
21 - 30	2	1	1
31 - 40	0	0	0
41 - 50	8	2	6*
51 - 60	11	7**	4
61 - 70	7	4	3
71 - 80	1	1	0
81 - 90	4	2	2
91 - 100	7	5	2
101 - 110	1	1	0
111 - 120	1	0	1
Total	42	23	19

* made for "Girls"
** made for "Boys"

Table 2 describes this data further in terms of central tendencies and range.

TABLE 2

COMPARISON OF RANGE, MEAN AND MEDIAN
OF SOCIAL QUOTIENT SCORES FOR BOYS AND GIRLS

Sex of Child	No. of Cases	Range of S.Q. Scores	Mean S.Q. Scores	Median S.Q. Scores
Boys	23	74	68	62
Girls	19	92	64	59

It was noted that the mean and median social quotient scores were somewhat higher for boys than for girls and that there was a wider range of scores (22 - 114) for girls than for boys (27 - 101). Table 1 indicated that in the middle range of the distribution (31 - 90) there were proportionately more girls 79% than boys (70%). However, at the high extreme of scores (91 - 120), there were proportionately more boys (26%) than girls (16%). At the low extreme of scores (0 - 30), there were almost equal proportions, with 4% of the boys and 5% of the girls located in this range. The majority of cases fell into the 41 - 70 range, representing a cluster of 26 cases with a greater proportion of girls than boys (68% and 57% respectively).

Social maturity was also analyzed in relation to the mother's level of academic education. Table 3 presents the

findings.

TABLE 3

DISTRIBUTION OF MEAN SOCIAL QUOTIENT SCORES
IN RELATION TO MOTHERS' LEVEL OF ACADEMIC EDUCATION

Mothers' Level of Academic Education	No. of Cases	Mean S.Q. Scores of the Children
Grade 5	3	51
" 6	3	50
" 7	2	63
" 8	5	78
" 9	5	73
" 10	9	68
" 11	9	71
" 12	2	81
Above Grade 12	4	46
Total	42	

It was observed that there was a generally rising trend in the mean social quotient scores from grades 5 to 12, with some variation and a decrease in scores after Grade 8 until the peak was reached at the Grade 12 class. There was a tremendous drop in the scores between Grade 12 and the next class, "Above Grade 12" respectively representing the highest and lowest mean social

quotient scores in the sample. The highest level, "Above Grade 12" and the lowest levels of academic education, Grade 5 and Grade 6, corresponded to the lowest mean social quotient scores in the sample.

The above analyses, concerning social maturity of the children in relation to the two variables, sex of the child and mother's level of academic education were further steps proceeding from analysis of data pertinent to the second sub-hypothesis, namely that maternal acceptance is related to the variables of sex of the child and mother's level of academic education. In this way, the two main hypotheses were more closely linked and tested.

Data relating to sub-hypothesis I was analyzed by observing the distribution of Rating Scale discrepancy scores (which measured maternal acceptance) on an interval scale in relation to the sex of the child. Central tendencies and ranges were then compared for boys and girls. These findings are presented in Table 4 and Table 5.

TABLE 4

DISTRIBUTION OF DISCREPANCY SCORES FOR BOYS AND GIRLS

Discrepancy Scores	No. of Cases	Boys	Girls
0 - 10	1	1	0
11 - 20	1	0	1

TABLE 4 - Continued.

Discrepancy Scores	No. of Cases	Boys	Girls
21 - 30	2	2	0
31 - 40	5	3	2
41 - 50	4	0	4
51 - 60	5	3	2
61 - 70	9	5	4
71 - 80	6	2	4
81 - 90	3	2	1
91 - 100	5	4	1
101 - 110	0	0	0
111 - 120	1	1	0
Total	42	23	19

TABLE 5

COMPARISON OF RANGE, MEAN AND MEDIAN
OF DISCREPANCY SCORES FOR BOYS AND GIRLS

Sex of Child	No. of Cases	Range of Discrepancy Scores	Mean Discrepancy Scores	Median Discrepancy Scores
Boys	23	108	64	69
Girls	19	77	59	62

It was noted that the mean and median discrepancy scores were somewhat lower for girls than for boys and that there was a wider range of scores (7 - 115) for boys than for girls (18 - 95). In the middle range of the distribution (31 - 90) there were proportionately more girls (89%) than boys (65%). At the high extreme of scores (91 - 120) there was a significantly greater proportion of boys (22%) than girls (5%). At the low extreme (0 - 30), 13% of the boys compared with 5% of the girls falling into this range. It was noted that there was a wider range of scores for boys with more boys than girls at both extremes. It was also noted that many classes of scores contained only a single case or no case at all, especially in the classes at the extreme ends of the distribution. This pertained to the distribution of social quotient scores in Table 1, as well.

Data pertinent to sub-hypothesis II, the relationship between maternal acceptance and the mother's level of academic education was analyzed by calculating the mean discrepancy scores for each of the levels of academic education. The findings are presented in Table 6.

TABLE 6

DISTRIBUTION OF MEAN DISCREPANCY SCORES
IN RELATION TO MOTHERS' LEVEL OF ACADEMIC EDUCATION

Mothers' Level of Academic Education	No. of Cases	Mean Discrepancy Scores
Grade 5	3	73
" 6	3	51
" 7	2	38

TABLE 6 - Continued.

Mothers' Level of Academic Education	No. of Cases	Mean Discrepancy Scores
Grade 8	5	50
" 9	5	55
" 10	9	69
" 11	9	60
" 12	2	74
Above Grade 12	4	75
Total	42	

It was observed that the highest mean discrepancy scores occurred at the extremes of the distribution, that is the Grade 5 and the Grade 12 and over classes. Between these extremes in the lower and middle levels of education, the mean discrepancy scores were lower, with the lowest score occuring in the Grade 7 class.

A final step in the analysis of data consisted of comparing the mean discrepancy scores and the mean social quotient scores in relation to the mothers' level of academic education (Tables 3 and 6). In general, the highest discrepancy scores corresponded to the lowest social quotient scores as hypothesized. The one notable exception was the Grade 12 class in which a high discrepancy

score was accompanied by the highest social quotient score. The social quotient scores for the Grade 6 and Grade 7 classes were not as high as might be expected in terms of the very low discrepancy scores for these classes.

Table 7 presents the mean discrepancy scores in rank order (indicating lowest to highest level of acceptance) with their corresponding mean social quotient scores and mothers' educational levels. The numbers in brackets refer to the rank order (from lowest to highest) of mean social quotient scores.

TABLE 7

RANKING OF MEAN DISCREPANCY SCORES AND MEAN SOCIAL QUOTIENT SCORES IN RELATION TO MOTHERS' LEVEL OF ACADEMIC EDUCATION

Mean Discrepancy Scores	Mean S.Q. Scores	Mothers' Level of Academic Education
(1) 75	46 (1)	Above Grade 12
(2) 74	81 (9)	Grade 12
(3) 73	51 (3)	Grade 5
(4) 69	68 (5)	Grade 10
(5) 60	71 (6)	Grade 11
(6) 55	73 (7)	Grade 9
(7) 51	50 (2)	Grade 6
(8) 50	78 (8)	Grade 8
(9) 38	63 (4)	Grade 7

Another final step in the analysis of data consisted of comparing the mean and median social quotient scores and the mean and median discrepancy scores in relation to the sex of the child, (Tables 2 and 5). We observed that the mean and median social quotient scores were higher for boys than for girls as compared to the lower mean and median discrepancy scores for girls, a low discrepancy score indicating a high level of acceptance.

Interpretations of these findings and conclusions will be discussed in the next, final chapter.

CHAPTER V

CONCLUSIONS

This study attempted to provide a better understanding of mental retardation; in particular, to determine whether a relationship existed between a child's level of social maturity and maternal acceptance, and to determine possible factors underlying maternal acceptance.

The first major hypothesis tested was: "In a group of trainable mentally retarded children between the ages of 6 and 12 years inclusive, who are enrolled in the Kinsmen School for Retarded Children, there is a direct relationship between the child's level of social maturity and the mother's acceptance of the child in the family." This hypothesis was substantiated by our findings which indicated a low negative correlation between social maturity and maternal rejection (i.e. lack of acceptance). Therefore, a direct relationship between social maturity and maternal acceptance did exist although it was not statistically significant. The findings were in line with our knowledge about the primary importance of the quality of the mother-child relationship in influencing a child's emotional and social growth. The findings substantiated Worschel and Worschel's prediction that parents having more positive attitudes would have better

adjusted children.[1] We may speculate upon the reasons for the low negative correlation between the variables. The fact that we did not control all of the variables affecting social maturity and maternal acceptance, and the given time element are two factors which affected our results. Another factor was the subjectivity of the mothers' responses which was not entirely eliminated by the interviewers' skilled judgement in scoring the Vineland Social Maturity Scale. The discrepancy scores of the Rating Scale were somewhat skewed, to the extent that the mothers were aware of, and threatened by the nature of the instrument.

The second major hypothesis tested was: "There are variations in the level of the mothers' acceptance of their trainable mentally retarded children which are related to the sex of the child and the mother's level of academic education." The conclusions regarding this hypothesis will be dealt with by considering the findings in relation to the two sub-hypotheses.

The first sub-hypothesis stated that: "The mothers' acceptance of the trainable mentally retarded girls is greater than their acceptance of the trainable mentally retarded boys." This sub-hypothesis was substantiated conclusively. The findings were in accord with our rationale regarding sex-role theory and

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[1]Worschel and Worschel, *op. cit.*, p. 787.

greater cultural expectations for boys. Further, Levine's study[2] which concluded that fathers devalued boys more than the mothers did, suggests that boys were rejected in the home situation to a greater degree than indicated by studying only the mothers' attitudes. However, the wide range of discrepancy scores for boys and the greater proportion of boys located in the low extreme of scores, might suggest a good deal of variability in the attitudes of mothers towards boys, with some mothers extremely accepting of boys. Another consideration was the observation that some mothers relate better and are more accepting of one sex or the other, apart from the presence of retardation. The number of mothers in our sample who were more naturally inclined to accept girls would affect our results.

A further step was taken to determine the relationship between the differences in the sex of the children and their levels of social maturity, in light of the conclusion that the girls were more accepted by their mothers than were the boys. It was expected that the findings would substantiate the first major hypothesis, i.e. that there was a direct relationship between maternal acceptance and the child's level of social maturity. A surprising finding was that the boys achieved higher

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[2] Levine, op. cit., p. 822.

levels of social maturity than the girls although they were less accepted by their mothers. While the boys had a higher mean social quotient score than the girls, it may have been somewhat distorted by the greater proportion of boys in the high-extreme of scores. It may be noted that there were proportionately more girls than boys in the middle range and in the cluster of the majority of cases. The findings may appear to be misleading then. Another interpretation of the findings was that the greater social maturity of the boys reflected greater striving to achieve in order to meet greater expectations and to gain acceptance, i.e. a measure of overcompensation for maternal rejection.

The second sub-hypothesis stated: "There is a direct relationship between the mother's acceptance of her trainable mentally retarded child and her level of academic education." The findings, that the mothers with the lowest and the highest levels of education were the least accepting of their retarded children, did not substantiate this hypothesis but were in line with the controversial nature of the hypothesis. Mothers with the lowest level of education may have rejected their children because they were unable to comprehend the children's retardation and unable to compensate for their own lack of education through their children. In their study, Ewert and Green found a significant relationship between mothers' educational level and

accuracy of their estimates of their retarded children's functioning age levels. Although better educated mothers were better able to realistically perceive their children's abilities and limitations, it was stated that this was an intellectual awareness rather than a measure of emotional acceptance.[3] Therefore, we conjectured that there were factors other than knowledge per se, perhaps maternal expectations (whatever the mothers' level of education) which influenced maternal acceptance. This agreed with Rosen's finding that "one-half the mothers felt their own feelings constituted the greatest obstacle impeding acceptance of the retardation, while the other half attributed it to symptoms in the child's behaviour which they could not control or understand."[4]

Again, a further step was taken to determine the relationship between the mother's level of academic education and the child's level of social maturity. The findings were inconclusive and contradictory. The weak but generally rising trend in the levels of social maturity from Grade 5 to Grade 12 may have been attributed to the correspondingly greater degree of stimulation in the home environment. However, the finding that the highest level of

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[3]Ewert and Green, op. cit., p. 521.

[4]Rosen, op. cit., p. 526.

education corresponded to the lowest level of social maturity indicated that other factors needed to be considered, for example the effect of professional working mothers whose interests were more career than home-centred.

In relating the mother's level of education and the child's level of social maturity to maternal acceptance, we found that, in general, the lowest level of social maturity was related to the lowest level of acceptance, which supported the first major hypothesis. The contradiction occurred in the finding that the two highest levels of education, both having a very similar rating of low acceptance, showed the greatest differences in social quotient scores, ranging from the highest to the lowest scores in the entire sample.

In spite of certain incongruities, our findings had validity in reference to this particular study. Throughout, there were certain limitations which affected the study and would limit the applicability of our findings to other studies of a similar nature. For example, it should be noted that the scope of the study was limited to the middle range group in the classification system of mental retardation, that is, the "trainable" group. Therefore, the findings could not validly be transferred to other levels of retardation, the severely or "educable" retarded groups, whose characteristics and potentials differ. Other limitations were

outlined in Chapter I and briefly referred to in this chapter with regard to our conclusions for the first hypothesis. A relevant limitation was the small size of the sample which resulted in many classifications containing only one case, from which generalizations could not validly be made. We did not consider the effect that the teacher, as a substitute "mother" figure, had on the child's social maturity, or the effect of the training program itself, i.e. the length of time that the child had been enrolled at the Kinsmen School, as a factor underlying social maturity.

Findings which were not related to the hypotheses but relevant for direct social work intervention and community organization of services referred to the subjective and objective sources of stress which we observed in interviewing the mothers. The mothers had a need to ventilate their feelings and share their problem, at the same time tending to express denial of the extent of the retardation. They showed concern with the past (i.e. etiology), the present (problems in the child's daily functioning), and the future (special schools and other resources for long-range planning), revealing lack of understanding of the child's needs and capacities. This indicates the need for professional counselling, the need for concrete and general knowledge regarding the growth sequence of the children, and

the need for community education and planning.

Our study suggested the need to develop more scientific techniques, perhaps of a clinical or projective nature, to measure a more comprehensive definition of acceptance, the kind of mature acceptance which recognizes discrepancies between the actual and the ideal and comes to terms with these. This study also suggested the need for further research in this area, including the other variables suggested, i.e. father's attitude, socio-economic class etc., which would expand and refine our findings. Similar studies, using samples from the "severe" or "educable" population would also be valuable in this respect. It is hoped that this study has added to the body of knowledge and motivated further interest and research in the field of mental retardation.

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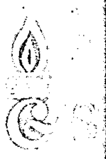
APPENDIX A

TABULATION OF RESULTS

CASE	SOCIAL QUOTIENT SCORE	DISCREPANCY SCORE	SEX OF CHILD	MOTHERS' LEVEL OF EDUCATION	AGE OF CHILD
1	47	75	F	Grade 5	7 years
2	62	84	M	" 9	12 "
3	70	78	F	" 12	11 "
4	27	115	M	Above Grade 12	11 "
5	56	62	F	Grade 10	12 "
6	59	95	F	" 6	10 "
7	60	91	M	" 11	10 "
8	87	65	M	" 9	7 "
9	65	83	M	" 8	8 "
10	49	53	F	" 11	7 "
11	22	39	F	" 6	12 "
12	41	78	M	" 8	9 "
13	101	21	M	" 9	8 "
14	63	62	M	" 10	8 "
15	55	66	M	Above Grade 12	8 "
16	96	92	M	Grade 10	7 "
17	93	55	M	" 11	7 "
18	53	100	M	" 10	12 "
19	71	96	M	" 10	11 "

CASE	SOCIAL QUOTIENT SCORE	DISCREPANCY SCORE	SEX OF CHILD	MOTHERS' LEVEL OF EDUCATION	AGE OF CHILD
20	93	21	M	Grade 8	8 years
21	51	59	M	" 11	8 "
22	56	39	M	" 10	6 "
23	85	44	F	" 11	10 "
24	50	53	F	" 9	9 "
25	53	54	M	Above Grade 12	11 "
26	67	50	F	Grade 9	7 "
27	42	43	F	" 10	6 "
28	83	31	M	" 11	12 "
29	60	41	F	" 10	9 "
30	50	65	F	Above Grade 12	11 "
31	92	69	M	Grade 12	9 "
32	114	85	F	" 10	9 "
33	84	37	F	" 7	11 "
34	57	74	M	" 5	12 "
35	54	62	F	" 11	10 "
36	49	72	F	" 5	12 "
37	96	80	F	" 11	6 "
38	97	7	M	" 8	9 "
39	70	18	F	" 6	11 "

CASE	SOCIAL QUOTIENT SCORE	DISCREPANCY SCORE	SEX OF CHILD	MOTHERS' LEVEL OF EDUCATION	AGE OF CHILD
40	42	39	M	Grade 7	13 years
41	93	63	F	" 8	10 "
42	68	69	M	" 11	9 "



By
EDGAR A. DOLL, Ph.D.
Consulting Psychologist
Bellingham, Washington, Public Schools
Formerly Director of Research
The Training School at Vineland, N. J.

APPENDIX B

Vineland Social Maturity Scale

NAME..First........Sex..........Grade........Date........Year........Month........Day
(Last)

Residence..School........................Born........Year........Month........Day

MA..................I.Q...............Test Used........................When....................Age........Years........Months........Days

Occupation..Class....................Years Exp................Schooling....................

Father's Occupation..Class....................Years Exp................Schooling....................

Mother's Occupation..Class....................Years Exp................Schooling....................

Informant..Relationship........................Recorder........................

Informant's est...Basal Score*........................

Handicaps...Additional pts........................

REMARKS: Total score........................

Age equivalent........................

Social quotient........................

Age Periods

O - I

Category†	Score*	Items	LA Mean
C	....	1. "Crows"; laughs	.25
SHG	....	2. Balances head	.25
SHG	....	3. Grasps objects within reach	.30
S	....	4. Reaches for familiar persons	.30
SHG	....	5. Rolls over	.30
SHG	....	6. Reaches for nearby objects	.35
O	....	7. Occupies self unattended	.43
SHG	....	8. Sits unsupported	.45
SHG	....	9. Pulls self upright	.55
C	....	10. "Talks"; imitates sounds	.55
SHE	....	11. Drinks from cup or glass assisted	.55
L	....	12. Moves about on floor	.63
SHG	....	13. Grasps with thumb and finger	.65
S	....	14. Demands personal attention	.70
SHG	....	15. Stands alone	.85
SHE	....	16. Does not drool	.90
C	....	17. Follows simple instructions	.93

†Key to categorical arrangement of items:
SHG — Self-help general; C — Communication; L — Locomotion
SHD — Self-help dressing; SD — Self-direction; O — Occupation
SHE — Self-help eating; S — Socialization

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I - II

L .... 18. Walks about room unattended 1.03
O .... 19. Marks with pencil or crayon 1.10
HE .... 20. Masticates food 1.10
HD .... 21. Pulls off socks 1.13
O .... 22. Transfers objects 1.20
HG .... 23. Overcomes simple obstacles 1.30
O .... 24. Fetches or carries familiar objects 1.38
SHE .... 25. Drinks from cup or glass unassisted 1.40
HG .... 26. Gives up baby carriage 1.43
S .... 27. Plays with other children 1.50
SHE .... 28. Eats with spoon 1.53
L .... 29. Goes about house or yard 1.63
SHE .... 30. Discriminates edible substances 1.65
C .... 31. Uses names of familiar objects 1.70
L .... 32. Walks upstairs unassisted 1.75
SHE .... 33. Unwraps candy 1.85
C .... 34. Talks in short sentences 1.95

II - III

SHG .... 35. Asks to go to toilet 1.98
O .... 36. Initiates own play activities 2.03
SHD .... 37. Removes coat or dress 2.05
SHE .... 38. Eats with fork 2.35
SHE .... 39. Gets drink unassisted 2.43
SHD .... 40. Dries own hands 2.60
SHG .... 41. Avoids simple hazards 2.85
SHD .... 42. Puts on coat or dress unassisted 2.85
O .... 43. Cuts with scissors 2.88
C .... 44. Relates experiences 3.15

III - IV

L .... 45. Walks downstairs one step per tread 3.23
S .... 46. Plays cooperatively at kindergarten level 3.28
SHD .... 47. Buttons coat or dress 3.35
O .... 48. Helps at little household tasks 3.55
S .... 49. "Performs" for others 3.75
SHD .... 50. Washes hands unaided 3.83

IV - V

SHG .... 51. Cares for self at toilet 3.83
SHD .... 52. Washes face unassisted 4.65
L .... 53. Goes about neighborhood unattended 4.70
SHD .... 54. Dresses self except tying 4.80
O .... 55. Uses pencil or crayon for drawing 5.13
S .... 56. Plays competitive exercise games 5.13

V - VI

O .... 57. Uses skates, sled, wagon 5.13
C .... 58. Prints simple words 5.23
S .... 59. Plays simple table games 5.63
SD .... 60. Is trusted with money 5.83
L .... 61. Goes to school unattended 5.83

VI - VII

SHE .... 62. Uses table knife for spreading 6.03
C .... 63. Uses pencil for writing 6.15
SHD .... 64. Bathes self assisted 6.23
SHD .... 65. Goes to bed unassisted 6.75

VII - VIII

SHG .... 66. Tells time to quarter hour 7.28
SHE .... 67. Uses table knife for cutting 8.05
S .... 68. Disavows literal Santa Claus 8.28
S .... 69. Participates in pre-adolescent play 8.28
SHD .... 70. Combs or brushes hair 8.45

VIII - IX

O .... 71. Uses tools or utensils 8.50
O .... 72. Does routine household tasks 8.53
C .... 73. Reads on own initiative 8.55
SHD .... 74. Bathes self unaided 8.85

IX - X

SHE .... 75. Cares for self at table 9.03
SD .... 76. Makes minor purchases 9.38
L .... 77. Goes about home town freely 9.43

X - XI

C .... 78. Writes occasional short letters 9.63
C .... 79. Makes telephone calls 10.30
O .... 80. Does small remunerative work 10.90
C .... 81. Answers ads; purchases by mail 11.20

XI - XII

O .... 82. Does simple creative work 11.25
SD .... 83. Is left to care for self or others 11.45
C .... 84. Enjoys books, newspapers, magazines 11.58

XII - XV

S .... 85. Plays difficult games 12.30
SHD .... 86. Exercises complete care of dress 12.38
SD .... 87. Buys own clothing accessories 13.00
S .... 88. Engages in adolescent group activities 14.10
O .... 89. Performs responsible routine chores 14.65

XV - XVIII

C .... 90. Communicates by letter 14.95
C .... 91. Follows current events 15.35
[illegible] .... 92. Goes to nearby places alone 15.55
D .... 93. Goes out unsupervised daytime 16.13
D .... 94. Has own spending money 16.53
D .... 95. Buys all own clothing 17.37

XVIII - XX

L .... 96. Goes to distant points alone 18.05
D .... 97. Looks after own health 18.48
O .... 98. Has a job or continues schooling 18.53
D .... 99. Goes out nights unrestricted 18.70
D .... 100. Controls own major expenditures 19.68
D .... 101. Assumes personal responsibility 20.53

XX - XXV

D .... 102. Uses money providently .... 21.5 +
S .... 103. Assumes responsibility beyond own needs .... 21.5 +
S .... 104. Contributes to social welfare .... 25 +
D .... 105. Provides for future .... 25 +

XXV+

O .... 106. Performs skilled work .... 25 +
O .... 107. Engages in beneficial recreation .... 25 +
O .... 108. Systematizes own work .... 25 +
S .... 109. Inspires confidence .... 25 +
S .... 110. Promotes civic progress .... 25 +
O .... 111. Supervises occupational pursuits .... 25 +
D .... 112. Purchases for others .... 25 +
O .... 113. Directs or manages affairs of others .... 25 +
O .... 114. Performs expert or professional work .... 25 +
S .... 115. Shares community responsibility .... 25 +
O .... 116. Creates own opportunities .... 25 +
S .... 117. Advances general welfare .... 25 +

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APPENDIX C

THE UNIVERSITY OF MANITOBA
School of Social Work

THE RATING SCALE

Mother's Name...................................

Address...

Telephone.......................................

Child's Name....................................

Age...

School he (she) attends.........................

TRAITS	COLUMN I	COLUMN II
	My child is . . .	I wish my child were . . .
Aggressive	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Alert	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Ambitious	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Annoying	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Anxious	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Busy	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Calm	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Competitive	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Confident	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Confused	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Considerate	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Cruel	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Defiant	1 2 3 4 5 6 7	1 2 3 4 5 6 7

	My child is . . .	I wish my child were . . .
Demanding	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Dependable	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Destructive	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Docile	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Dominating	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Fearful	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Friendly	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Hostile	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Inquisitive	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Jealous	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Meddlesome	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Merry	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Nagging	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Negative	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Nervous	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Patient	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Possessive	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Reckless	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Selfish	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Self-sufficient	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Sensitive	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Spoiled	1 2 3 4 5 6 7	1 2 3 4 5 6 7

	My child is . . .	I wish my child were . . .
Stable	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Timid	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Ungrateful	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Well-mannered	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Withdrawn	1 2 3 4 5 6 7	1 2 3 4 5 6 7

KEY

(1) Never

(2) Seldom

(3) Occasionally

(4) About half of the time

(5) Frequently

(6) Very frequently

(7) Always

APPENDIX D

THE UNIVERSITY OF MANITOBA

School of Social Work

GROUP D

DEFINITION OF TRAITS ON THE RATING SCALE

Aggressive	- unpeaceful, belligerent, shows fight.
Alert	- watchful, attentive, takes notice.
Ambitious	- purposeful, pursues something, bent upon doing certain things.
Annoying	- vexing, bothersome, source of irritation.
Anxious	- uneasy, unsatisfied, concerned, on pins and needles.
Busy	- active, animated, lively, eager, on the go.
Calm	- tranquil, mild, peaceful, gentle as a lamb.
Competitive	- contrary, ready to pitch into things.
Confident	- firm trust in oneself or ones chances, feeling or showing assurance.
Confused	- thrown into disorder, mixed up, fail to know which is which.
Considerate	- thoughtful for others, careful not to hurt feelings or give inconvenience.
Cruel	- delighting in or callous to other's pain or act illustrating these feelings.
Defiant	- expressing disbelief in power of (person) to do, refusing obedience to or set at naught authority.
Demanding	- constantly making requests.
Dependable	- reliable.
Destructive	- destroy, make away with, reduce to nothing or to uselessness.

Docile	- gentle, tractable, teachable, submissive, easily managed or handled, readily trained or taught.
Dominating	- controlling, ruling over, governing, to tower above, overshadow.
Fearful	- afraid, frightened, timid, nervous, apprehensive, restless, fidgety, anxious, dismayed.
Friendly	- familiar, cordial, hospitable, neighborly, on good terms, amiable, genial, kindly, inclined to approve, help or support.
Hostile	- antagonistic, opposed, unfriendly, belligerent, adverse.
Inquisitive	- desirous of or eager for knowledge, curious, prying, questioning, meddlesome.
Jealous	- covetous, envious, suspicious, resentment against a successful rival, suspicious fears.
Meddlesome	- interfering, concerned with or in something without warrant or necessity.
Merry	- cheerful, good humor.
Nagging	- disagreeing.
Negative	- contrary, opposite.
Nervous	- restless, fear and trembling.
Patient	- persistent, constant, steady.
Possessive	- holding, to keep, to seize, not wanting to give up.
Reckless	- impulsive, rash, acting without thinking.
Selfish	- to look after one's own interest, not sharing freely.
Self-sufficient	- independent, able to look after oneself.

Sensitive	- impressionable, easily moved.
Spoiled	- gets own way.
Stable	- secure, level-headed, firm, being able to take daily ups and downs.
Timid	- fearful, cowardly, shy.
Ungrateful	- thankless.
Withdrawn	- shrinks away from.