RETARDED CHILDREN IN THE LOCAL CHURCH

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Evelyn Claire Brubaker
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Examining Committee

Paul R. Dunk
P. Frederick Fogle
PREFACE

After having taught retarded children in special education in the public school, this writer became interested in the possibility of helping retarded children through the local church. This thesis is the result of her study of retardation as it affects Christian education. It is hoped that this study will make a valuable contribution to Christian education literature in the field of retardation.

Many people helped to make the production of this thesis possible. The writer is sincerely grateful to Professor Paul R. Fink for his help as adviser, and Mr. Howard L. Wilson, Director of Cardinal Learning Center, Warsaw, Indiana, for his help in conducting the parent survey.
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CHAPTER I
INTRODUCTION
CHAPTER I

INTRODUCTION

The church is filled with children. They come and they learn; they are taught and they grow. They pass through the church programs and then they go out trained to reach others. This is what Christian education is all about.

Other children come to the church. They come, but they do not learn; they do not grow. They pass through the classes, perhaps, but they remain children. Yet they can be helped. They are the retarded children, the three out of one hundred children whose minds do not develop as they should. Yet they can learn that God loves them. They can learn to love Him. This is Christian education too.

Need of the Study

Approximately 3% of the general population is retarded, and most of these are children. Thus a Sunday school of 100 children could expect to have three retarded children. A church with 500 members could expect to have fifteen retarded persons. If the normal population is represented to these degrees in evangelical churches, then something must be done for these retarded children and their parents.

To determine the need for this study, the twenty-five largest Brethren churches were surveyed by questionnaire regarding their programs for retarded children. Forty-seven retarded children were
reported from the fifteen churches that responded. Only two churches
had special classes, but the remaining thirteen all were willing to hold
special classes if there were enough children. Eleven pastors reported
having counseled with parents of retarded children. Only eight of the
fifteen pastors had read any books on retardation, but almost all of
them expressed an interest in having more information on retardation and
Christian education.

A second survey was made of eleven parents of children enrolled
in a local class for trainable retarded children. Only six of the chil-
dren were enrolled in Sunday school and none in a special class. All
eleven parents felt that their children could learn about God. Five
reported having received counseling from their pastors. While only one
said he would attend another church if it offered a special class, four
wanted their own churches to establish special classes. Most parents
felt that the churches didn't really understand the problem.

The need for churches to understand and to do something for
retarded children can be seen from one mother's response regarding what
the church could do to help her daughter. "I would like the church
people to be kind and thoughtful to her and not tell her to stay home." 1

These brief samples are in no way conclusive, but they do demon-
strate the need for churches to do something for retarded children and
their parents.

Purpose and Scope of the Study

As Christian education reaches out into every area of the church
and strives to teach every child and every adult, it becomes necessary

1Reply in answer to questionnaire.
for Christian education leaders and pastors to have a basic understanding of mental retardation as it affects children in the local church. It is the purpose of this study to provide church workers with basic understanding of mental retardation with the two-fold aim of helping the parents and of teaching the child. This study will include both trainable and educable retarded children and will be limited to those children who live at home with their parents. The focus of Christian education will be as it affects the Sunday school.

**Method of the Study**

In developing this study it will be the purpose to suggest what the church can do to meet the needs of its retarded children. Three main suggestions will be made: (1) the church can understand retardation, (2) the church can understand the three types of retarded children, and (3) the church can help the parents of retarded children. In the first suggestion the necessary facts about the general nature of mental retardation with its definition, characteristics, and causes will be discussed. In the second suggestion the three most frequently appearing types of retardation among children in the church will be given extensive consideration. In developing the third suggestion the needs and means of counseling the parents and of teaching retarded children in the Sunday school will be explored.

To make this study of greater benefit terms will be defined not only as they occur in the text but also in a special Glossary of Terms at the end of the work. Various tables will also be included to provide a clearer understanding of technical concepts and additional helps will be compiled in the Appendix. With the general plan thus in mind preparation is now made for consideration of the first suggestion.
CHAPTER II
THE CHURCH CAN UNDERSTAND RETARDATION

Introduction

A teacher is to teach; a student is to learn. It seems so simple. But then there is that special child, the retarded child, the one in thirty who cannot learn like the others. What will become of him? In the educational忽略了部分，他应该有比正常人更大的学习能力。他能理解他?

If a church is to meet the needs of its retarded children and their families, Christian educators and pastors need to have a working knowledge of the facts about retardation. Even in today's intellectually enlightened and well-read society, gross misconceptions and unfounded fears of retardation exist. It is the purpose of this chapter to provide church workers with a better understanding of mental retardation as to its definition, etiology, and description.

Development

Mental retardation is no new thing. Although its importance in the educational context is recent, in the century, intellectually normal persons have been born in every age. The study of retardation in America has several phases of development. Prior to this time little
CHAPTER II

THE CHURCH CAN UNDERSTAND RETARDATION

Introduction

A teacher is to teach; a student is to learn. It seems so simple. But then there is that special child, the retarded child, the one in thirty who cannot learn like the others. What will become of him in the educational agencies of the local church? None would deny that he should have the right to learn as much as he is capable of learning. Yet who can be found to teach him or even to understand him?

If a church is to meet the needs of its retarded children and their families, Christian education leaders and pastors need to have a working knowledge of the facts about retardation. Even in today's intellectually enlightened and well-read society gross misconceptions and unfounded fears of retardation exist. It is the purpose of this chapter to provide church workers with a better understanding of mental retardation as to its definition, etiology, and description.

Development

Mental retardation is no new thing. Although its importance in the educational context is recent in this century, intellectually sub-normal persons have been born in every age. The study of retardation in America has several phases of development. Prior to this time little
formal attention was given the retarded. These periods are not bounded by specific dates but reflect general trends.

Institutionalization

The years from 1850-1900 represent the institutional period. During this time the retarded and mentally ill alike were crowded into monstrous institutions with no thought given for their education and little for their care.¹

Alfred Binet, director of a psycholaboratory in Paris in 1904, headed a commission to investigate helping retarded children. This necessitated devising some way to determine which children were retarded, and so the psychological test, or the so-called IQ test, was born. Revised and refined many times, this test is now known as the Stanford-Binet Intelligence Scale.²

Public Awakening

Early in the 1900s compulsory school attendance forced the public schools to identify children who were unable to learn. This identification was made possible by the new IQ test. The immediate result was an increased interest in retardation. In 1912 the famed book was published, The Kallikak Family—A Study in the Heredity of Feeblemindedness.³ This not-too-well-founded study of an inbred family of retardates caused an educational stir and occasioned new studies and many

books on retardation. The general response, however, was one of fear and misconceptions. Levinson records a typical reaction for educational sources of the period: "The defect is often hereditary and incurable; it leads to poverty, degeneracy, crime, and disease."¹ By 1915 committees were being formed to find ways to "wipe out" mental retardation. "The most soberly considered ways were sterilization and segregation."²

**Special Classes**

Although the ensuing reports were often misleading and erroneous, yet they served to effect an important end. The result of all the attention was that it brought retardation out of the shadows of the institutions and into the public's awareness. As early as 1911 the special class movement began in New Jersey and spread until special education classes for the retarded exist in most school districts. But it is estimated that even now one-third to one-half of our retarded children are not placed in special classes.³

**Parent Associations**

There was yet another important result of the exposure of mental retardation to the public. As late as the 1930s parents often kept retarded children hidden in back rooms. But as the public discovered that retardation can and does occur in families of wealthy and educated people as well as to uncouth and illiterate ones, parents began to band together to do all they could to help their children. In this fashion the parent association was created. 1950 saw the formation of the National Association for Retarded Children. Immediately followed many

¹Levinson, p. 52. ²Ibid. ³Ibid., p. 51.
schools, clinics, and workshops instituted by parents' groups. The parents began agitating for action. Where there is concern there is progress and action.

Today retardation is more openly and frankly viewed than ever before. The lid is off; the problem is here to stay. Christian educators must know what they face.

**Definition of Retardation**

At this point it becomes necessary to clarify just what is meant by mental retardation. It is neither the same as mental illness nor is it shameful or contagious. But it is more difficult to define precisely what it is. Hutt and Gibby suggest that there are many complex facets to the consideration of intelligence and retardation:

> a modern concept of mental retardation must embrace far more than a consideration of intellectual factors alone. It must embrace all aspects of the child's maturation—including those of personality. It must also embrace more than the child's social adjustment. The intellectual functioning of a child cannot be considered apart from his emotional and personality functioning. Each of these does not exist as a separate "thing." Thus we must widen the scope of our approach—we must deal with the whole child in all his complexity.

**Concept of Retardation**

Understanding that retardation is not as simple a matter as a bare IQ score, the American Association on Mental Deficiency has adopted a concise definition of mental retardation written by Rick Heber:

Mental retardation refers to subaverage general intellectual functioning which originates during the developmental period and is

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associated with impairment in one or more of the following: (1) maturation, (2) learning, and (3) social adjustment.\(^1\)

Several of the terms used in this definition will be discussed briefly.

**Sub-average intellect.**—This includes all persons whose IQ scores fall one or more standard deviation below the general average as determined on a standardized psychological test. The upper limit varies, but below 84-80 is considered sub-average.

**Developmental Period.**—This is the time from conception to age sixteen when the intellect has reached adult capacity.

**Impairment of behavior.**—This impairment is determined in three areas. (1) The rate of maturation refers to the development of self-help skills: sitting, crawling, walking, talking, habit training and relations with others. These are important as detectors of retardation in preschool years. (2) Learning is understood to mean "... acquiring knowledge as a function of experience."\(^2\) This is best evaluated in the academic situation when the child enters school. Many mild cases of retardation are not identified until school failure occurs. (3) Social adjustment is evaluated in terms of the person's effectiveness in meeting the natural and social demands of his environment.\(^3\) This can be seen in the young child's ability to react acceptably to his parents and

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2. G. W. Jacoby, M.D., Medical Director, Apple Creek State Hospital. From a worksheet compiled for a workshop in connection with Special Education Department, Kent State University, Kent, Ohio.

siblings and peers. Later, it can be measured in terms of his ability to support himself in the community.

Mental retardation may be present in any one of these areas alone, but by the very nature of this affliction usually all three areas are sub-average as compared with accepted normal adaptive behavior.¹

This concept of mental retardation considers it as a developmental condition. It places the emphasis on the present level at which a child functions. It also makes no reference to innate intellectual capacity, origin of the defect or permanence. It merely describes a condition that presently exists and affects the child.

Concept of IQ

Deeply ingrained in the American mind is the concept of IQ. Frequent articles in popular magazines claim that parents can raise their child's IQ or other such appealing ideas. The sales soar; but the truth remains that while a test score may indeed be elevated, and can even vary greatly from day to day, the innate, in-born, God-given reasoning-thought capacity cannot be significantly altered.²

IQ is not synonymous with intelligence. It stands for Intelligence Quotient and is nothing more than a mathematical tool to express the relationship that exists between the chronological age of a child and the age (mental age) at which he is functioning. It may be expressed as CA × 100. The IQ, then, is not a magical formula that determines what a child can or cannot do. It is rather an attempt to express the fractional relationship between what a child should be able

¹Jacoby, Ibid.

to do at his life age and what he can actually do as determined by his performance on a psychological test.

Concept of Intelligence Tests

Alfred Binet, father of intelligence testings, purposed that his first test should require the child to "... perform tasks showing what he is capable of in the way of comprehension, judgment, reasoning, and invention." The IQ test consists of a series of verbal and manual tasks arranged in the logical order in which a normal child would learn to perform them ranging from simple to complex. Thus an eight year old child who could only do tasks the average four year old can do is said to have half of the expected normal intelligence (IQ-100) or an IQ of 50 with a mental age of 4. A child of ten with an IQ of 60 could be expected to function no higher than the normal child of six. Conversely, by the same principle a ten year old who functions only at the seven year level can be said to have an IQ of 70.

Concept of Mental Age

The IQ is useful as a means of comparing children. However, it is more helpful and meaningful to both parents and teachers to think in terms of the child's mental age rather than of a meaningless score. The IQ is best used as an indicator of the mental age expectancy. Naturally, as the chronological age of the child advances, the mental age also enlarges, but at a rate one-half to three-fourths as slowly. Regardless of the progression of the chronological age, then, the IQ continues

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1Levinson, p. 50. Quoting Binet, no source.
to indicate the optimal functioning level. However, this is not to guarantee that a retarded child can automatically do everything a normal child of the same mental age can do. He cannot. It means, rather, that with careful systematic training he can be expected to perform only that well. That would be the ceiling of his expectancies. Like normal children, few retarded children consistently work up to their limited capabilities. The IQ, then, is a useful tool in helping to determine the developmental level or mental age of a child, as mental retardation is best viewed as a developmental condition.

Table I can serve to illustrate concisely the proportionate relationship between chronological age, IQ, and mental age. By glancing at such a table a teacher can quickly estimate at what level a child may be expected to perform. If the teacher knows that a six year old's IQ is near 55, he may use this table to discover that his mental age is approximately 3-4, or third year, fourth month.

**Diagnosis**

The diagnosis of mental retardation is not based on IQ alone. The above-mentioned factors of learning, maturation, and social adaptation must be considered. Other systems consider both the physical cause of the defect and the symptoms involved rather than IQ. Diagnosis may be made by a competent psychologist or neurologist. Diagnosis of clinical cases may be made by a pediatrician.

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1Ibid.
TABLE 1
ESTIMATED MENTAL AGES FOR INCREASING CHRONOLOGICAL AGES AND IQ

<table>
<thead>
<tr>
<th>IQ</th>
<th>Chronological Age</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6</td>
</tr>
<tr>
<td>30</td>
<td>1-10</td>
</tr>
<tr>
<td>40</td>
<td>2-5</td>
</tr>
<tr>
<td>50</td>
<td>3-0</td>
</tr>
<tr>
<td>55</td>
<td>3-4</td>
</tr>
<tr>
<td>60</td>
<td>3-7</td>
</tr>
<tr>
<td>65</td>
<td>3-11</td>
</tr>
<tr>
<td>70</td>
<td>4-3</td>
</tr>
<tr>
<td>75</td>
<td>4-6</td>
</tr>
<tr>
<td>80</td>
<td>5-1</td>
</tr>
</tbody>
</table>

Rule of Fives: To derive grade capacity subtract 5 from the mental age. So for a pupil with a mental age of 8-0, subtract 5 to find that his capacity for school work is at the beginning of grade three.

\[
\text{8-0 MA} - \frac{5}{3-0 \text{ grade level}}
\]

Mental Age: The mental age is expressed in terms of year and month. MA 5-6 is interpreted to mean the fifth year, sixth month.

1Department of Special Education, Kent State University, Kent, Ohio, 1965.
Degrees of Retardation

The range of abilities among retardates is almost as great as that among persons of normal and superior ability. To describe a child merely as retarded tells little about him. Various schemes of degrees of retardation have been devised and numerous names created to describe them. Earlier designations such as moron, imbecile and idiot are no longer acceptable. More exact and emotion-free terms are preferred.

Based on IQ

Despite the inadequacies of the IQ, it is still necessary for the classification of ability levels. Many such classifications are used, but the following one proposed is representative and simple. The following terms and divisions will be referred to throughout this work. Mild retardation refers to IQs 80-66. Moderate retardation includes IQs 65-50. Mildly and moderately retarded children are generally reared in the home. Severe retardation ranges from IQs 49-25. These children may or may not be institutionalized. Profound retardation occurs below IQ 25. These children are more usually placed in custodial institutions.

As retarded children vary and as no IQ score can be precise, the cut-off lines between the various levels must be flexible. There may be no intellectual difference between youngsters with IQs of 49 and 51, yet one would be termed severely and the other moderately retarded. This serves as an illustration of the reason maturity, learning, and social development as well as etiology must be considered.
Based on Educational Expectancy

Retarded children are also described and classified by terms indicating their educational expectancy. Again IQ scores are used, and again the divisions are rather arbitrary and flexible. **Borderline children with IQs 82-76 may achieve as high as a fifth grade level. Educable retarded children with IQs 75-50 can profit from academic instruction in special education classes and may achieve as high as a third or fourth grade level. Trainable retarded children, IQs 49-25, cannot benefit from academic instruction. They can profit from attending special schools and workshops to learn self-care and communication skills. At maturity they will function at best at a four to six year old level. Custodial children are those profoundly retarded children who have no educational future. A few are able to help meet their personal needs; most remain dependent upon custodial care.** Table 2 illustrates this classification system concisely for easy reference.

**Divisions of Etiology**

**Definition of Common Terms**

Etiology is used to refer to the investigation of the cause of retardation. The terms **familial** and **endogenous** will be used interchangeably to describe children lacking physical cause for retardation and whose families show evidence of retardation. **Educable mentally retarded** will be used to indicate children within the IQ range 50-70. The terms **brain-injured**, **brain-damaged**, **organic** and **exogenous** will be used synonymously to refer to children whose mental retardation can be ascribed to some physical or organic cause. **Mental deficiency**, **mental**
handicap and mental retardation will be used to describe the same condition.

TABLE 2
A CLASSIFICATION OF RETARDATION

<table>
<thead>
<tr>
<th>Level</th>
<th>IQ</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on IQ</td>
<td></td>
</tr>
<tr>
<td>Mild Retardation</td>
<td>80-66</td>
</tr>
<tr>
<td>Moderate Retardation</td>
<td>65-50</td>
</tr>
<tr>
<td>Severe Retardation</td>
<td>49-25</td>
</tr>
<tr>
<td>Profound Retardation</td>
<td>24-</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Level</th>
<th>IQ</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on Educational Expectancy</td>
<td></td>
</tr>
<tr>
<td>Borderline</td>
<td>82-76</td>
</tr>
<tr>
<td>Educable</td>
<td>75-50</td>
</tr>
<tr>
<td>Trainable</td>
<td>49-25</td>
</tr>
<tr>
<td>Custodial</td>
<td>24-</td>
</tr>
</tbody>
</table>

Etiology of Endogenous Retardation

Endogenous retardation is due to causes within the genetic structure of the child and is called hereditary. In rare cases retardation can be caused by a dominant gene or by a defective gene. Several more common types of hereditary retardation due to recessive genes and abnormal chromosomes will be discussed here.

Recessive Genes

A common metabolic disorder that causes retardation, phenylkatonuria (PKU), is caused by a recessive gene. PKU accounts for 1% of all institutionalized retardates and occurs once in every 10,000
births. This defect is due to the absence of the specific enzyme in the body chemistry that changes a protein into a more usable form. As a result phenylpyruvic acid is released into the blood stream and it damages the brain tissue. This condition can be easily identified by the musty odor of the infant's urine. A simple diaper test, now required in many states, can detect the defect in the first week of life. If the diet is adjusted to eliminate foods that contain the specific protein by a rigid diet until age four, it is thought that the danger of retardation can be eliminated. PKU almost always results in severe retardation; many have to be institutionalized. It is interesting to note that almost all are blonde and blue-eyed. This too is related to the gene.

Many Genes

Retardation which is apparently without organic cause or radical symptoms is inherited, like facial features, by many genes. Almost all such children fall in the mild or moderate ranges of intelligence and come from families in which at least one relative evidences some retardation. This is called familial retardation and will be more completely discussed in chapter three.

Abnormal Chromosomes

A large proportion of severe retardation is due to an abnormal chromosome. Down's Syndrome or mongolism is a common cause of severe retardation. It has recently been discovered that mongols' cells contain 47 instead of the normal 46 chromosomes. This error in

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1 Robinson and Robinson, p. 109. 2 Hutt and Gibby, p. 79. 3 Robinson and Robinson, p. 104.
chromosomes is the cause of mongolism. This syndrome will be more completely discussed in chapter three.

**Etiology of Exogenous Retardation**

Retardation that results from an external factor is exogenous, commonly called brain-injury. This refers to all forms of mental retardation that are not genetically caused from within the child himself. It specifies retardation caused by some external infection or trauma suffered by the individual before, during, or after birth. The possible causes of brain injury are many. Representative causes will be discussed here.

**Prenatal Causes of Brain Injury**

Prenatal injury of the brain may be due to physical blows (trauma), infection, anoxia, toxic reactions, or malnutrition.

**Trauma.**—Any physical blow to the mother might affect the unborn child. As the fetus is well protected there is little danger of injury, but severe trauma might cause injury.

**Infectious disease.**—Infectious disease in the mother is a more common cause of brain injury. Rubella, or German measles, is well known to cause severe central nervous system damage accompanied by mental retardation and frequently blindness if it is contracted by the mother during the first three months of pregnancy. Other infectious diseases in the mother that can cause retardation are syphilis and certain virus infections.

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Anoxia.—Oxygen deprivation, or anoxia, can result from a disorder in the mother’s system such as a heart defect or internal bleeding. This lack of oxygen causes the deterioration of brain tissue.

Toxic reactions.—Chemical reactions due to poisoning from drugs and alcohol in the mother’s bloodstream may reach the unborn child and cause damage.

RH factor.—The mother’s blood type might be negative and the baby’s positive. If the blood of the baby should pass through the placenta into the mother’s bloodstream, although this doesn’t normally occur, the mother becomes “allergic” to the infant, and her body begins to build up antibodies that will destroy the baby’s red blood cells which carry the life-giving oxygen to the brain. Mental retardation, serious defects and even death can result. The first child is generally safe; the danger increases in each following conception.¹

Malnutrition.—A serious lack in the mother’s nutrition may result in a chemical imbalance in the child which may then cause brain injury.

Neonatal Causes of Brain Injury

It is said that being born is the most traumatic event that will ever occur in a human’s life. Many times the birth is difficult and the infant is injured. Common birth hazards that cause brain injury are prematurity, anoxia and trauma.

Prematurity.—Prematurity is a frequent factor in brain damage. Any infant weighing less than 5.5 pounds at birth is considered

¹Ibid., p. 10.
The more premature the infant is, the greater are the chances of its being defective. Premature birth may be caused by disease in the mother, by detachment of the placenta, or by many other factors; thus the infant may have already been injured before birth. This incomplete baby has to complete his development in an artificial environment. "He must rely on his own breathing, digestive, and waste-removal systems, which at a premature level often are not capable of meeting his needs adequately." He also is not as able as a full-term baby to stand the tremendous pressure exerted on him during the birth process and so is more liable to birth injury.

Socioeconomic position of the family is also a factor in prematurity and its resulting damage. The Robinsons say:

It is well known that both intelligence and prematurity are highly related to social status, and a finding of low intelligence in a group of premature children might thus reflect family background as thoroughly as it does the fact of premature birth.

Several studies have attempted to relate prematurity to retardation with interesting results. In a study of forty-nine children who had weighed less than three pounds at birth, Drillien found that one-half were ineducable in public schools because of mental or physical handicap or both, one-fourth required special education, and one-fourth were low average or better in intelligence. Her general conclusion is that there is a much increased risk in very small premature babies of brain injury and mental retardation.

1 Robinson and Robinson, p. 148. 2 Thorne, p. 11.
3 Robinson and Robinson, pp. 148-149.
Anoxia.—Retardation may be caused by oxygen deprivation during the birth process. If the life-carrying umbilical cord is kinked or strangled during a difficult or prolonged labor or if it detaches too soon so that oxygen is cut off for even a few minutes, the brain of the infant may be seriously damaged. Anoxia may also occur if the baby fails to begin to breathe immediately.

Trauma.—The baby might also be injured by physical force in a difficult labor. Danger is greater if the baby is presented feet first or bottom first (breach) rather than head first. The use of forceps and other instruments may also damage the baby’s head. Very rapid labor (less than two hours) may also cause brain damage because the rapid change of pressure on the head may cause hemorrhages in the brain.¹

Postnatal Causes of Retardation

Mental retardation can be caused by any of numerous factors brought to bear on the brain at any point in the young child’s life. Some postnatal causes to be discussed are infectious diseases, toxins, skull defects, and trauma.

Infectious diseases.—Most postnatal brain injury is due to infectious disease. The danger is caused by inflammation of the brain and its linings and the destruction of tissue. Among these, the various forms of menengitis and encephalitis are the greatest contributors to mental retardation.

Menengitis, caused by a bacteria, affects the linings or meninges of the brain. This disease used to be fatal; modern drugs now keep alive hundreds of children who are permanently impaired. The

¹Thorne, p. 11.
epidemic form, cerebrospinal menengitis, caused by the meningococcus bacteria, is less deadly.\(^1\) As a result, more children survive it; thus it causes more retardation than other forms. The degree of the resulting retardation varies from profound to mild. Other side effects may be deafness, paralysis or epilepsy.\(^2\) If diagnosed quickly and treated by antibiotics, menengitis does not present the severe threat it once did.\(^3\)

Encephalitis is simply a brain inflammation resulting from any number of viruses. It also results from the fever of childhood diseases, usually measles, but also scarlet fever, whooping cough and chicken pox. Mental retardation and/or epilepsy may result as well as definite personality changes. The epidemic form known as sleeping sickness causes the same personality changes and mental deterioration.\(^4\)

**Toxins.**—Poisoning by lead, carbon monoxide and other toxins "can produce very severe inflammation of the brain with subsequent hemorrhages and lesions."\(^5\) A common source of lead poisoning used to be the paint on infants' furniture and toys until safer plastic paints were developed. Although rather rare, lead poisoning is extremely dangerous. Few children die; but few who develop brain infection avoid mental retardation.

**Skull defects.**—Hydrocephalus is a common abnormal skull condition that causes retardation. It is frequently called water-on-the-brain. The head is greatly enlarged due to the accumulation of cerebral

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\(^1\) Robinson and Robinson, p. 155.  
\(^2\) Ibid.  
\(^3\) Thorne, p. 13.  
\(^5\) Robinson and Robinson, p. 154.
spinal fluid that normally drains off. This excess pressure stretches the skull and squeezes the brain causing severe retardation and death. Fortunately a drain can be surgically made for this extra fluid and the damage controlled.

In microcephalus, the bones of the skull fuse before the brain has a chance to grow and develop. The result is severe retardation.

**Trauma.**--Trauma is a frequent cause of brain injury in young children. Any severe blow to the head may result in hemorrhages, blood clots, or lesions (cuts) in the brain. If the brain is damaged its function is impaired; injury to the cortex would impair thinking while injury to other parts may cause paralysis or cerebral palsy.

More severe and extensive brain injuries may not only affect thinking and learning, but also the control of some of the more basic physical functions of the body, such as circulation and respiration. In such cases the damage is more profound and indeed may ultimately result in death.

In this study, brain injury will be limited to that causing only psychological and behavioral impairment.

These are the major contributing factors in exogenous, non-hereditary mental retardation.

**Summary**

In this chapter it has been shown that mental retardation is a developmental lag in physical, social, and intellectual maturation. It was shown that the IQ is the relationship between what a child should be able to do and what he actually can do. Some of the causes of retardation have been examined. With an understanding of these basic facts as

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1 Thorne, p. 19.  
2 Ibid., p. 18.  
3 Ibid.
a foundation, preparation is now made to study in greater detail causes and characteristics of three of the most frequently occurring types of retardation.
CHAPTER III
THE CHURCH CAN UNDERSTAND THREE TYPES OF RETARDED CHILDREN

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Sunday morning comes and so do the children. A young mother carefully brings to the door of the beginner department a stocky little child with a flat face and puffy slanted eyes. The child is weak, she sits quietly, she talks solemnly, but she does not laugh.

She is a mongoloid.

As usual, attractively dressed, she runs around, he hits the child next to him. He seems anxious to love, but he cannot sit still. He cannot listen. He cannot read or write. Other children shun him. Teachers despair of him. They think he is lazy and undisciplined. He is brain-injured.

The class of junior boys listens attentively to the teacher.

The dull, perhaps leading astray, perhaps just sitting. The boys are in gradebooks and begin to write answers and to read from their books. The other boy looks on. He can read only a few words; he can write only his name and a few simple words. He cannot comprehend what is going on as he just sits. He is not bad, he is not blind. He has no interest. He is not a problem. He is just plain slow. He has intellectual retardation.

They are really they are our children. When they come to our parishes we must be prepared to help them. Understanding the tasks of
CHAPTER III

THE CHURCH CAN UNDERSTAND THREE TYPES OF RETARDED CHILDREN

Introduction

Sunday morning comes and so do the children. A young mother apologetically brings to the door of the beginner department a stocky clumsy child with a flat face and puffy slanted eyes. The child is docile, she sits quietly, she beams broadly, but she does not learn. She is a mongoloid.

A small, attractive boy runs into the primary room. He calls out, he runs around, he hits the child next to him. He seems anxious to please, but he cannot sit still. He cannot listen. He cannot read or color. Other children shun him. Teachers despair of him. They think him lazy and undisciplined. He is brain-injured.

The class of junior boys listens attentively to the teacher. One sits dully, perhaps looking around, perhaps just sitting. The boys turn to workbooks and begin to write answers and to read from their Bibles. The other boy just sits. He can read only a few words, he can write only his name and a few simple words; he cannot comprehend what is asked of him so he just sits. He is not bad, he is not loud; no one resents him. He is not a problem. He is just plain slow. He has cultural-familial retardation.

They are real; they are our children. When they come to our churches we must be prepared to help them. Understanding the basic
concepts of mental retardation will be helpful. But pastors and other Christian education workers should be acquainted in more detail with three of the forms of retardation they will meet most frequently in the church family.

The purpose of this chapter is to discuss the causes, characteristics and implications for Christian education of mongoloid, brain-injured, and cultural-familial retarded children.

Mongolism

Definition

The name itself is a misnomer ascribed the slanty-eyed appearance of victims of this form of retardation which reminds many of an Oriental or Mongolian person, hence the terms mongoloid, mongolism and mongol. The clinical name is Down’s Syndrome. Mongolism is a type of retardation due to a defect in chromosomes resulting in a definite syndrome of physical characteristics and severe retardation.

Incidence

Mongolism accounts for 10% to 20% of all severely and profoundly retarded individuals.1 It commonly occurs in all strata of society; no group is immune. The incidence is as high as 1 of every 600 births. An interesting relationship exists between the age of the mother and the incidence of mongolism. The risk of bearing a mongol rises proportionately with the age of the mother. Thus for mothers from 15-24 the chance is 1 in 1500 and from age 25-34 it is 1 in 1000, while for

mothers of 35-39 the risk is 1 in 150, from 40-44 it is 1 in 70 and for
mothers over 45 the incidence is 1 in 38. It should be noted that
while young mothers face less risk statistically, there are in actuality
far more young mothers than older so that 1 of every 4 mongoloid chil-
dren is born to a mother under 30.

Etiology

Mongolism is endogenous in that it stems from a source within
the individual. Until recently mongolism was a great mystery somehow
related to the age of the mother. But since modern methods of cell
study have been developed, the chromosomal deviation that causes mongol-
ism has been identified and studied.

Historical development.—People have long recognized the strik-
ing similarities between completely unrelated mongoloid children. Many
felt genetic factors were to blame. Multiple cases in the same family
were rare; but they were, in fact, more frequent than they should have
been statistically. Of the few children reported born to mongoloid
mothers, about half were also mongoloid.

It was not until the late 1950's that cell preparation was suf-
ficiently advanced so that the chromosome defect could be identified. In
1959 three French researchers, Lejeune, Gautier, and Turpin, published
their discovery of extra chromosomes in the cells of mongols. Three
major causes of chromosomal deviation were found to result in mongolism.
They are (1) the failure of chromosomes to separate, (2) linking
together of chromosomes, and (3) inequality of chromosomes. The

1Ibid. 2Ibid., p. 98. 3Ibid., p. 104. 4Ibid.
The importance of chromosomes. The basic element of life, the cell, is only beginning to be understood. The nucleus of each cell is made up of genetic material, chromosomes which link with one another to form 23 pairs. As basic cell division proceeds and results in the growth of the embryo into a child, these 23 pairs of chromosomes also divide and are reproduced in each cell and govern the formation of the various body systems.¹

It has been found that nearly all mongoloid children possess 47 rather than the normal 46 chromosomes in their cells. There are now three known causes of mongolism related to this extra chromosome.

Failure of chromosomes to separate. Most mongolism is not hereditary or familial. The defect is caused when the chromosomes of one pair, #21, fail to separate in the process of cell division. This is called non-disjunction and it produces an abnormal ovum or egg with an extra chromosome, with three #21s instead of two.² This genetic disorder produces a child completely unlike either parent. This type is more common among older women, but the cause is yet unknown. Most mongoloid children are the result of non-disjunction.

Linking together of chromosomes. A familial type of mongolism is due to the translocation or linking together of two chromosomes. The result is the normal 46 chromosomes but with a "double dose" of #21. One of the child's parents had this translocation first, giving that

¹Tbid., p. 67.
individual all the normal chromosomal material in only 45 instead of 46 chromosomes. By the random sorting and distribution of the chromosomes in cell division, this "carrier" has one chance in three to produce a mongoloid child.

Robinson explains it:

Each conception may produce a normal offspring free of translocations, a clinically normal offspring with the translocation, or a mongoloid offspring.

The mongoloid child carries both the translocation (doubled-up chromosome) and an extra unattached chromosome #21 giving him, again, 47 chromosomes. Either parent may be the carrier of the translocation. This familial type of mongolism is more frequent among young mothers and the chances are that the young mother of a mongol will have other mongols.

Inequality of chromosomes.—A third cause of mongolism is very rare. Rather than in the ovum, this chromosome error, called mosaicism, takes place in the division of the cells of the tiny embryo. Some cells have 45 and others have 47 chromosomes. As a result the individual may have different numbers of chromosomes in various body systems. Not all individuals with this defect are mongols, but many are.

Characteristics

Physical symptoms.—Mongoloid children resemble each other in facial features and in body build. Other physical symptoms occur to

1Ibid. 2Robinson and Robinson, p. 105.


4Ibid.
some degree in most mongols, but no one child will have all of the following symptoms. The characteristic small head and flat face with puffy eyes, slanted in appearance due to the fold of skin at the inner corner, produce the Oriental look. Small, irregular teeth, shallow mouth and protruding tongue cause mouth-breathing and respiratory infections that contribute to their high mortality rate. A short neck, stubby fingers and toes, flat feet and palms with a single deep crease are also characteristic. They have sparse, coarse, straight hair, generally light-colored. Short stocky statures and poor muscle tone and congenital heart defects are also common.

Intelligence.—Most mongols are severely retarded with IQ's from 20-40. Institutionalized mongols have an average IQ of 25 while those living at home are somewhat higher. There seems to be no relation between the number of physical symptoms and the degree of retardation.

Personality.—More than any other type of retarded child, the mongoloid has a special reputation for being happy, docile, and friendly. Benda writes:

Mongoloid children, if treated well, are lovable little creatures full of affection and tenderness. A visitor of an institution summarized her observations: "As playmates, they are always hugging and kissing one another with vague but genuine smiles of affection. They come up and put their arms around the stranger as confidently as a puppy jumping up on a visitor, and though not understanding a word said to them, good-naturedly answer yes to any question, hoping that will please."

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1 Robinson and Robinson, p. 98.  2 Hutt and Gibby, p. 68.
3 Telford and Sawrey, p. 246.  4 Robinson and Robinson, p. 99.
However, not all mongols fit this stereotyped description. In one study of 75 mongoloid children living at home, 50% were rated as "docile-affective" while 14% were rated "aggressive-hostile." Another study found mongoloids less emotionally unstable and attention-seeking than non-mongoloid trainable children. It seems that the behavior pattern depends largely on the "affectional environment" of the child. Mongols, like any children, respond in kind to tension, frustration and anger or to love, acceptance and patience. However, these and other studies continue to support the idea that on the whole mongoloid children are docile and affectionate.

Learning

Educationally, mongoloid children are considered trainable. That is, they will not learn to read and write for all functional purposes. They can, however, be trained to perform simple tasks, to learn basic manners, to master habits of self-care, and to communicate their needs. They are dependent in most ways. In special classes they listen attentively to simple material presented on a concrete level and rarely tire of repeating routine tasks or of hearing favorite stories repeatedly. In sheltered workshops older mongols can be trained to do manual piece work under supervision. Mongoloids can also be taught to manage simple household tasks.


Implications for Christian Education

The high rate of incidence of mongolism indicates that mongoloids are also born to Christians. If the pastor is understanding and if the Sunday School and its workers are accepting, these mongoloid children will be brought to the Sunday School rather than being hidden away at home. Pastors and Christian education directors should take the initiative in several areas.

Counseling with the parents.—Parents of severely retarded, especially of mongoloid children because they are so obviously retarded, are often understandably hesitant to ask for help. But it must be offered. A later section will deal with specific problems of parents. The parents should be urged to include these children in the Christian education program of the church as soon as they are old enough. The earlier their training is begun the better the child adjusts.

Preparing the teachers.—Teachers often tend to fear retarded children, probably due to ignorance and misconceptions. The wise pastor or Christian education director will help teachers understand retardation and reassure them that the mongoloid will not disrupt the class. He should be treated, basically, like the other children. It will help teachers to keep in mind the basic rule that the child should be expected to behave at his mental age, his developmental age rather than his life age. A simple trick to determine a rough estimate is to expect a mongoloid to act half his age or even less, because his IQ will be less than 50 or half his normal expectancy.

Adjusting to the child.—If the church doesn't have enough retarded children to group into special classes, these children will probably have to be placed, when young, in the beginner department and
allowed to remain until their size makes this impossible. Retarded children are usually small in stature and many times they can participate with younger children satisfactorily. Other children in the Sunday School can be consistently taught by word and by action to accept kindly this child who is different. This problem of placement and the special class will be further discussed in another section.

An important consideration at all times is that the mongoloid must be accepted and loved just as the rest of the children are, as he is. He cannot change; the Sunday School will have to make some adjustment to him. He loves easily when well treated. He can be taught to love God and to trust Him as he grows.

Brain-Injured Children

In recent years one of the most important developments in the study of mental retardation has been the distinction between brain-injured and non-brain-injured mentally retarded children. Many studies on brain-injured children have resulted in greater understanding of and special teaching methods for the brain-injured retardate. Perhaps more than any other single group of retardates, brain-injured children practically defy definition and stereotyped description.

Brain-injured children cannot be considered as a generic class, because among other reasons, they differ from each other in the nature and extent of their disabilities.\(^1\)

For the purpose of this study, some generalizations may be made that would not apply to every brain-injured child.

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\(^1\)Virginia Halpin, "Basic Issues Concerning the Education of Children with Cerebral Defects," American Journal of Mental Deficiency, LXIII (January, 1958), 36.
Definition

The following definition by Strauss will serve to clarify just what is meant by brain-injured:

A brain-injured child is a child who before, during, or after birth has received an injury to or suffered an infection of the brain. As a result of such organic impairment, defects of the neuro-motor system may be present or absent; however, such a child may show disturbances in perception, thinking, and emotional behavior, either separately or in combination.

Development

During and after World War I, Goldstein encountered a number of soldiers who had survived serious head injuries resulting in many changes in behavior and perception. In working with children and adults who were known to have suffered brain injury, Strauss noticed that they displayed behavior patterns similar to those of mentally retarded children. That is, they seemed to have a reduced ability to think, and to tolerate distraction and frustration.

Etiology

Brain damage may be caused by high fever, infectious disease, trauma and numerous other difficulties during the prenatal, neonatal or postnatal stages of development. The specific causes have been discussed already.

1Alfred A. Strauss and Laura E. Lehtinen, Psychopathology and Education of Brain-Injured Children (New York: Grune and Stratton, 1947), p. 4.

2K. Goldstein, Aftereffects of Brain-Injury in War (New York: Grune and Stratton, 1942).

3Strauss and Lehtinen.
Diagnosis

A child may not show evidence of organic damage on an electroencephalogram (EEG, brain wave test) or other physical examination, but he may still be diagnosed brain-injured on the basis of the symptoms he displays. A wide variation between success of verbal and non-verbal tasks on the psychological (IQ) test is also used as evidence of brain injury.

Incidence

The symptoms of brain-injury are more pronounced at the lower IQ range level. Almost all profoundly retarded custodial children are the result of gross brain injury. However, most brain-injured retarded children fall into the moderately or mildly retarded IQ ranges. Many borderline and low average children also show symptoms of some brain injury. It has been estimated that as many as one of ten children have suffered some degree of brain damage and display some of the characteristics, although all these are not retarded.

Characteristics

While it has been stated that brain-injured children vary greatly, yet they show significant disturbance in perception, thinking, and behavior as a group. Cruickshank has broken these characteristics into six areas of exceptionality—distractibility, motor disinhibition, dissociation, disturbance of figure-background, perseveration, and inadequate body image.¹ These characteristics are to be found in all

brain-injured retarded children singly or in combination to some degree.

**Distractibility.**—It is felt that distractibility is the chief characteristic of brain-injured children. It is almost universally reported by those who study brain damage, being called distractibility, hyperactivity, or being driven to response to unessential stimuli. Distractibility refers to a limited ability to attend or to an extremely short attention span.\(^1\) Perhaps it should be stated instead that hyperactive children attend too well, their attention being drawn to every stimulus that they see. One study showed that 75% of the professional doctors, teachers and psychologists questioned named the following to be the primary characteristics of hyperactivity or distractibility:

1. fidgets and restless,
2. inattentive,
3. hard to manage,
4. cannot sit still,
5. easily distracted,
6. low frustration level.\(^2\)

Closely related to distractibility is motor disinhibition, which may be defined as a compulsion to make a motor response to all stimuli.\(^3\)

Gallagher,\(^4\) in his study of twenty-four familial and twenty-four brain-injured children, concluded that brain-injured children as a group

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\(^1\)Ibid., p. 4.


\(^3\)Cruickshank, p. 5.

were more distractible. However, Cruse studied the effect of distraction on a test of twenty-four matched pairs of brain-injured and familial children and concluded that brain-injured children as a group were not more distractible. He felt that the familial children were just as distractible; in fact, he advocated a similar program of education in a low distraction setting for both kinds of retarded children. So the researchers are not able to agree on the matter of distractibility. It seems that distractibility can be accepted as characteristic of brain-injured children whether or not they are more so than familial children. The teacher will soon recognize distractibility to be an outstanding symptom in the child’s behavior. He simply cannot sit still; he jumps to the window or runs to the door to see what caused a noise; he cannot listen long enough to understand directions. His attention must be captured before he can be taught.

**Perceptual problems.**—Brain-injured children also suffer defects in their ability to perceive things as they are. This causes great difficulty in their ability to learn. Cruickshank describes two aspects of this perceptual handicap. First, dissociation refers to the inability of the child to see and conceive of an object as a whole. He tends to respond to the parts and not even to see the whole. For example, he may see only the geometric shapes rather than the houses or buildings in the picture. Second, figure background disturbance is the tendency of such a child to confuse the background of a picture with the main figure.

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2. Cruickshank, p. 4.

Warner and Strauss\textsuperscript{1} illustrated this defect by an interesting study in which familial and brain-injured children were asked to report what they saw on a card bearing the line drawing of a man's hat set on a background of jagged lines. The familial children responded to the hat while almost all of the brain-injured children did not even see the hat. These children are likely to see a farm scene and completely overlook the boy standing in the center of the picture. Such perceptual defects make reading and writing almost impossible.

**Perseveration.**--One of the most annoying aspects of the brain-injured child's behavior is perseveration. It is the inability to shift from one activity to another.\textsuperscript{2} The response continues long after the need for it has passed. Thus this child will continue clapping after the others have stopped; he may work an entire page of arithmetic problems using one process despite the signs. He falls into habits easily and may ask the same question repeatedly or give the same answer regardless of the question he is asked. He may write row after row of numbers right off the edge of the paper. However, perseveration can be taken advantage of in the training of this child. If he is trained in good habits he will retain them. But the converse is true; bad habits are difficult to change.

The child whose brain has been damaged so that he cannot pay attention, who cannot see things as they are, who is compelled to react to everything around him will be hard to manage and difficult to teach.

\textsuperscript{1}H. Werner and Alfred A. Strauss, "Pathology of Figure-Background Relation in the Child," *Journal of Abnormal and Social Psychology*, XXXVI (September, 1941), 236-248.

\textsuperscript{2}Cruickshank, p. 6.
Learning

Brain-injured children can learn if they are helped to pay attention and if the material is made simple, concrete, and easy to perceive. The educational expectancy is about the same for familial children, determined by the mental age expectancy. Brain-injured children are more successful at verbal tasks than manual because of their poor eye-hand co-ordination, while familial children are just the opposite. Special education is necessary for the brain-injured child.

Management

The greatest problem in dealing with a brain-injured child is not his lack of ability to learn in school. It is his unacceptable and often uncontrollable behavior. This presents a grave and frustrating problem for both teachers and parents. Some methods have been suggested for handling such children. It will be helpful for pastors to help parents understand the difficulties they have with their brain-injured child and to be able to suggest some ways he can be better handled in the home.

The central principle in the management is that the child cannot control himself in his environment, so the parent must exercise the control for him through his environment. Any visible handicap would be accepted and adjustments in the family would be made for it; adjustments must be made for him. This child’s handicap is internal. It is his inability to focus on the essential, his inability to control his activity and to understand what is expected of him, to think clearly.

Routine.—Because of his tendency to perseverate, the brain-injured child can retain good habits if they are carefully developed and
made to be a routine part of his daily life. It is helpful, therefore, for parents to establish a comfortable routine for the child and thoroughly explain to him any deviations in it to eliminate his insecurity and frustration.

Getting up, eating, going to school or church, going to bed should all be routinized and calmly explained until a pattern is formed. This requires conscious effort on the part of the parents to structure into the child controls he needs to make his own.

Routine is the cornerstone of the new edifice of behavior which must be built for the child. Its virtue lies only in the possibility it affords of clearly patterning the day's activities, and in helping the child to relegate to an automatic level many activities on which he otherwise would need to expend conscious effort and attention.  

Discipline.—He is loud, he is rude, he is destructive. But it is not willful. He may destroy a new toy car because he focused on the wheels and tore them off—or he may not have been able to perceive why it wouldn't roll sideways, and being frustrated, may have dashed it against the wall. A wise policy is not to force an issue but to sidetrack his easily shifted attention to a less harmful activity. Fighting him only causes tantrums.

Discipline cannot be neglected. It is a vital part of any child's education but especially for the brain-injured child who lacks self-control. As a rule, discipline should be appropriate to the motive behind the deed. The same act may be done in anger or out of helpless frustration, or merely out of awkward perception and co-ordination. Discipline should be regarded as training rather than deserved punishment.

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This does not advocate utter permissiveness. The brain-injured child requires rigid bounds. He must be stopped when he cannot stop himself. Permissive parents only confuse his already inadequate perception of his limits.

Doing everything he wants to when he wants to do it makes him increasingly restless and hyperactive. The child needs to know that there are limits and that he is expected to observe them. Lacking control himself, and lacking the ability to perceive for himself where the limits of a situation might be, he is made insecure and anxious if they are not clear to him.1

Rewards.--Lewis stresses that threats and bribes are not effective with brain-injured mentally-retarded children because they cannot comprehend them and furthermore they cannot will to control themselves.2 It is far more effective to give a small reward with appropriate praise after a task is successfully completed. For example, the brain-injured child cannot eat his carrots for thinking of the ice cream that is being offered as a reward. He cannot comprehend the adult reasoning that insists on carrots when he knows there is ice cream. It would be better to get the carrots down him, then follow them with ice cream with no mention of threat or bribe. This is true with all young retarded children.

Tantrums.--Brain-injured retarded children seem to be more subject to emotional outbursts commonly described as temper tantrums. Such an outburst is not of anger but rather of frustration. It is evidence of a breakdown of inner controls. In such a condition no amount of spanking or anger will stop him. It will, in fact, add to his frustration. This child who lacks self-control due to brain damage is actually suffering a small nervous breakdown. He cannot cope with his

1Ibid., p. 100. 2Ibid., p. 101.
environment any longer. At this time he requires much support from a sympathetic person. He should be removed from the situation of stress and helped to relax in a quiet, unstimulating atmosphere. He needs to be reassured that he is loved, and that his parents or teacher will help him learn to control himself.

It does only harm for a parent to exert pressure on the child to prevent future breakdowns. This only builds anxiety and creates emotional disturbances.

A positive approach to prevent extreme situations of stress is better. The sensitive mother or teacher will see the storm coming and will remove the child from the situation much as she would lead him away from a supply of deadly chemicals.

Socialization.—The brain-injured child is ego-centric and cannot play well in a group. He cannot "take turns" or "play by the rules," so he is usually rejected by other children. He may become frustrated and try to break up the others' game. His perceptual difficulties as well as his inability to understand complicated rules make him awkward and illfit to participate in sports.

Implications for Christian Education

Classes are already crowded and noisy. The class time is too brief and the material is already prescribed. Often teachers are unprepared or ineffective in achieving order. In such a class a single mildly retarded brain-injured child can indeed create havoc. What can the church do to help this child and the teachers who meet him?

1Ibid., p. 10.
Create understanding. — The pastor or some other Christian education leader must be able to identify the problem and to interpret it to the teachers involved. Many times the parents, especially of very young brain-injured children, are not themselves aware of a physical defect or if they are, they may be reluctant to discuss their child’s "problem" with the Sunday School teachers. As a result, the teachers may resent this overactive child and actually pressure him into more acting-out behavior. A basic atmosphere of understanding and kind but firm control will do much to ease this problem.

Speaking of brain-injured children Petersen says: "Their religious experience needs no concepts—it is linked directly with the stark realities of love or its absence."¹ So they must feel love and understanding in the classroom.

Adjust the environment. — To a limited degree the routine of the class can be set to provide an environment of security for the brain-injured child. In fact, all young children feel more secure in a familiar routine. If participation in a rhythm band is too much for him unaided, perhaps a worker could help the brain-injured child confine his pounding to the drum only. Do not be surprised if he continues to pound on the table after the rhythm session is over. This is perseveration. Instead, provide him with something to shift his attention. If it seems that the child is becoming overwrought, a quiet trip to the restroom may divert his attention. Rather than punishing him for pulling out toys during the story time, it is easier to seat him so he cannot see the toys, or better yet, to keep all toys and extra material out of view of

the entire class to eliminate distraction. It may help to seat him near the teacher so she can get his attention by a gentle touch. These children respond well to warm, affectionate bodily contact with those who control them. Sitting near the child, putting an arm around him, stroking his hair, even holding young ones on the lap does much to restore to an upset child a feeling of security, acceptance and well-being.

It is regrettable that the lovely, adorable bright children who least need it get the most attention and praise from significant adults in their lives while all mentally retarded children, specifically brain-injured ones, who can least tolerate rejection and antagonism, are the most subject to anger, impatience, misunderstanding and total rejection. This should never happen in a Christian church.

To reject or to expell from class such a child is to mar his emotional development and to alienate his parents and drive them from the church.

The environment must be adapted to the child as much as is possible. The church may not have special classes for retarded children, but every teacher can and should have informed, sympathetic, and accepting attitudes. This attitude is basic to the treatment of any type of retarded or exceptional child in the church family. The appropriate placement, use of visual aids, and adaptation of materials will follow if this attitude prevails.

**Cultural-Familial Retardation**

The largest group of retarded children remains yet to be discussed. Cultural-familial retarded children constitute the majority of educable mentally retarded children in institutions and in the community.
They exhibit a fairly uncomplicated picture of borderline to mild mental subnormality. Lacking the gross physical handicaps or dramatic symptoms of the pathologic syndromes ..., they often seem to be developing in a rather normal intellectual pattern which is remarkable primarily for its slowness.

Definition

The cultural-familial retarded child is one who is in the mild or moderate educable retardation range, who has no evidence of organic brain damage, and who has other mildly retarded members somewhere in his family. Other names are familial, garden-variety and endogenous.

Etiology

The cause of cultural-familial retardation is undetermined. The old nature-nurture controversy still rages in this field. Studies of families such as the Jukes and the Kallikaks served as fuel for each group. Heredity advocates stressed the genetic characteristics while the environment advocates pointed out the poor physical and moral conditions in which these children lived. So it is that both heredity and environment are thought to cause this form of mental retardation.

This retardation is not generally noticed in the pre-school years. It is not until he fails in school that retardation is generally diagnosed by means of appropriate tests. When this child finally gets out of school, he is usually able to perform an unskilled job and to support himself and often a family. He becomes reabsorbed in the community and is no longer viewed as retarded. It may be that this is just the lower end of the normal distribution of intelligence and that it is an educational problem rather than an intellectual one.

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1 Robinson and Robinson, pp. 208-209.  2 Ibid., p. 217.
**Characteristics**

Most cultural-familial retarded children appear to look like their normal peers. They may seem smaller, less sturdy and less well-dressed than normal children, but these are a result of socioeconomic class rather than of intelligence.

**Socioeconomic level.**—Most cultural-familial mentally-retarded children come from the lower socio-economic levels of society. Many come from stable borderline families in which education is not stressed and in which the slow child does not seem different from the others. Most likely they are all slow. Robinson points out that:

... It is because there are so many families in the lower reaches of the socio-economic scale that the frequency of these cultural-familial mentally-retarded children is so great.¹

Another group of cultural-familial children comes from the drastically poverty stricken homes of our ghettos, slums, and isolated rural regions where lack of education and medical attention are the rule.

Factors other than heredity also may affect mental retardation among families such as these. Brain injury may be an additional environmental factor.

The high incidence of biologic disorders, especially complications of pregnancy, among those who are lowest on the socioeconomic ladder has been seriously advanced as a major cause of retardation. The combined effects of poor nutrition, such prenatal conditions as toxemia and bleeding, premature birth, and other damage producing causes may well account for a large number of the retarded children born to deprived families.²

**Physical.**—The familiar saying, "strong back, weak mind" is not true of cultural-familial retarded children. While there are some hefty exceptions in the borderline areas, most familial retarded children are

²Ibid.
smaller, weaker, and more frequently sick than are normal children. This may be directly related to conditions of hygiene, nutrition and medical attention in the lower socio-economic homes from which they tend to come. However, familial retarded children can perform manual tasks dealing with concrete objects better than abstract verbal ideas. Their hand skills and co-ordination are nearer the normal. For this reason they are better adapted to semi-skilled and unskilled jobs.

**Social.**—Familial retarded children are more near the average child in both physical and social development. It is his mental development that lags. While a twelve year old may have a mental age of 7 and he may barely be able to do what an average seven year old can do academically, his social maturity is more nearly that of his normal peers and he is not interested in the childish pursuits of a seven year old.

**Learning**

These children constitute most of the population in special education classes in public schools and that of mildly retarded persons in institutions. They can be taught to read at their mental age level.\(^1\) They can learn as readily as normal children of the same mental age but their overall rate of mental development is slower.\(^2\) Thus while a ten year old with an IQ of 70 and a mental age of 7 may be able to do what a normal seven year old can do, he will learn it more slowly. It would not

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\(^1\)G. Orville Johnson, *Comparative Studies of Some Learning Characteristics in Mentally Retarded and Normal Children the Same Mental Age* (Syracuse: Syracuse University Research Institute, Syracuse University Press, 1958), pp. 114-115.

\(^2\)Ibid.
solve the problems to put him in second grade. His ceiling is lower and his rate is slower. Concrete lessons learned through experience and much meaningful repetition are the most effective in teaching him.

**Implications for Christian Education**

A church that reaches a community including some lower socio-economic families may well expect to find some familial-retarded children in its classes. This is not at all to say that all children from poorer homes are retarded. It is also possible that children from middle class homes may be retarded from no physical cause, and so considered familial. For this group, the greatest problem is not behavior as with the brain-injured group, but with identification and effective teaching.

**Identification**—Often parents of mildly retarded children refuse to admit any defect. Indeed the child may appear normal, quiet and polite. The problem is noticed only when he is called on to read or to recite a memory verse. Soon, rather than embarrass the child, the teacher will overlook this child and pass him by as incapable of learning anything. Many times a teacher can learn if the child attends a special class in school and so determine his problem.

**Teaching attitudes**—Here again the teacher’s awareness of mental slowness and his attitude toward the retarded child are vital. The teacher who treats this child with disgust and irritation will add to his feelings of inadequacy and drive him from the class. But even if he is unable to teach the child much, an understanding accepting teacher can build in that child a feeling of worth and security and can teach him the basic principle that God loves and cares for him. When such learning is reinforced by loving acceptance and genuine interest, it is
long-remembered and becomes a part of the thinking of the child. Like brain-injured, familial children tend to perseverate, and routine and repetition can help to reinforce and pattern proper learning into the child. Peterson writes: "... these children are persons who can respond in meaningful ways, and, therefore, we must conceive of them in terms of human values and divine purposes."\(^1\) Positive teaching is dependent upon this accepting attitude.

**Effective teaching.**—Too much of Sunday School teaching is verbal—strictly the lecture type. Familial children think in concrete terms and find it hard to form concepts from an abstract verbal idea. If all children learn best by experience and through personal involvement, the mentally retarded children require such reinforcement even more. Repetition of basic ideas in simple concrete terms can be employed in each lesson. Children can be involved in simple skits or pantomines of the action of Peter and John helping the lame man. If older children are required to take tests, some may be excused to help the retarded child make a mural. He can cut items for the bulletin board. He can be made a part. If he is accepted by the teacher, he will be accepted by the other students. The child who feels welcome in his class, even if he is retarded and he knows he is different will return and will grow.

**Summary**

In this chapter the causes and characteristics of mongolism, brain injury, and cultural-familial retardation have been examined. It has been shown that brain injury results in many behavioral problems.

\(^1\) Petersen, p. 14.
It has been demonstrated that most brain-injured and almost all familial children are educable.

But it is not enough to know about the child. It is necessary to move on to a study of how parents react to the retardation of a child and the ways the church can help these parents. Then it will be possible to propose some ways the church can help the retarded child.
CHAPTER IV

THE CHURCH CAN HELP PARENTS OF RETARDED CHILDREN

FOR CHRISTIAN PARENTS, IT IS ONLY NATURAL THAT THEY TURN TO THEIR LOCAL CHURCH FOR HELP, FOR SPIRITUAL ADVICE, FOR DIRECTION. THE CHURCH THAT IS PREPARED CAN OFFER HELP IN SEVERAL AREAS. THE PASTOR CAN BE EQUIPPED TO COMMUNICATE WITH THESE PARENTS, AND THE CHRISTIAN EDUCATION AGENCIES OF THE CHURCH CAN BE ORGANIZED TO PROVIDE FOR THE RETARDED CHILD.

The Responsibility of the Church

Jesus Christ, whose representative on earth the Church is now, came as a humble servant. The early Church evangelists have often been seen as the ideal of serving, yet Christ said, "For as thou hast done it unto one of the least of these my brethren, thou hast done it unto me" (Matt. 25:40). By application, retarded children can be considered "the least of these" for whom the Church has a responsibility to
THE CHURCH CAN HELP PARENTS OF RETARDED CHILDREN

Introduction

The long-expected child arrives. He is greeted with love and acceptance. Eager parents watch for every sign of growth. But he does not develop according to the prescribed schedule in the baby book. It may be noticed immediately or it may take several months or even years, but soon there is no doubt. Something is wrong with their precious child. The parents are heartbroken. To whom do they turn?

For Christian parents, it is only natural that they turn to their local church for help, for spiritual aid, for direction. The church that is prepared can offer help in two main areas. The pastor can be equipped to counsel with these parents, and the Christian education agencies of the church can be organized to provide for the retarded child.

The Responsibility of the Church

Jesus Christ, whose representative on earth the Church is now, came as a humble servant. For some reason evangelicals have grown to fear the idea of serving, yet Christ said, "Inasmuch as ye have done it unto one of the least of these my brethren, ye have done it unto me" (Matt. 25:40). By application, retarded children can be considered among "the least of these" for whom the church has a responsibility to
meet their needs and to communicate Christ to them. Mrs. Dorothy Hampton, the mother of a retarded child, speaks passionately of the lack of concern in evangelical circles for the "least" and unfortunate members of our communities:

Why are some evangelicals letting their liberal friends do most of the works of compassion, while they argue about immersion versus sprinkling and whether Christ will come before or after the tribulation—and all the time souls in the agony of despair over a mentally retarded child, an alcoholic or mentally sick relative, are perishing all around them? While Christians who have knowledge and understanding of the power that alone can save souls and ease burdens quibble over how separated they are, there is intense spiritual suffering going on in the very blocks where they live. And somehow they are strangely uninterested in helping.... It is time to come down out of the clouds of theological controversy and spiritual pride and to take our share of responsibility for the unfortunates of society. Our great-grandparents did it for the slaves. We can do it for the "least of these."... 1

Another mother of a retarded child writes concerning churches and the retarded:

It is my belief that as a rule churches cannot be bothered with the retarded although God is very interested in them. Also, to a great degree the churches who would like to cater to the retarded cannot afford it and those who can afford it are not interested in it. I believe that the retarded class in a church is just one of the many avenues of getting to lost souls. I believe Christ died for all, and all should be reached. 2

What is our answer to such parents? It is indeed to the shame of evangelicals that the liberals have been the pioneers in providing church services and special classes for retarded children. Evangelical churches need not compromise their doctrinal stands to begin to help retarded children. Pastors can become aware of counseling needs and

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2 Reply in answer to questionnaire.
Parent Counseling

Many hard things come to families and they survive, their faith unharmed. Physical illness and even death may come and the family can accept it and adjust. But somehow mental retardation is something so foreign and unknown that parents feel they are outside the providence of God.

The Importance of Counseling

At such times, a Christian parent must be able to find in his pastor an understanding and helpful guide. Weber describes the importance of such guidance:

Any condition of life which destroys or permanently damages one's concept of a loving and merciful God presents a serious problem—a problem with which the person must have help lest he sink into a state of despair from which there is no return. For this reason, it is very important that clergymen... should have competent professional knowledge of the facts of mental retardation so as to be more able to advise and counsel wisely with members of their parish who are faced with this terrible problem.1

Rote suggests that Christian counseling is basic to parental adjustment:

What the parents of a mentally retarded child need is acceptance along with understanding. Somehow, they must learn to accept their special problem. They might never learn to understand fully why they were given it, but to survive they must learn to accept it. To achieve this requires skill, patience, understanding, prayer, and guidance on the part of the counselor.2

The pastor who would counsel the parents of a retarded child should be familiar with their emotional reactions.

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Types of Emotional Reactions

There are three basic emotional reactions in parents when they learn that their child is retarded. Parents may react by accepting, by disguising, or by denying the fact of retardation. The type of emotional response will to a great degree determine their behavior toward the child.

Accepting.—The parents may acknowledge maturely the fact that the child is retarded and come to accept him fully just as he is. They do not blame themselves unduly and do not avoid facing the bitter truth. "This acceptance is by no means an easy task, and its achievement is dependent upon the psychological maturity of the parent, and also upon appropriate guidance."\(^1\)

This acceptance needs to be both intellectual and emotional. A mother may accept intellectually the fact that her retarded youngster needs to be taught to dress himself, but she may be emotionally unable to watch him struggle with that difficult task without doing it for him.

Disguising.—Parents may attempt to avoid facing the fact of retardation by disguising the reality of the child's obvious slowness. These parents go from doctor to doctor in search of some mysterious element that will explain away the defect and cure it. The problem may be disguised as poor vision, immaturity, or bad tonsils. Often the child is accused of deliberate laziness and great pressure is exerted on the innocent child. Often the school and its teachers and methods are blamed. This is a result of the emotional inability to face reality.

Denying.—Parents may even be compelled to deny completely the existence of a defect in their child. This is a form of defensive behavior similar to the ostrich with his head in the sand illustration. This is usually not a deliberate, but a subconscious reaction.

Causes of These Emotional Reactions

Some causes of the undesirable reactions are misconceptions regarding the nature and cause of the retardation, and guilt feelings. Many still confuse retardation with mental illness and regard it as shameful. It is almost the natural reaction of parents to feel responsible and to wonder what they had done to deserve such a disaster. Parents often suffer severe spiritual conflicts over the cause of their child's defect, thinking that it is the direct result of some sin. Parents may lay heavy blame on themselves or on the marriage partner for the inheritance of such a defect.

Results of These Emotional Reactions

Withdrawal.—The parent who blames himself and is filled with grief often withdraws. He hides it in himself and withdraws from society. His self-image is lowered. He dreads meeting people. He may refuse to take the child out in public. Such reactions are reflected on the child, too.

Rejection.—The parent may even reject the child. "His own emotional reactions are then reflected in his behavior toward the retarded child, and often these unfortunately assume the form of rejection of the child."¹

¹Ibid., p. 247.
This rejection leads to strict discipline of the child and forcing him to do what is impossible for him—"for his own good"—causing frustration and emotional maladjustment in the child. Such rejection is usually unconscious.

Marital problems.—Problems may develop within the marriage relationship as the parents may blame each other for the defect. The social isolation to which they have confined themselves, the hidden hostilities and anxieties, the extra care required by the dependent child, and the feeling of social shame all may compound any existing discord or create new ones. ¹

Personality problems.—The presence of a retarded child may cause severe personality problems in the parents. The defective child may be seen as a blow to the parent's narcissistic (self-love) pride. A dependent, clinging type of mother may suffer severe emotional maladjustment because she is not able to meet the demands of a dependent child. Continual fear for the child's future haunts the parents, adding to their anxiety and tension. The retarded child may not be the cause, but he usually accentuates the personality problems that already exist. Hutt and Gibby explain it: "The emotional reactions of the parent of the mentally retarded child are essentially a function of his own personality characteristics."²

So basic instability in the parent may be compounded by the added emotional strain of a retarded child.

¹Ibid., p. 311. ²Ibid., p. 251.
What the Parents Need to Know

The cause of the retardation. -- Parents cannot accept what they do not understand. The pediatrician or psychologist who diagnoses the retardation should provide them with the basic information if it is known.

The capacity of the child. -- The concept of IQ is probably meaningless to most parents, but they should know both his limitations and his assets so that total planning for him can be realistic. Parents should be given an idea of a reasonable expectation for the child so that they will not continually frustrate themselves and the child.

Emotional needs of parents. -- Both parents should be made aware of potential problems and helped to gain insight into their conflicts and guilt feelings regarding the child. The pastor can show these parents that they are not alone and may urge them to join the local parents' group of the National Council for Retarded Children. He should urge them to seek help from their physician, the school psychologist, child study center, or other agency.

Emotional needs of child. -- The parents should be helped to understand how and at what rate the child is expected to develop. They should know his unique needs. They should be aware of the need to accept him, to set reasonable goals for him and to avoid frustrating him with impossible demands. They should know his basic needs of being loved, being secure, and being accepted.

Help for the child. -- Through guidance, the parents can find out what they can do at home to help their child. They can train him, read

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1 National Association for Retarded Children, 420 Lexington Avenue, New York, New York.
and sing to develop language skill, provide him with experiences to talk about, and provide acceptance. They should also be made aware of community facilities such as special education classes in the public schools, community-sheltered workshops and classes, day-care centers and nurseries and parents' groups.

Levels of Adjustment

Adjustment to a retarded child does not occur spontaneously. It is a long developmental process in which parents grow through certain phases. Rosen suggests five levels of growing comprehension about the child in mothers. (1) The mother becomes aware that the child is different somewhere between the ages of two and eight. (2) She next realizes that the child is retarded near the age of five. (3) Then she begins to search for the cause of the defect. Almost all mothers first attribute the problem to some physical condition. (4) She then seeks a solution to the problem and begins the rounds to doctors, specialists, and educators. (5) Finally, she accepts both the child and his retardation.¹

Hutt and Gibby point out that the growth through these phases "... depends not only upon the basic emotional maturity of the parent himself, but also upon the guidance he receives in coping with the problems involved."² This is the reason Christian counseling for parents of the retarded is so important. It may help determine the whole area of adjustment.


²Hutt and Gibby, p. 251.
The mother of a trainable retarded child, Mrs. Hampton, describes the problems of a Christian adjustment in these perceptive words:

There are several stages through which one goes upon learning that one's child is mentally handicapped. For those who do not know that Christ controls all that happens in their lives, there is usually a harrowing time of guilt and self-examination. Parents ask themselves again and again, "What did I do to give birth to such a grievously handicapped child?" . . . Yet even with the most scripturally grounded believers, the human element of what may be called a built-in psychological mechanism is not wholly cancelled. . . . Parents cannot help asking, "Lord, why me? How can I live with this? What shall I do?"

She continues to describe the stages through which a Christian parent may pass in making an adjustment. She expresses it well:

Parents cannot help asking, "Lord, why me? How can I live with this? What shall I do?"

Some unfortunate parents never progress beyond this stage. To the great detriment of themselves and their handicapped children, to say nothing of any other children in the family, they remain preoccupied with "I," "me," and "us." Most parents of retardates, however, pass out of this stage to a second, in which their thinking is all directed toward the child involved. Here the normal reaction is to ask, "What can I do to help my child, only mine?" Some parents, unfortunately, remain in this second stage, and are almost as useless to themselves and to the child as those still in the first stage. Hopefully, most parents pass into a third stage, that of asking, "What can I do to help all mentally handicapped children?" Only then, they realize, can they help their own child.

Spiritual Understanding

Every Christian parent of a retarded child asks these questions. No one can give pat answers, but there are certain Scriptural principles and examples that help.

Example from scripture.—When asked why a certain man was born blind, Jesus replied: "Neither hath this man sinned, nor his parents; but that the works of God should be made manifest in him" (John 9:3).
The defect was not due to sin, for all parents are sinners. His parents surely did not understand, but it is evident to us from Jesus' words that God had a specific purpose for this man's handicap. The same is true of retardation.

Principles from scripture.—God is sovereign and nothing occurs outside His knowledge and purpose. Scripture assures us that God "... worketh all things after the counsel of his will" with the purpose "That we should be to the praise of his glory" (Eph. 1:11, 12). This is the same God who said, "Who hath made man's mouth? or who maketh a man dumb, or deaf, or seeing, or blind? is it not I Jehovah?" (Ex. 4:11). This classification of handicaps can be expanded to include the retarded. God will surely accomplish His holy purpose in it. The parents may not understand now; they may never understand, but God is working out His purpose. It remains for parents to trust Him implicitly with the faith of Job who declared stoutly, "Though he slay me, yet will I trust in him" (Job 13:15).

The Christian parents who are faced with this problem are suddenly forced into an evaluation of their faith and trust in the love of God. If all they have believed is true, then it follows that Christ must be sufficient for them now. Faith is demonstrated in the hard things. Surely this is one of the hardest.

Information

The pastor who knows something of the causes and characteristics of retardation will better be able to help parents interpret the extent of their child's handicap. Pastors of twenty-five Brethren churches with memberships over 290 were surveyed regarding retarded children in
their churches. Only eight of the fifteen pastors who responded had read any books about retardation. Thirteen felt the need for more information about retardation and about how to help parents of retarded children. There seems to be a need for such materials written for pastors. The pastor then can provide helpful information to parents.

Referrals

Many times parents simply do not know where to turn for help when they suspect something is wrong with their child. While the pastor may be able to give helpful information, he is not qualified to make a diagnosis or pass any professional judgment. He should be prepared to refer parents to such appropriate agencies as the Council for Exceptional Children or the National Association for Retardation, or to the school psychological center, to the community child study center, or to a neurologist. A simple referral to a good pediatrician would be helpful as a wise first step.

Planning For the Future

Most retarded children today are cared for at home, but there are cases in which it is deemed best to place a profoundly retarded child in a state or private hospital for custodial care. In most states such children must be at least six years of age before admission. The pastor may be able to help the parents weigh the decision as to what is best for the defective child and for the rest of the family, in terms of time spent caring for the child, his effect on other children and the availability of money to cover special care. The pastor can help parents contact the state board nearest them.
Most children will be reared in the home. Special classes are available under the local school board in most communities. The greatest problem for parents is to plan for the time when they will no longer be able to care for the child in their age or in the event of their deaths.

The importance of pastoral counseling has been discussed. But other agencies and individuals in the church need to become involved in helping retarded children.

The importance of Christian education and individuals in Christian education will be discussed next.

The Place of Christian Education

Many people, when considering Christian education of retarded children, question whether or not these children are capable of understanding the great doctrines. The Gospel of Jesus Christ is so wonderfully constructed that the simplest child can comprehend love while the profoundest thinker cannot analyze its source. Effective teaching can place the Gospel on the level of the immature mind of even a trainable child. Mrs. Hampton writes her convictions concerning her own child and spiritual understanding:

Most retardates understand something about death; many can understand, to a limited degree, the concept of an all-powerful Being; many understand wrongdoing; virtually all can understand love—the quality they need more than any other. Thus many mentally retarded persons are able to understand something of the central truth that Jesus is God and that he loved them enough to die for them. And after all, what else is there? This is the magnitude of the Gospel and its magnificent simplicity.

I believe that my little girl understands this great truth. Whether she is or ever will be at the age of discernment I may never
know; but she loves Jesus, and she knows that he loves her. And if she could not grasp even this, I would still know that he loves her.1

As it was pointed out in another section, retarded children can be expected to understand and perform at the level of their mental age. Normal children of four and five are often ready to ask Jesus to come into their hearts. It is reasonable to feel that retarded children of such a mental age may do so also. They must be taught; they need to be included in our concept of Christian education.

The branch of the church that deals most directly with the children and with their problems is the Christian Education department with its Sunday School and various youth and children's groups. It is into this broad agency that the retarded child will come, if it is open to him. The director of Christian education and the teachers need to be prepared to teach retarded children, too.

The Christian Education Director

The Christian education director is responsible for organizing and implementing the various educational agencies of the local church so that the needs of each student are met. It is he who must establish a program or policy for retarded children. The Sunday School superintendent may be responsible for this in churches that have no Christian education director. He must be prepared in the areas of information, identification, placement, promotion, and teacher preparation.

Information.—The Christian education director should be well informed as to the general nature of retardation, as previously

1Hampton, p. 146.
discussed, for his own benefit. Also he should be informed so that he can advise teachers in understanding the matter of retardation.

Identification.--While mongoloid and other trainable children are easily identified, other frequent forms of retardation are not so readily distinguished. The brain-injured mildly retarded child might be thought undisciplined and rude and the familial child indifferent or sullen. If the director of Christian education can be aware of some guidelines by which to "spot" retardation, they may be able to help teachers understand these "problem children." In this way much frustration can be avoided, both of the child and of the teacher.

Christian educators may be helped in recognizing the ability level of a child so they will know what to expect from him. Table 3 shows the comparison of normal developmental levels to various intellectual levels. A child's developmental level can be approximated quickly by use of a growth chart which details normal behavior at various ages (see Appendix). By checking what the child can do, the teacher is able to determine the approximate mental age and developmental level of the child. Table 3, then, will show the intellectual level, trainable, educable, or custodial. This tool is very helpful in determining how to teach a child, particularly if not much is known about his background. However, such a chart is not a diagnostic tool.

Placement.--The Christian education director or Sunday school superintendent must consider carefully many factors in placing a retarded child in the correct class. This is admittedly a great problem. A young trainable child will best be handled in the nursery and then in the beginner departments where stories are simple and concepts are built by activity and repetition. He can probably be kept with
younger children until he grows too large to fit. After that time his educational needs cannot be met in any class, for he will never learn beyond approximately a six year level. But his emotional needs can be helped if he is allowed to participate in a primary class. If the teacher is aware of his need for utter simplicity, she can adapt her lesson to include something for him. She can provide some simple handwork for him to do while the others do more complicated workbooks. This is not discrimination; it is meeting individual needs, and it is the basis of special education for the retarded. The important element in any placement is that the teacher and the other children be willing to accept him as he is. Normal children in the Sunday school

... should be told that handicapped children may be coming to church or Sunday school, that this is how God made these children, that they are to be helped and loved. Normal children will surprise parents and teachers with their matter-of-fact acceptance and eager willingness to help.\(^1\)

### TABLE 3

**A TABLE FOR ESTIMATING LEVEL OF RETARDATION***

<table>
<thead>
<tr>
<th>Level of Development achieved</th>
<th>Educable if child's age is: years</th>
<th>Trainable if child's age is: years</th>
<th>Custodial if child's age is: years</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>(1 \frac{1}{2} ) to 2</td>
<td>2 to 4</td>
<td>4 up</td>
</tr>
<tr>
<td>(1 \frac{1}{2})</td>
<td>2 to 3</td>
<td>3 to 6</td>
<td>6 up</td>
</tr>
<tr>
<td>2</td>
<td>(2 \frac{1}{2} ) to 4</td>
<td>4 to 8</td>
<td>8 up</td>
</tr>
<tr>
<td>3</td>
<td>4 to 6</td>
<td>6 to 12</td>
<td>12 up</td>
</tr>
<tr>
<td>4</td>
<td>(5 \frac{1}{2} ) to 8</td>
<td>8 to 16</td>
<td>14 up</td>
</tr>
<tr>
<td>5</td>
<td>7 to 10</td>
<td>10 up</td>
<td>16 up</td>
</tr>
<tr>
<td>6</td>
<td>(8 \frac{1}{2} ) to 12</td>
<td>12 up</td>
<td>**</td>
</tr>
</tbody>
</table>


\(^1\) Hampton, p. 148.
Brain-injured and familial children usually fall in the mild retardation level and can be more readily assimilated into the normal classes. It is especially helpful, though, if their teachers are aware of their limitations in reading and reasoning. Mildly retarded children are more like normal children than they are like trainable children.

**Special classes.**—If a church has several retarded children it may well consider beginning a special class for them. It will be the responsibility of the director of Christian education to select and probably to train a teacher who is able to understand the needs of such children and who can make the Gospel message simple and basic. He will need to select the appropriate materials, too. The Lutheran Missouri Synod has published materials for special classes. Even this sort of lesson material may need to be adapted to make it even more simple.

All too few churches have entered into this field of Christian service. It has been left to the liberal churches to pioneer in this needy area. While an average-sized evangelical church might not have within its membership very many retarded children for whom to provide a special class, this may well be an excellent area of community outreach. Parents of retarded children need the fellowship of the church. They will be attracted to any church that demonstrates its concern and love by holding Sunday school classes for retarded children. Local parents' groups will spread the word around; soon there will be more retarded children and their families in the church where they will hear the Gospel and can be saved and trained.
Some evangelical churches are entering this field. Two Brethren churches reported having classes for the retarded, and a third had held one previously.¹

One large Baptist (Regular) church now has a department in its Sunday school for retarded children. Started six years ago as an evangelistic outreach to get parents into the church, the Shepherd department has grown to thirty children in three classes with about a dozen teachers and helpers. The director of this program has adapted Child Evangelism Fellowship lessons and other teaching materials for their use. An important emphasis in this program is parent involvement, and four families have been saved and added to the church through this ministry. This church even added a summer vacation Bible school program for retarded children. When the class was started, not one child was already in the church family. Publicity and contacts quickly brought them into the church. The pastor regards this as a community evangelism approach.² Other evangelical groups should be encouraged to survey the need and consider beginning such classes in their churches.

Curriculum.—Once a class is initiated, the Christian education director will have to work with the teacher to plan a workable curriculum for retarded children. Generally, there is little published Sunday school material that is suitable or simplified enough for retarded children. Even the Lutheran material for retarded children is too advanced for trainable children.

¹See Appendix for list of churches.

²Interview with Dr. Kenneth Masteller, Pastor, Haddon Heights Baptist Church, Haddon Heights, New Jersey.
Christian education for retarded children cannot be merely a watered-down version of the regular curriculum. Nor is it appropriate to use kindergarten materials for a twelve year old retarded boy. The lessons should not be primarily a rote learning of facts.

It is true that with days and days of repetition and rote drilling, a retardate could learn the names of the books of the Bible, and could (perhaps with much frustration) learn to recite Bible verses that tell of God's love for him. But his potential for applying this factual knowledge to everyday life is sadly lacking; therefore, we do not include in his religious education the presentation of any great amount of factual information.¹

The lessons should be based on the interests of the children. They should see how God loves them and learn what He does for them each day in terms of real-life experiences. The program should include activities, songs, stories, simple handwork, and much patient repetition. One simple concept at a time should be built and carefully reinforced. It is through these activities that the best learning will occur for retarded children.

However, it should be remembered that these children can learn and need to learn the basic truths of the gospel message. They can be led to trust Christ as Savior and to pray and to give. A proper balance should be struck between conducting a play time and forcing meaningless "facts" into them.

The key to the curriculum is the resourceful teacher who can take simple illustrated Bible story material and make it even more simple and attractive to hold the attention of retarded children. A ministry of prayer and consistent love will enable these too often neglected children to learn about God's love for them.

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Educating teachers.—The greatest problem in providing instruction for retarded children in the church is the lack of qualified teachers who are both acquainted with the nature of mental retardation and able to express the Bible message in the simplest of terms. The attitude of the Christian education director will have a great effect on teachers who volunteer to help in this new and needy area. They will need much help, support and encouragement. They will need ideas and concrete suggestions.

The Christian education director or Sunday school superintendent will have a key position in the church’s program to help retarded children.

The Teacher

Ultimately, the most important person in the experience of the young retarded child as he comes to church will be the teacher. The teacher will determine how other children act toward the retarded child, whether or not he will be able to learn about God’s love, and eventually, whether or not his parents return to the church.

Attitudes.—Even the slowest child can sense attitudes of love and acceptance or of repulsion and impatience. It is important that the teacher develop a wholesome perspective of the retarded child. He should see him as a unique individual who needs to be loved and wanted even more than does the normal child; he should see the youngster first as a child for whom Christ died, then as mentally handicapped. He should see the child as God sees him. He is easy to please; he is usually affectionate; it is rewarding to see him grow. There is nothing to fear, nothing to dread. The teacher’s attitudes will be expressed in
the manner with which he treats the child and greets the parents. He must remember that the parents are justifiably sensitive and anxious about their little one. He should be understanding and accepting to them.

**Information.**—No one can teach retarded children without having some knowledge about general retardation and the individual child in his class. The teacher should be aware of the severity of the child's handicap and should have an accurate idea of his capabilities. It is not a matter to be discussed with everyone, of course, but the teacher should be given the approximate mental age of the youngster so he can know at what level of comprehension to direct his teaching. The pastor or the Christian education leader may be the one to consult with the parents and give the teacher the information that is necessary.

**Summary**

In this chapter some of the adjustment problems of parents of retardates have been pointed out and some ways a pastor can help by counseling have been suggested. One of the greatest needs, acceptance, can be met by providing a welcome for these children in the church. So some ways of helping retarded children in the church were discussed. It will now be helpful to draw together the foregoing thoughts into a positive conclusion.
CHAPTER V
CONCLUSION

This study has attempted to demonstrate the need for the local church to be concerned about the retarded child both in the church family and in the community. The purpose of this book has been three-fold:
1. to provide pastoral guidance to parents of retarded children
2. to provide information about the general nature of retardation
3. to describe three frequent types of retardation (cerebral, mental, and familial) as they relate to Christian education. It has also shown how the church can help parents of retarded children by counseling and by providing for their children in the Sunday School program.

Conclusion
It is hoped that this book may have some specific contributions to the field of Christian education. It has attempted to provide a source of usable information in consultation for churches, to demonstrate the need for churches to be concerned about retarded children, to encourage more teachers and young people to become involved in helping retarded children, to promote the writing of more literature in this field, to bring up the need of materials designed for the retarded, and to urge the preparation of evangelistic materials for this purpose.

Recommendations for the Sunday School
Based on this study several recommendations can be made for the Sunday School program of the local church: (1) The church must assets
CONCLUSION

This study has attempted to illustrate the need for the local church to be concerned about the retarded children in the church family and in the community. The purpose of this study has been three-fold: (1) to provide pastors and Christian education workers with information about the general nature of retardation, (2) to describe three frequent types of retardation (mongolism, brain-injury, and familial) as they relate to Christian education, and (3) to show how the church can help parents of retarded children by offering counseling and by providing for their children in the Sunday school program.

Contributions to Christian Education

It is hoped that this study has made some specific contributions to the field of Christian education. It has intended (1) to provide a source of usable information on retardation for churches, (2) to demonstrate the need for churches to be concerned about retarded children, (3) to encourage more teachers and young people to become involved in helping retarded children, (4) to promote the writing of more literature in this field, (5) to point out the dearth of materials designed for the retarded, and (6) to urge the preparation of evangelical materials for this purpose.

Recommendations for the Sunday School

Based on this study several recommendations can be made for the Sunday school program of the local church. (1) The church must meet...
the needs of every retarded child who may be in its family, either by an understanding teacher in a regular class or in a special class; no child should be excluded. (2) Formation of a special class should be considered if there are as many as three or four retarded children in the church. (3) A church should at least consider a special class to bring in retarded children from the community who are not already in the church. (4) Teachers should be able to identify retardation in children and so understand them better. Children who continually act out may be brain-injured; children who seemingly refuse to learn may be frustrated familial retardates. (5) Teachers of retarded children should simplify the material and set reasonable goals for them. (6) The church can treat retarded children with love, patience, acceptance and friendliness. Other children should not be allowed to mock them.

Implications for Church Outreach

This study of retarded children in the church leads to several implications for an evangelistic church outreach. The church that will teach retarded children will reach their parents. Every gesture of concern from the church opens the door to reaching the parents and families for Christ. A number of courses of action will be suggested for the purpose of helping retarded children and reaching their parents. The concerned church might be able (1) to initiate a special Sunday school class for retarded children, (2) to extend that class through church time so the parents can join in the worship service, (3) to have parties and programs for the children that the parents could attend, (4) to begin a parents' study group to discuss problems and to present answers in Christ, and (5) to offer counseling for parents.
A church might wish to go beyond the Sunday school program and provide further service. Women's and youth groups could contribute by volunteering (1) to establish a day care center at the church one or more days a week to free mothers of dependent retarded children for a few hours, (2) to teach Bible stories for the Bible hour in a local school for trainable retarded children, (3) to visit and play with children in a nearby state hospital, (4) to conduct a separate Vacation Bible School program for retarded children, (5) to secure names of parents of retarded children enrolled in special education classes and invite them to the church's special class, or even (6) to direct a nursery school for very young retarded children. These are but a few suggestions of avenues a local church might explore to help retarded children and to reach their families for Christ. People might not heed words of welcome, but they cannot help but respond to the demonstration of love in action.

The study comes to a close, but the children are still with us. It is with the sincere desire that it encourage Christian churches to do something about retarded children that this thesis is offered. It is hoped that it may prove of practical help to Christian education leaders who would inquire into this needy field.
Glossary of Terms

Brain Injury—Damage to the brain resulting in a slowing of thought processes, an infection and resulting in impairment of thought, orientation and behavior. Identified child development disorders is due to a physical defect.

Chromatophagy—Cell digestion, a part of the normal processes of the cell which forms matter and energy. It may be inherited characteristic in nature.

Eating—Moderate of eating between the ages 20 to 75.

Emotional—Describes mental or emotional condition within the child rather than caused by physical defect. May be familial and hereditary.

Eldercare—The study of the aging process or condition, or other condition.

Emotional—Describes mental or emotional condition rather than by inheritance.

Emotional—Describes emotional condition, not caused by physical defect.

Intellectual—Below average intellectual functioning that affects learning, memory, and thinking.

Muscular—Muscular retardation caused by a chromosome error accompanied by physical characteristics such as slanting eyes, large tongue, and flat head.

Neuro—Describes retardation caused by a physical defect. The cases of brain injury and neuro.

Pneumonia—A rub of characteristics which is used to distinguish a physical condition, such as pneumonia.

Tremor—Severe range of retardation including IQs 25 to 50.
GLOSSARY OF TERMS

Brain Injury--Damage to the brain caused by a blow or an infection and resulting in impaired thinking, perception and behavior. Identifies children whose retardation is due to a physical defect.

Chromosomes--Basic genetic material composing the nucleus of the cell which forms twenty-three pairs to transmit hereditary characteristics in cell division.

Educable--Moderate of retardation including IQs 50 to 75.

Endogenous--Describes retardation caused from within the child rather than caused by physical defect. The same as familial and hereditary.

Etiology--The study of the cause of retardation, or other condition.

Exogenous--Describes retardation caused by physical defect rather than by inheritance. Brain injury.

Familial--Describes hereditary retardation, not caused by physical defect.

Mental Retardation--Below average intellectual functioning that affects learning, maturity, and behavior.

Mongolism--Severe retardation caused by a chromosome error accompanied by physical characteristics such as slanting eyes, large tongue, and flat head.

Organic--Describes retardation caused by physical defect. The same as brain injury and exogenous.

Syndrome--A set of characteristics which distinguish a physical condition, such as mongolism.

Trainable--Severe range of retardation including IQs 25 to 50.
APPENDIX
TYPICAL BEHAVIOR PATTERNS

SOCIAL RESPONSES

12 months
1. He is beginning to vary his behavior according to the emotional reactions of others.
2. If some of his actions are laughed at, he is apt to repeat them.
3. He tries to get attention by making noises, squealing, or other means.

18 months
4. His play is on the solitary level.
5. He is aware of other children and likes to watch them and have them around, but he does not play with them. He tries to manipulate or push other children as he does objects.
6. He is beginning to claim certain possessions as his own.
7. He shows toys or offers them to someone else as a means of social contact.

2 years
8. His play is on the parallel level.
9. He likes to play near other children, often doing the same things, but he does not play cooperatively with them.
10. He seeks adult commendation for correct behavior.
11. He shows signs of affection, pity, guilt.
12. He tries to make others laugh by suddenly laughing himself or making some unexpected movement or gesture.

3 years
13. In his play with two or three children he is beginning to cooperate, but much of his play is still on the parallel level.
14. He is beginning to take turns, to share, and to settle quarrels verbally.
15. In dealing with adults he tries to please, tries to follow directions, and is responsive to approval and disapproval.
16. He shows an interest in the family and family activities.
17. He likes to have little household responsibilities.

4 years
18. He plays on the cooperative level with other children.
19. He knows it is necessary to share and take turns although he may ignore it when it is his turn to share.
20. He prefers children to adults.
21. He prefers to play in a group and often has a special friend.
22. He is social and talkative.
23. He is often found bragging, exaggerating, and boasting about himself or his family to other children.
24. He is more aggressive and resistant to authority.

1 Professor M. Wood, Language Arts for Slow Learners, Summer Session, 1965, Department of Special Education, Kent State University, Kent, Ohio.
He is less responsive to praise and blame. With guidance he will avoid interrupting the play or conversation of others.

5 years
He plays well in a small group of children.
He accepts adult supervision, and is more interested in conforming to rules and regulations.
He is more protective of younger brothers and sisters, although he is not dependable in taking care of them.
He likes family excursions, picnics, and outings.
He seeks and finds his own friends.
He is independent and is more aggressive in a group, disagreeing more with other children since he now has more ideas of his own.
He is sensitive to other people, especially to his parents’ reactions.
He responds negatively to pressure.
Under criticism he is apt to sulk or even become rude.

PHYSICAL BEHAVIOR

12 months
1. He can stand alone without holding on to anything
2. He can take a few steps with help.
3. He gets about freely.
18 months
4. He walks well and can get about the room or house without constant attention.
5. He is beginning to run, but his running is stiff and awkward with frequent upsets.
6. He is able to walk up and down stairs without assistance.
7. He is able to seat himself in a chair.
8. He can turn the pages of a book, one at a time.
2 years
9. He runs quite well, seldom falling.
10. He can string large beads.
3 years
11. He not only walks but runs smoothly and can stop quickly and turn corners in running without falling.
12. He can go up and down stairs using one foot per stairstep instead of bringing both feet together on each step.
13. He is beginning to ride a tricycle.
14. He can throw a ball without losing his balance.
15. He swings, slides, climbs, making good use of playground equipment.
4 years
16. He is lively, agile. He runs a lot, skips a little, and can make a standing or running broad jump.
17. He spends much of his time running, climbing, riding, and doing "tricks."
18. He goes up and down stairs in an adult fashion, even dashing up or down.
19. He throws a ball overhand.
20. He has good balance and can carry a glass of liquid safely.
21. His physical activity is more purposeful. It is directed toward a goal, is more controlled, less restless.
22. He is more capable in handling play equipment, fast on a tricycle, well coordinated in climbing.
23. He tries to roller skate, use stilts, jump rope, and similar complicated activities.
24. He skips smoothly, hops on one foot, and turns somersaults.
25. Right-and-left-handiness is well established.
6 years
26. He is quite independent physically. He can run fast, jump rope, skate, ride a scooter, and in general handle himself without supervision.
27. He tends to go to excess in physical activity. Sometimes this makes him appear clumsy.
28. His balance and rhythm are good.

**LANGUAGE**

12 months
1. He can imitate some familiar words.
2. He meaningfully uses some other words in addition to "ma-ma" and "da-da".
3. He will hand you a block or a toy or familiar object upon request.

18 months
4. His vocabulary consists of from five to 20 single words, usually names of people, familiar objects, or activities.
5. He chatters in nonverbal sounds or jargon which often takes on adult inflections of voice and sounds as if he were "talking" in another language.
6. He understands some language, often responding to such directions as: "Come here," "Give me a hug," "Do you want some milk?"
7. He can point to familiar objects in pictures, to objects in the room, and parts of his body such as eyes, ears, and nose.
8. He listens to rhymes and songs and interesting repetitions of sounds for short periods.

2 years
9. He has a vocabulary of from 12 to several hundred words.
10. He tries to use words in telling his physical needs or answering simply questions, but does not carry on conversations.
11. He is beginning to use pronouns, especially me and mine.
12. He combines two and three words to express an idea, such as "Daddy gone," or "Want a drink.
13. He understands simple directions and simple requests.
14. He carries on a "conversation" with himself or with his dolls.
15. He asks the names of things, "What's that?" "What's this?"
16. He listens to simple stories, especially liking those he has heard before.

3 years
17. He uses language easily to tell a story or relay an idea to someone else.
18. He expresses feelings, desires, and problems verbally.
19. He uses longer sentences, often with complex structure.
20. He uses plurals, past tense, personal pronouns, and prepositions such as "on", "behind", "under", "in front of".
21. He listens and can be reasoned with verbally.
22. He refers to himself as "I".
23. He knows many such items as his last name, his sex, the name of the street he lives on (but not the number), and a few rhymes.
24. He listens to longer and more varied stories.
25. His speech may be infantile but is usually understood even by those outside the family.

4 years
26. He chatters a lot and can carry on lengthy conversations with adults and children, though he may make grammatical errors and misuse words.
27. He asks questions endlessly, especially, "How?" "Why?"
28. He speaks of imaginary conditions, such as "Suppose that...", and "I hope..."
29. He tells tall tales and often mixes fact and fancy, truth and make believe, in his language.
30. He can repeat the numbers from one to ten in their proper order.
31. His speech is quite understandable.

5 years
32. He is interested in word meanings, asks what they mean, tries to use new words, can define some simple ones.
33. He spends considerable time looking at books.
34. He likes to be read to.
35. He can count pennies, four blocks, four steps, and so forth.
36. He knows such things as the names of colors, his own age.
37. He tries to draw numbers and letters, but his eye-hand coordination is too poor for accurate reproduction.

6 years
38. He is aware of mistakes in other people's speech.
39. He is apt to use slang and mild profanity.
40. He can use the telephone.
41. He understands roughly the differences between time intervals; for example, minutes compared with hours, or a week compared with a year.
42. He understands the seasons of the year in terms of what kinds of things you do in each.
43. He can tell how two similar objects are different.
44. He can count to 30 or more.
45. He can recognize pennies, nickels, dimes.
46. He can write or print his name and a few other words.
47. He is beginning to distinguish left from right on himself, but not on other people.
LIST OF CHURCHES WITH CLASSES FOR RETARDED CHILDREN

**Brethren**

Rev. David L. Hocking  
First Brethren Church  
3601 Linden Avenue  
Long Beach, California

Rev. Ward A. Miller  
Community Brethren Church  
11000 East Washington Blvd.  
Whittier, California

Rev. Robert B. Collitt  
Grace Brethren Church  
First and Spruce Streets  
Hagerstown, Maryland

**General Association of Regular Baptist**

Mrs. Irma Sheppard  
Shepherd Department  
Haddon Heights Baptist Church  
Haddon Heights, New Jersey

Dr. Joseph Stoll  
First Baptist Church  
Anderson Park  
Hackensack, New Jersey
ADAPTING REGULAR BAPTIST PRESS SUNDAY SCHOOL MATERIALS 
FOR USE AT SHEPHERDS HOME AND SCHOOL

MATERIALS WHICH WE USE:

1. **Songs:** All songs recommended for the quarter are taught. If possible we use large booklets. In teaching these songs, we introduce the song by singing and playing it. Since they love music, this gives them a desire to learn it. Then we teach the words without the music (sometimes with it) but we only teach a phrase at a time, explaining the meaning as we go along.

2. **Special Scripture Memory Portion:** These portions of scripture are mastered by the children as a result of daily repetition. We teach them word upon word and phrase upon phrase. We never pass by an unfamiliar word without explaining it or demonstrating it. Gestures familiar to children are helpful. If one uses much the same rhythm each time, the children become more confident in reciting it.

3. **Class Memory Verses:** We teach these verses in the same manner as we would the Scripture Portions mentioned above. However, we like to teach the entire verse rather than a portion of it. We do this only if the entire verse is meaningful to the lesson. In teaching the verse, we repeat the reference before and after reciting the verse.

4. **R.E.P. Flannelgraph Figures** are used successfully in all our classes.

5. **Worship Service:** We follow the Worship Service form in the teachers' manual but have added to it the teaching (introducing) of the new class verse, the recitation of the special memory portion, and praise and prayer time giving opportunity for several children to pray.

6. **Primary Pal Sunday School Take Home Paper:** The school teachers familiarize the children with the contents of this paper during their morning chapel hours. We're glad it is correlated to the lesson.

7. **Bible Readings for the Instructor:** Our teachers and housemothers have appreciated these extra portions of scripture with their titles.

8. **Objectives of the Lesson:** The objectives of our lessons are the same for our mentally retarded children as they are for other children.

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1Provided by Andrew H. Wood, Director, Shepherds, Inc., Box 111, Union Grove, Wisconsin.
9. **Teaching Tools:** Likewise, we use the same teaching tools.

10. **Review, Point of Contact, and Lesson:** These three items cannot be taught to mentally retarded children in one session. We take care of the review during the week. If we use the point of contact we separate it from the lesson by songs, stretching, etc. The reason for this is two-fold:
   a. The attention span of our children is short. It would be better to get directly to the Bible narrative and have them learn that than present the point of contact and have them tire before the actual lesson is taught.
   b. A brain injured child will be distracted by an object used in the point of contact to the extent he may not be able to divorce his thoughts from it in order to listen to the lesson. In other words, his mind will dwell upon the point of contact all through the teaching of the lesson.

11. **The Lesson:** Most of the time the lessons are proper length and on a good level for our children. We change nothing. If something seems out of reach of their mental capabilities, we do our best to simplify our teaching of it. We never by-pass any teaching.

Sometimes the lessons are too long and involved, especially if it is a review lesson. For example, the lesson "God is Real," July 7, 1968. This reviewed Joseph, the famine in Egypt, the new Pharaoh, persecution of the children of Israel, the 10 plagues, discussion on God including God is omniscient, omnipotent and omnipresent and the crossing of the Red Sea. We gave the entire lesson to our teachers and instructed them to select a portion or two for the review lesson.

12. **Changing Lessons:** It takes us two weeks to teach one lesson. Since we teach and review every day, our children probably have learned the lesson better than primaries who attend a 30 minute class once a week on Sunday.

When Shepherds opened in 1964, it took us four weeks to put a lesson across.

**MATERIALS WE OMIT FROM THE LESSONS:**

1. **The Pre-Session:** Housemothers are our Sunday school teachers and the children are with them up until Sunday school time.

2. **Attendance Posters and Contests, etc.:** All children attend Sunday school unless they are ill.

3. **Departmental Activities, Parties, Trips, etc.** are not used in conjunction with Sunday school at Shepherds.
4. **Letters to Parents:** We do not send the information regarding Sunday school to parents in letter form but in our monthly Shepherds Folder we inform our parents and churches specifically what is being taught, often including our goals and aims.

5. **Offerings:** We omit the offering and songs about it as the small children have no money and the older children place their tithes on the offering plate in church. (This is the tithe of their allowances.)

6. **Activity Book:** We could use much of the material in the activity book if we had time to do so. It would take considerable time for us to do this. The pictures used are very appropriate but our children do not read, therefore, could not do the exercises where they are required to fill in blanks (copying from the Bible or following paths from one point to another). Some of them are capable of following from dot to dot but in such cases the numbers would have to be enlarged. Actually, we have not evaluated the workbooks sufficiently but do feel much of it could be used in our program.
I. General Information

A. The National Association for Retarded Children
   420 Lexington Ave., New York, N.Y. 10017
   Ask for general bibliography and religion bibliography.

B. Superintendent of Documents
   Ask for bibliography of materials on mental retardation.

II. Christian Education of the Mentally Retarded

A. Sunday School Guidebook
   Shepherds, Inc.
   Box 111, Union Grove, Wisconsin 53182

B. Petersen, Sigurd D. Retarded Children: God's Children.

C. Stubblefield, Harold W. The Church's Ministry in Mental Retardation.
   This is an excellent tool for anyone interested in spiritual training for the mentally retarded.

D. Golden, Edward S. Pastoral Psychology (September, 1962 Issue)
   National Association for Retarded Children
   420 Lexington Ave., New York, N.Y. 10017

III. Good Reading

A. Schultz, Edna M. They Said Kathy was Retarded.

B. Lee, Carvel. Tender Tyrant.

C. Murray, Dorothy. This is Stevie's Story.

D. Thorne, Gareth. Understanding the Mentally Retarded.

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1Provided by Andrew H. Wood, Director. Shepherds, Inc., Box 111, Union Grove, Wisconsin.


Dear Pastor,

Three per cent of our children are mentally retarded. There may be retarded children in your own church family. I am writing my masters thesis for Grace Seminary on the problems of the retarded child in the local church. Your help in completing this brief questionnaire will be greatly appreciated. Please return it as soon as possible. Thank you.

Sincerely,

Evelyn Brubaker

1. Name __________________________ Church __________________________
   Approximate membership ________
   Type of community: rural _____ suburban _____ urban _____

2. Can you estimate how many mentally retarded children you know of in your immediate church family? ________ How many? ________
   Please indicate how many fall in these divisions:
   Ages: Integration: Help received:
   1 - 5 ____ Attend Sunday School ____ Institutionalized____
   6 - 10 ____ Attend youth groups ____ Special class_____
   11 - 20 ____ Don't attend ______ Not in school_____

3. What is currently being done for placement of any retarded children who may be in your Sunday School?
   Regular age group_____
   Younger age group_____
   Special class for retarded children_____

4. Would you be willing to establish a special class for retarded children? ______

5. Do you think your church would react favorably to the establishment of such a class? ______

6. Have you ever had occasion to counsel with the parents of a retarded child? ______ If so, with what success?

7. Do you feel the need for more information on how to help retarded children in the Christian education program of your church? ______

8. Do you feel the need for more information about retardation in general and on how to better help parents of retarded children? ______

9. Have you ever read any good books about mental retardation that have helped you? ______

10. Additional comments:
Dear Parent,

I was a teacher of retarded children in Akron, Ohio for two years. I am now writing my masters thesis at Grace Seminary on the problems of the retarded child in the local church. I hope to discover areas in which the local church can help both the child and his parents. Only candid answers from parents like yourself can provide the information our churches need to better help retarded children. Your help in completing this questionnaire will be greatly appreciated. I will be glad to make the results of my study known to you when it is finished.

Sincerely,

Evelyn Brubaker
267-3883

1. Parent's name ______________________ Phone __________

2. Church ______________________________ Child's age ______

3. Is your child presently attending a Sunday School class? ______
   If so, what department or age group? ______________________
   Is this placement satisfactory? ______
   If not, has he attended in the past or when he was younger? ______
   Can you say why he stopped going? ______

4. Do you feel that your child can benefit from simple teachings about God?

5. Would you like to see your church establish a special class? ______

6. Would you attend another church if it offered a special class? ______

7. Have you received any counseling help from your church in relation to your child? ______ If so, what kind? (adjustment, acceptance, training, future)

8. What kind of help would parents of retarded children like to receive from their churches?

9. What do you see as the greatest problem(s) relating to the retarded child in the church? Be as specific as you can.

10. Additional comments.
BIBLIOGRAPHY

Books


Periodicals


Werner, H. and Strauss, Alfred A. "Pathology of Figure Background Relation in the Child," Journal of Abnormal and Social Psychology, XXXVI (September, 1941), 236-243.


Unpublished Materials

Worksheet on retardation compiled for a workshop held in connection with Special Education Department, Kent State University, Kent, Ohio held at Apple Creek State Hospital, July, 1965.