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ABSTRACT

Discussed are the effects of parental attitudes on the early development of the congenitally blind child. The disproportion between family reactions and the limitations of the handicap are attributed to symbolic aspects of blindness and previously existing pathological elements in the parents. Compared are developmental milestones (such as the year's delay in establishing J. Piaget's concept of object permanence) of young blind and seeing children. Stressed is the importance for emotional health of the 4- or 5-year-old blind child's recognizing and verbalizing his blindness. The author reports on his examination of over 500 blind children under 6 years of age which involved a scale of development and an interview with the parents (usually the mother). It is concluded that one third of the children are relatively normal and come from accepting homes (more than half of these children have some useful vision); that another group of children with high verbal skills but low autonomy, sensory-motor, and sociability skills have mothers who are nonrejecting but overprotective due to lack of information; that a third group with high autonomy but low sociability, language and sensory-motor scores typically have mothers who were never able to overcome initial depression and rejection; and that a final group with very low overall development appear to have suffered severe affective deprivation. It is stressed that a blind child's upbringing requires greater virtues in the mother than does the normal child's upbringing. Appended are two scales of development for preschool blind children. (DB)

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THE BLIND CHILD AND HIS PARENTS
CONGENITAL VISUAL DEFECT AND THE REPERCUSSION OF FAMILY ATTITUDES ON THE EARLY DEVELOPMENT OF THE CHILD*

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INTRODUCTION

It is evident that the mere existence of a handicapped child invariably alters the balance of the family. While this situation is held by many writers to be responsible for any evident upsetting of the balance, from the separation of the parents to severe psychiatric pathology of one of its members, an alternative view is that the family reaction depends rather on "pre-existing psychological conditions," inasmuch as the handicap would seem to permit the expression of feelings which, in the normal course of events, would have been less intense or better controlled (Coughlin, 1941). Furthermore, for many of those in charge of guidance or educational services, it is always the inadequate attitude of the family which is blamed as the origin of vicissitudes in the child's development and his failure to adapt to his handicap.

On looking into the literature concerning family reactions to the handicap of a child, one constantly meets a number of stereotypes, irrespective of the handicap in question: parental depression, especially in the mother; wounded narcissism; anxiety and guilt at the time of discovery of the handicap; later, compensatory attitudes of rejection or of overprotection, etc. In practice, going beyond these similarities, one is struck by the disparity of these family reactions and by the frequent disproportion between their possible intensity and the real limitations which the handicap implies. It is from this dual viewpoint that one may grasp, on the one hand, the symbolic value of the handicap and, on the other, the possible role of pathological elements in the parental structure which already existed prior to the new situation created by the handicapped child.

It is not our intention to attempt a comparative study of the respective parts played by blindness and by other handicaps in originating an early disturbance of the child-family relationship. In fact, it seems clear to us that the early or congenital visual defect of the child is indisputably specific:

on the level of reality, blindness is not equivalent to any other handicap; even granted an ideal mother-child relationship and the best possible education, the earliest development of the blind child will follow a very different evolution from that of

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the sighted child, and all his later adaptation, both educational and socioprofessional, will run up against great difficulties;

on the symbolic level, blindness is in a special position owing to the fact that in every individual it evokes very primitive fantasies relating immediately to sexuality and castration. It is enough to recall the position of blindness in mythology as being a condign divine punishment for incest, reserved strictly for men. The well-known ambivalence of these fantasies, which bestow simultaneously on the blind person both total impotence and a magic omnipotence, could not be better illustrated than by the image of the adolescent albino in Fellini's *Satyricon*, blind and impotent, but hermaphrodite and a god. In the parents of a child born with a visual defect, this often provokes phobic reactions, which in turn influence the child's development through his object relations and his learning processes. In fact, the absence of sight rules out any possible grasp of the world at a distance. This grasp can come about only through the mediation of "tactile seeing" and will thus depend on "what is given to touch," with all the imaginable limitations due to prohibitions against eroticized touch.

This immediate phobic *reaction* can be overcome, either spontaneously, or more especially with the aid of guidance. However, when a phobic *structure* exists in one of the parents, and particularly in the mother, prior to the birth of the blind child, an almost inevitable arrest of development or the psychosis of the child is to be expected.

That a blind person can reach a normal or even a superior level of development and integration is a truth underlined by many writers, and on this is based the claim that blindness as such is not a sufficient condition for the hindrance of intelligence in the widest sense (Hatwell, 1966). However, the proportion of backwardness or of psychosis is distinctly higher among children born blind than among sighted children, which frequently gives rise to the diagnosis of "multihandicap" even in the absence of any other associated physical defect. This notion, which is very widely turned to account in countries where the appropriate educational and therapeutic possibilities remain unreliable, certainly deserves to be very widely criticized.

On the other hand, in countries where more systematic studies have been carried out, the notion has gradually evolved that the retarded or deviant development of blind children depends more on early education than on their blindness as such. Thus, from a survey carried out over a period of five years on a group of nearly 300 children born blind (Norris, 1956) arrived at the conclusion that the development of the blind child who has no other major physical handicap may show a regular pattern of progress, at the end of which he will reach, at school age, the same level as that of sighted children of his age, provided that the educational situation has been "favorable."

This writer emphasizes the extreme diversity of the levels of achievement of blind children, the importance of fluctuations in the scores gained by a child in the course of studies over a period of time--fluctuations which are always linked to variation in the factors of the child's environment and concludes that what creates problems is not so much blindness as the adult's incapacity to know what he may *expect* from a blind child and how to encourage his optimal development.

We owe the most remarkable studies of the congenitally blind child to psychoanalysts. The descriptions and interpretations to which we shall refer are the outcome of their direct observation of children carried out within the framework of guidance begun as early as possible after the discovery of blindness, and of the treatment of certain cases referred to them at

a later stage with records suggesting retardation or psychosis (Burlingham, 1961, 1964, 1965; Fraiberg and Freedman, 1964; Fraiberg et al., 1966; Fraiberg, 1968; Omwake and Solnit, 1961; Burlingham and Goldberger, 1968).

These studies allot a position of primary importance to the environment in general and to the family in particular. First, guidance as conceived by these writers represents a therapy for the parents, to the extent to which it is not confined to outlining suitable behavior towards the child and to giving educational advice concerning his training, but inasmuch as it enables the initial shock of the discovery of the handicap to be toned down and permits them to understand the meaning of the phases of regression which will inevitably mark the child's path of development, even if this is a favorable one. Second, the therapy of very disturbed children also consists of taking in hand the whole family, even in psychoanalytic treatment of one of its members.

In France there is no systematic guidance service or any possibility of early specialized education for the visually handicapped, and it is often from the age of five or six onwards, and sometimes very late, that we are asked to assess these children with a view to their schooling or institutional care. However, at our instigation we have for several years been able to see younger children, chiefly in an ophthalmological capacity, and to trace the development of a number of them. Our observations, compared with those of writers who have been able to study blind children from birth or during the first months of life in the framework of intensive guidance, enable us to consider the disturbances in the child's development and their relation to the family attitude not only phenomenologically, but also dynamically; and to specify what in these disturbances and attitudes can be influenced toward "normality."

SELECTED DATA FROM THE LITERATURE

We shall attempt to summarize the views of the writers concerning, first, the optimal development of the blind child under guidance, by making an artificial division into various "sectors" which we shall again make use of in the analysis of our own data, followed by the picture of delay or "deviation" in this development.

During the first year, and especially the first eight months, there may be no quantitative retardation (by the Gesell tests, for example) of the postural development of the blind baby: the holding up of the head, the movements of the body turning over in the cradle, the seated position, the position standing with support--all these may be observed at the same ages as in the sighted child. This continues to be true of the selective smile at sound or contact (the mother's voice, or contact with the mother), the first vocalizations, and the acquisition of the first words.

Clear differences become apparent beginning in the last quarter of the first year and during the whole of the second year: no crawling on all fours; considerable backwardness in walking; a halt in acquiring new words; continuation of a great selectivity of affects, with extreme dependence on the mother or on a small number of special members of the household. These difficulties may be overcome later, chiefly from the third year onwards, when the child is able to acquire normal autonmy of movement and speech.

It is in the *sensorimotor* field, the field of exploring and manipulating objects, that distinct differences are observed very early. During the greater part of the first year, the blind child has no spontaneous tendency to move his hands and arms. He does not hold out his arms to be picked up. Burlingham (1961) correctly observes that the blind child in the cradle moves his feet and legs much more than his hands and arms, which for a long time retain the newborn position, with arms bent and hands at shoulder level. The hands are rarely brought to the midline and the child does not play with his fingers.

The reactions of orientation to noise, which appear about the second month in the sighted child, are

observed only towards the seventh month in the blind child.

The voluntary grasping of an object (which appears spontaneously at approximately five to six months of age in the sighted child) begins in the blind child at about seven months, for an object which has just been handled and then taken away from the child, and at about one year for an object located by purely auditory clues. The concept of object permanence, in Piaget's sense, takes root only very late and remains weak for a long time. In this area the blind child shows a developmental delay of at least a year, which bears witness to the primary role of vision in the constitution of mental representation. This notion can be acquired by the blind child only after a prolonged phase of training in which tactile manipulation plays an essential part, as purely auditory information is not enough to give substance to the object unless it has been handled simultaneously, or very recently. Thus, for a long time there is no active seeking for the object lost, as if it existed only while in direct contact with the child.

The development of speech undergoes a very special course of development starting from actual verbalization during the second year. Whereas the sighted child rapidly enlarges his vocabulary, the blind child does not increase his stock of words and may even forget words already learned. Only in the third year, and especially when he is able to move about autonomously and enter into contact with more and more objects, does his language really become richer (Fraiberg, 1968). But one may also note the acquisition and use of a great number of words which are devoid of meaning for the child and are a mere imitation of the speech of sighted persons.

Burlingham (1961) considers that the oral pleasure derived from the first babbling plays a greater role and lasts longer in the blind baby than in the sighted one. Before being used for communication, words are toys, and talking is an activity which is an end in itself. The excessive prolongatibn of this mechanism may lead to the echoed speech, or verbalism of the blind. Here, too, one may expect the adequacy of the child's speech as a means of communication to depend on the adequacy of his environment.

In the foregoing outline we have, as much as possible, limited the consideration to motor and cognitive development. Indeed, a fundamental notion which is much stressed by these authors is that this development demands a much more intensive training than in the case of the sighted child; that this training is not spontaneous but must be induced by the adult and, above all, that it can be meaningful only in a context of satisfactory libidinal object relations. Here lies all the importance of the family attitude (which for the sake of simplicity is often limited to the mother's attitude) and of the quality of the mother-child relationship.

For the first few weeks or months of his life the blind child is in fact very quiet and may remain passively, for a dangerously long period, in what S. Fraiberg (1968) calls "a void" which can be filled only by what is given from outside. It is most important that from birth the child should be held in the arms, played with, and placed at the center of family activities during his waking hours; but it is still more important that the stimuli given to him should be a source of pleasure to their originators as well as to him. Only through shared pleasure can a "dialogue," in Spitz' sense, be set up between the baby and his human environment.

This is indeed not peculiar to the blind child and is valid for all children, but--and this is the first stumbling block--the blind child who needs more stimulation than a sighted baby, both quantitatively and qualitatively, is likely to be to a great extent deprived of this, as on the one hand he asks for less, which is the first expression of his passivity, and on the other the mother may remain withdrawn from the child owing to her depression. It is at this point that early guidance finds its full justification and usefulness if it succeeds in diminishing this initial maternal reaction and in encouraging mutual pleasure through interaction.

Libidinal object relations may, therefore, be established normally during the first year and the child may show a selective attachment to his mother or to the people around him, whom he distinguishes from strangers by the sounds of their voices, by the way they hold him and, later, by exploring their faces. Differences are noticed very early, however. The smile is less frequent in the case of the blind child and is less distinct, as if deadened; it arises only from interaction with another person and is not evoked by inanimate objects. During the second year open displays of affection remain induced responses and the child behaves as if he cannot himself be the initiator of a relationship.

This lack of initiative is linked with a defect in the gradual gain in independence from the mother. The role of sight is here again a determining factor in the process of mental representation and internalization of the libidinal object. The same delay is seen in the realization of the concept of the libidinal object constancy as for the object permanence. Hence, the separation anxiety shows particular intensity and continues well beyond the end of the second year. The blind child seems to be reduced to a state of helplessness and panic as soon as he loses contact with his mother, and may react to this loss by a global regression in all his acquisitions. The reaction to anxiety and frustration is very characteristic in the blind child. All writers have been struck by the fact that he reacts by withdrawal, regression, immobility, and autoaggression; that energy is discharged through his axial rather than his peripheral musculature; and that there is no spontaneous tendency towards a motor discharge directed against an external object. The prolonged dependence on the mother, which entails on her part an increased dependence on the child, and the weak nature of acquisitions forever challenged by unforeseeable emotional shocks, make the child's second year a difficult and trying period. Concrete circumstances (the child's being put into hospital, ophthalmic treatment, the illness or death of a parent, etc.) may give rise to real crises which are difficult to overcome (Colonna, 1968).

Many writers, in particular Parmelee et al. (1958), have observed that even in the best conditions of guidance mothers who have quite got over the initial shock of the discovery of the child's blindness may later decompensate, not knowing how to control and master this regressive anxiety.

The service of guidance and early special education (such as some "Sunshine Houses") can help considerably in coping with this critical period by widening the child's field of cathexes, by developing his motor initiative and his mastery of an environment which offers both richness and security, and especially by helping the mother to understand her child's needs and to meet them without excessive anxiety or guilt.

It is between the ages of three and five that the child is able to acquire progressively greater self-control and improved emotional stability. At the age of five or six he may attain qualities of autonomy, control, and curiosity which render him fit to begin schooling, as such, with the appropriate technical facilities.

Inasmuch as this result is strongly dependent on previous training which involves the active intervention of the mother at every stage, the difficulties and hazards of this learning process must be stressed. Winnicott defines the *good mother* as one who "must be capable of adapting actively to the child's needs." In the case of the blind child, these needs are at once unexpressed (initial passivity) and very complex; the necessity to compensate for the absence of sight by awakening all the other channels of sensation, tactile, auditory, kinaesthetic, etc. (but the child has no spontaneous tendency towards such compensation), and the necessity of existing in the other's fantasy in spite of the difficulties of identification created by blindness.

Learning by itself, or "overstimulation," might suggest that the blind child should in every way and at the same ages behave "like" a sighted child. In fact, what is necessary is to create and maintain gratifying conditions of exploration

(both for the mother and for the child) which may in turn facilitate motility, intentionality of movement, dialogue and so on, not by a simple imitation or "veneer" of the sighted child's behavior, but by means suited to the blind child who is accepted as being different and as having a special pattern of development.

Burlingham (1965) rightly insists that learning and play should merge and that this is one of the things which should be taught to mothers. She attaches a high value to bodily games: the mother's playing with the child's body and the blind child's exploring his own body and his mother's body, which is still more necessary to him than to the sighted child.

In the opinion of this author the mother's body retains its function of a "toy" well beyond early infancy and certainly until the age of three. She attributes to a scarcity or absence of these early bodily games not only the lack of libidinal cathexis in the child's own body (which could, we believe, be the source of disturbances in the body scheme so often observed later) but also the blindisms (rhythmic rocking movements and repetitive movements of the body or the hands) so common among blind people that this name has been given to them, even though they may also be seen in autistic sighted children.

These blindisms are also attributed by the same writer to the restriction of movement caused by blindness to the extent to which it deprives the child of any possibility of controlling the consequences of his actions, and which is maintained by the household because of the real or supposed dangers which they wish to spare him in the external world. In her view they have the double function of autoerotic activity and of discharging energy which cannot be otherwise discharged.

The choice of "toys," vehicles of the learning process, should be decided upon in accordance with the blind child's own needs (Burlingham, 1965); many traditional toys (small scale models, for example) have no meaning for him, although handling the real adult objects may interest him (saucepans, car, light switch, etc.); certain children's games hold no interest unless they are played differently (for example, building a tower with blocks becomes a game only if the child is first allowed to knock down the tower built by somebody else) and certain activities take on a special importance (games with doors, for example). The ingenuity and tolerance of the family may be measured by the diversity and adequacy of the play activities supplied or at least not forbidden to him in his family environment.

It seems that the completion of the blind child's early development requires the recognition and verbalization of blindness by the child, and the most favorable time is at about four or five years of age (Burlingham, 1961; Cratty et al., 1968), but often later (Deutsch, 1940). The other's ability to see is experienced by the child as a magic power: the sighted person can "feel" and "know" without touching; one cannot hide from him, whereas he can disappear or reappear as he pleases, etc. The magic omnipotence of the sighted adult for the blind child finds support in reality which experience tends to strengthen instead of progressively controlling. It is clear that the recognition of the blind/sighted difference is superimposed on that of the difference between the sexes. The latter may be hidden or distorted to an equally great extent by the absence of sight, and especially by the attitude of sighted adults, the mother in particular and then the teachers. They very often feel that learning or information at this level is useless, or impossible, even forbidden, as the blind person can be conceived only as castrated or hermaphrodite, but not as a sexually differentiated being. Here we must stress the absence of reported data, the rarity of experiments on sexual information or education of the blind, and the very belated nature of this education when it is finally planned (Van't Hooft and Heslinga, 1968; Wright, 1968).

On the other hand, we do find in the available literature cases of congenitally blind children whose development, far from being optimal, is very delayed or "deviant," but whose disturbances can be totally or partly reversible at the cost

of intensive care of the child and of his family.

Fraiberg (1968) points out the uniformity of the clinical pictures, and the descriptions of other authors (Keeler, 1958; Parmelee, 1955; Parmelee et al., 1958) correspond to hers. The children she has studied show the same symptoms irrespective of age, and their behavior at ten years old may be identical to that at three years old, with the exception of progress made in the field of locomotion. This would seem to be an arrest of the ego development occurring in the second year, which resembles psychosis but differs from the cases of autism observed in the sighted child and coincides rather with the classic case of Spitz' *abandonism* where the child spends most of his time lying in bed, in an armchair, or on the floor, chewing an object with an absent-minded air. Objects or toys hold no other interest than to be put into the mouth, which remains the primary organ of perception. The hand has no autonomy of its own and is not used for exploration or manipulation. It is the *blind hand*, incapable of a voluntary coordinated movement, which seems to be solely at the service of the mouth yet unable to be used for voluntary feeding.

Contact with human beings is of a very primitive kind, symbiotic fusion, or clinging and biting. The mother may be the preferred object, but sometimes the mother is in no way distinguished from the environment and this behavior is generalized. Also to be noticed in these children are the ceaseless rocking movements of the head or body, or rhythmic flapping of the hands and arms. Speech is essentially echoed, with repetitive use of words, sounds, or phrases which the child has heard. He refers to himself in the third person and speech is not used for communication.

Most of the authors who have analyzed these cases emphasize the considerable disturbances in the family which the blindness has brought about; severe and long-lasting depression and guilt in the mother and her failure to establish "emotional contact" with the child in the course of the first few months (Keeler, 1958). Fraiberg (1968), Burlingham and Goldberger (1968) stress the fact that these patterns can be reversed if they are treated (both mother and child) early enough. The later the educative therapy begins, the more incomplete and hazardous will be the improvement.

But here, too, one may wonder whether the limits of this improvement are not those of the environment, therapeutist included. In the case of "Peter," described at length by Fraiberg and Freedman (1964), the treatment was abandoned at the advent of puberty, it being considered that the results attained could not be surpassed. This is oddly reminiscent of the case of Itard's wild child.

SUMMARY OF THE AUTHOR'S OWN DATA

Over the last eight years we have examined about fifty children, either completely blind or with very poor sight (legal blindness), under six years old, and chiefly at the National Ophthalmological Centre of the Quinze-Vingts. We have been able to follow the progress of a number of them insofar as their parents asked to see us again or accepted our suggestion to follow the development of their child.

In the case of multiple examinations long and repeated interviews with the parents enabled them to become conscious to some extent of their attitude towards the child, and even to alter it.

During these examinations we very frequently came across some of the kinds of behavior just described, but if we were impressed by the magnitude of the disturbances both of the child and of the parents, the diversity of the pictures seemed to us as striking as their gravity. This brought home to us the need for a method of examination whereby the quantified evaluation of a level of development would take on meaning only in the context of observation of the child and the parents in their reciprocal relationship. For every case and at each consultation the examination lasted for several hours and was carried out by two different people. It consisted on the one hand of the application of a scale

of development, and on the other of an interview with the parents (most often the mother) and observation of the child in their presence.

The test used was the scale of social development of Maxfield-Bucholz (1957), (Leger and Lairy, 1965), which is the only test standardized on a population of young blind children. Its internal organization has been rearranged and complemented with items from Brunet-Lezine for children less than one year old, and from Hayes-Binet for older children.*

The Maxfield-Bucholz scale of social maturity is a questionnaire which asks of the person questioned--usually the mother--a detailed description of the child. Its chief interest lies in the fact that this description rapidly transcends the boundaries of the questions asked and develops into a free discussion, in which ignorance, errors of judgment, feelings expressed, and emotional coloring permit an understanding of the way the mother sees her child; the mother-child relationship influences the protocol in two ways. This relationship determines the child's level of social functioning and conditions its presentation in the mother's account; but compared to reality the mother's account constitutes a distortion which must be circumvented and assessed if the inquiry is not to be meaningless. Observation remains the only means of finding out the way in which the child does or does not do certain things, his attitudes toward objects and the environment, and his interactions with adults.

The criticisms which may justly be made of these tests spring from the fact that they are adaptations of tests for sighted children, and that they assess the behavior of blind children from the point of view of those with sight and in relation to them. The disguising of certain items, adaptation of performances calling upon sight, to performances calling upon the sense of touch or hearing, should not obscure this point, even if standardization on a population of blind children specifically involves blindness in the classification.

The original Maxfield-Bucholz scale is comprised of 85 items divided into six age groups, from one to six years, and these items are again divided into seven categories: general autonomy, ability to dress without help, communication, socialization, locomotion, activity. The distribution of the different categories in each age group is rather uneven.

The reorganization of this scale results in the grouping together of the scale's original items under five headings completed by items taken from the Brunet-Lezine or the Hayes-Binet tests. The five sectors of behavior are thus distinguished: posture, sensory-motor, sociability, speech, and autonomy.

Under the heading Posture (whose items only cover the first three years), only the postural *abilities* of the child are tested (ability to master the seated and standing positions, and later walking) but not their *efficiency*, which depends on learning and on what is allowed by the mother. These are assembled under the heading "Autonomy."

The Sensory-Motor sector tests in turn the motor aspect of grasping; interest in sounds, objects, and the environment; activity directed toward objects; the capacity of attention and of fixation on a given action; play activities with sounds and words and later with objects and people.

The sector entitled Sociability consists of items testing, first of all, sensitivity to human contacts, reaction to the voice, affective displays expressing the need for contact, exploration by the child of his own body and the beginning of object relations, and the distinguishing of familiar

*These modifications have been elaborated upon by E. M. Leger, to whom we also owe a great many sets of psychological reports serving as a basis for this work.

and unfamiliar voices; later, the modalities of exchange and the internalization of prohibitions; later still, verbal knowledge of the parts of the body, the ability to cooperate and to adapt to day-to-day surroundings; finally adaptation to a wider collective existence, consciousness of self and cooperation with other children, adaptation to the group and the ability to respect its rules. Under this heading we have added a further item for the second year, measuring the ability to surpass the first oral stage by accepting solid food, and another for the third year testing the faculty of sphincter control; these two activities seem to us to assess a type of relational modality rather than the acquisition of autonomy.

Under the heading Speech we have grouped items testing solely communication with the help of ordered sounds. Verbal games, songs learned by heart, and counting rhymes have been placed under the heading Sensory-Motor.

Finally, the Autonomy sector comprises items expressing the child's ability to do things "by himself." This sector assembles the things which stand out most clearly in what is allowed, encouraged, or forbidden by the mother. This becomes evident first of all with regard to locomotion: moving about indoors and outdoors, awareness of obstacles and ability to avoid them, assessment of distances, etc.; but it is relevant to all daily activities, such as feeding, dressing, care of the body, cleanliness, etc. As for sphincter control, we have considered it important to dissociate the ability to exercise this control (measured in the Sociability sector) from the putting into practice of this ability, as the latter depends on the attitude of the mother. It may appear arbitrary that we have compiled this sector separately from that of Sociability. In fact, they test two fields which are distinct and which often are not parallel.

The results obtained from this scale lead us to the schematic description of four groups according to the overall level, but especially according to the elective nature of the disturbances in one or another of the sectors of development, and the qualitative differences between these disturbances which cannot be adequately rendered by quantitative assessment.

Group I. This group is characterized by an overall quotient near or equal to normal, with relatively homogeneous scatter in the five sectors of behavior studied. It comprises about one-third of our population and can be considered as the "normal" group. Study of the family environment shows that after a depressive phase, usually short, the child has been satisfactorily accepted and that the educational attitude has been on the whole neither limiting nor rejecting. Much more frequently than for children in the following groups, one sees siblings born after the blind child. The fact that the parents have been able to plan or to accept to have another child in itself bears witness to the family attitude. The younger child by his very existence will have a normalizing role on various counts. Being the child to "heal" the parents' narcissistic wound, he makes possible the positive cathexis of the blind child's progress, and by means of the games he shares with him he also has a favorable influence on his learning and the development of his relationships.

It should be noted that less than half the children in this group are wholly blind, and that the remainder have some useful remaining vision (legal blindness). It is certain that this weak residual sight, when it exists, can facilitate the child's early development; it allows the parents to ignore the blindness for a longer time or to valorize the remaining sight, and in this case it leads them to encourage him to use existing sight to best advantage and to develop visual-manual coordination. Later one sees in these children a good use of remaining sight in exploration or orientation.

Schooling for children in this group is taken for granted by their parents, and its variety depends on concrete factors: the degree of

sensory deficit, the geographical situation of the parents, etc. The child is even sometimes put into a kindergarten with sighted children, either spontaneously or at our suggestion.

Other types of profiles, to be found in nearly 40 percent of our population, are distinguished not so much by a mediocre overall social quotient (the average being around 75) as by the extremely wide scatter of performances, with certain sectors showing normal or superior scores, whereas others show extremely low scores. Several forms of dissimilarity may be observed, but two extremes seem to stand out in relation to the parental attitude, according to whether the failures reflects defective learning only or a disturbance of the object relations.

Group II. The second group is characterized by normal postural abilities, and especially by a normal or superior level of speech for the child's age. By contrast, performances in the Autonomy, Sensory-Motor, and Sociability sectors are mediocre and the scores under these three headings barely reach the level of approximately half the child's real age.

What is most striking in the field of behavior is the child's extreme passivity--a passivity maintained or even encouraged by the overprotective attitude of the mother, who does not encourage him to do things by himself, but takes over all daily activities from him. This state of infantile dependence also finds expression in other spheres: delay in accepting solid food, delay in acquiring habits of cleanliness (sometimes very late bed-wetting), etc. However, apart from blindisms and the usual manifestations of separation anxiety, we are dealing here with genuine delay--behavior which would be normal for a younger child--rather than with really pathological behavior.

The quality of speech should be emphasized. Indeed, the children in this group display considerable verbal richness, using language both as a means of communication and as a game. It is with these children that one often finds long periods, just before falling asleep, when they talk to themselves or to a favorite object in a way which reproduces in its terms or its rhythms dialogue with an adult. These episodes, during which the child usually seems very happy, may even precede true verbalization and testify that genuine preverbal dialogue has already been established between the child and his mother. And indeed, after the first depression, the mother waits for and experiences her child's learning to talk as a reassurance that she will be able to understand his needs and communicate with him. But these mothers very much underestimate the child's real capabilities in everything concerning his activity; they are very limiting, and spare him experiences which they fear may be traumatic. When there is some remaining vision, the child is not encouraged to make use of it for exploration, and later he behaves like those who are wholly blind with regard to orientation, locomotion, location of obstacles, etc.

It is interesting to note that there are a number of premature babies in this group. It seems that prematurity as such may play a decisive role in determining the mother's attitude. On the one hand, a very small and delicate baby handed over to the mother at a late stage and requiring special precautions in rearing during the first few months induces and justifies her anxiety and overprotection; at the same time, the real danger of the possibility of the baby's dying may annul unconscious wishes for the child's death so often observed in the mothers of full-term blind children, especially those of the following group.

These nonrejecting, "too good" mothers often become aware of their attitude in the course of the interview, and of their wish for the child to remain a small baby, easier to protect. They are quick to express their regret at being totally lacking in information hitherto, and respond readily to guidance. Usually they greet with delighted astonishment the demonstration that their child's capabilities exceed their own assessment. They willingly accept educational advice and the periodic interviews; they sometimes

even ask for them. During successive examinations of these children we have been able to measure the consequences of the change in the mother's attitude. Spectacular progress may be observed very swiftly in a few weeks or months, which has a bearing in particular on everything related to the Autonomy sector, but which can also raise the overall quotient by 15 to 20 points. This giving of autonomy to the blind child who has a good speech level will facilitate and hasten his starting school, which the mother would instinctively tend to postpone to a dangerous extent. We think in fact that disorders due to this type of parental overprotection are the most easily reversible in the preschool period. If we refer back to our earlier studies of the visually deficient child of school age, brought up without guidance (Lairy et al., 1962), we see that disorders of motor and emotional control, cognitive disharmony, and lack of eagerness to learn are frequent; the later that schooling begins the more serious they are and which then necessitate intensive education, reeducation, or even psychotherapy.

Group III. The other extreme form of disharmonious scatter is marked by normal postural development (always taking into account the characteristics of our test) and by a high score in the field of autonomy, sometimes above the normal. Yet, in the Sociability and Language sectors the scores obtained do not reach half the child's real age; the greatest failure is found in the sensory-motor field, where, in general, successes do not exceed nine months according to Brunet-Lezine and the first year on the Maxfield-Bucholz scale. Observation of the child makes it abundantly clear that these failures do not indicate a mere delay in development, but are the expression of very pathological behavior as much in exploration and learning as in relationships. With regard to grasping and manipulation of objects one may note that, in certain cases, the object is used only for aggressive outbursts, throwing, hitting, etc.; or with certain familiar objects, for delicate and complicated manipulations, stereotyped and repeated indefinitely. In other cases there is a definite refusal to hold and manipulate, or even a withdrawal by the child as soon as he comes into contact with the object, as if this contact were painful. Where food is concerned, the mother reports not only refusal of solid food but vomiting at contact with such food. Here one may justifiably talk of touching and feeding phobias. To these phobic symptoms may be added displays of terror at any unfamiliar noise.

On observation one is often struck by the child's appearance; the sartorial affectation of which he is the object, and sometimes the clash between the perfection of his clothes and the socioeconomic level of the parents immediately give the impression of a doll-child, a child-object. This child may remain clinging to his mother, huddled up against her in a symbiotic attitude, his immobility broken only by blindisms or the ceaseless movements of pressing against the eyeballs with a finger or the whole hand, and showing terror if he is touched or spoken to. He remains silent or tirelessly repeats phrases overheard, which have no connection with the immediate situation except that they seem to be intended to distract the mother's attention.

Study of their speech sometimes reveals complete mutism in the youngest children and, later, echoed speech as classically described: the vocabulary seems to be rich, and certain children are able to reproduce whole sentences which have just been spoken to them in the same tone and sometimes even in a similar voice; they may answer a question by repeating the question asked; they refer to themselves by their first name or in the third person, and they do not distinguish themselves from the person who is speaking to them or whom they are addressing. While they display an astonishing memory for words and occasionally a great interest in music, speech is not used or is used very defectively to express needs or to communicate.

The mothers of these children are very typical: they have all gone through a long depressive period on discovery of the child's sensory defect, compensated by an apparently strong attitude of attempt to overcome this. They have "decided" to

forget the sensory defect and to bring up the child "like any other," and in this way have encouraged a certain number of activities: walking, climbing, riding a bicycle, etc. In fact, during the interview it becomes clear that this depressive phase has not been left behind, that the wish for the child's death continues and that the mother is restructuring herself at the price of a negation of the defect, or of the child himself. Some mothers find it an unendurable ordeal to occupy themselves in a series of daily tasks for the child (feeding, bathing, etc.) and leave these to the care of other people--grandmother, domestic help, etc. They do not play with the child, who is often left for hours at a time with the radio or records; they pride themselves on his musical knowledge without seeming to be affected by the total absence of any possibility of dialogue. The rationalization of this attitude may be compulsive professional or housewifely activity, indispensable to their own balance. Sometimes refuge is taken in magical beliefs and the child is taken to healers or on yearly pilgrimages. All cathexis in the child is suspended while a miracle is awaited.

One is faced with a phobic structure fairly well compensated before the birth of the handicapped child, even if certain symptoms had appeared (feeding phobias, dirt phobias, etc.), and for which the upbringing of elder children would have posed no major problem. However, the possibility of having another child is always rejected in this context, even if there is no genetic reason to justify the fear of a repetition of the handicap.

These mothers are not very responsive to guidance. Interviews are difficult and are felt to be a trial and judgment to the extent that they arouse their guilt and question their defense system. They show an immediate need for individual treatment, but this treatment is always refused if the problem is raised during the interview. They ask for nothing, neither help for themselves nor educational advice for the child; if they ask for anything it is of the order of a miracle, or to place the child in an institution. In a few cases of repeated examinations we found that when new acquisitions had been made by the child they remained incomplete, or were even obtained at the price of regression in another sector. So our intervention on the mother could remove a prohibition in one sphere, but to all appearances left intact or even strengthened the mechanisms responsible for the child's retardation and its permanence.

Thus the child seems to be trapped in the maternal falsehood which consists of her apprent wish that he should be "like a sighted child" and her prohibition of his existence as a blind child. In his state of total dependence he appears to express by his phobic behavior both a response to his mother's phobia and the fear of losing his mother if he transgresses her prohibition.

These cases come close to those described by Fraiberg as *ego deviations*. It is doubtless possible to carry out therapy for the mother only from the moment of totally taking over the child--as in the case of Peter, to which we have already referred. We should recall, in this famous example, that Peter's mother embarked upon her own analysis only many months after the beginning of his reeducation in a psychoanalytic context--reeducation in which she had to participate and in the course of which she was able gradually to become aware of her own problems.

In our experience, in the absence of such possibilities most of these children are condemned to being placed sooner or later in a mental hospital. If they reach a special school, their level of acquisition remains very low and their noncathected learning remains, as it were, "external" to them and always fragmentary.

Group IV. The last type has a very low overall level of development, the social quotient according to our scale not exceeding 40, and a fairly homogeneous scatter for the scores obtained under all headings. It is certain that among these children are found genuine multihandicaps due to the association of blindness with an early encephalopathy. It may also be noted that certain children showing signs of deafness

associated with their blindness may come into this group, at least for as long as the deafness is not disclosed, thereby demonstrating the importance of combined sensory deprivations. But if these cases are excluded, a certain number are found for whom only a severe affective deprivation can explain the picture, identical in all respects to that of marasmus described by Spitz. In this picture of very widespread disturbance, blindness figures as an epiphenomenon. The marked delay in the postural sector should be emphasized. This has rarely been noted in the literature relating to blind children and in our population it has only been observed in this context. It may become apparent from the earliest months: general hypotonia, especially of the axial musculature; considerable delay in holding up the head and in the acquisition of the seated and the standing positions, even with support. These children also show great frailty and an extreme susceptibility to even trivial infections (rhinopharyngitis, otitis, etc.).

These cases of severe retardation through affective deprivation are relatively scarce in our population.* It is customary for them to be considered by pediatricians as "neurological" and ranked as multiply handicapped with associated brain damage. The prognosis is all the more serious in that this label deprives the parents of all hope at the same time as it soothes guilt and blocks any attempt at adaptated education.

*We are speaking here only of children seen with their mothers. While severe affective deprivation is exceptional when the child remains in his family, it must be mentioned that in France abandonment at birth is quite frequent for babies born blind. According to an estimate in 1947, the proportion of blind children left to the care of Public Assistance (compared with the total number of blind children) was more than four times greater than that of children without any sensory deficiency.

DISCUSSION

1. It is obvious that many fields could not be explored within the limits of this account. Among these, the specific role of the father, his own reaction to the child's visual handicap, and the impact of his attitude on future identifications would all merit special study.

2. Many theoretical questions arise with regard to the affective adaptation of the congenitally blind child. With reference to Freud one may recall the primary importance attached to the "visual" (the eye, seeing, seeing-drive) in the establishment of object relations and the entire structuring of the psychic apparatus (Bourdier, 1971); it would seem that the study of those born blind could either confirm or radically undermine these theories. Quite obviously the problem could be posed only by enhancing the "sensory" lack (a lack which at this stage is experienced as such only by others) to the detriment of that which relates to "drive," as no equivalent of the seeing-drive seems to play such a prevalent organizational role in the human being.

   Ambiguity arises from the fact that not to see does not imply not to perceive, but that the object perceived is different from the object seen. Congenital blindness must, therefore, be studied as a *different* organization in which *we do not know* what the ways and means of substitution for the seeing-drive are. We only know that without external assistance spontaneous development occurs in a way which, compared with that of sighted children, evokes psychosis. But even in cases of nonpsychotic development the implications of these considerations with regard to key moments in affective development, such as the internalization of the object, the primal scene, and the discovery of the difference between the sexes still have to be defined.

We have seen how the internalization of the object may be achieved despite the delays and the setbacks of this achievement, whose modalities are linked to the dominance of the sense of touch. The *optical* representation of the object's Gestalt, which is global and instantaneous, is replaced by the fragmented representation, successively built up by degrees, of the *haptic* field of perception (Revesz, 1932). The abolition of distance immediately involves the dependence of perception on the object given to touch, and the difficulty of distance judgment.

Concerning the other two points, however, information is very inadequate. In the literature we have found no psychoanalysis of a congenitally blind adult. Psychoanalyses of children relate to autistic children, and direct observation of nonautistic blind children is invariably modified by the presence of the analyst and his active influence on the mother. We have personally been able to follow the cases of two blind adolescent girls during psychotherapy. The fantasies of primal scenes evoked in the course of treatment were striking for their terrifying and, especially, unlimited nature; the whole body was in imminent danger of being broken into by *something* equally limitless. In addition, it became obvious that the visual *lack* for them amounted to the absence of this *something* which they were unable even to connect with the penis as a real object.

This experience is plainly too fragmentary for us to be able to draw any conclusions, but it does enable us to consider the corrective role of sight in the representation of conscious fantasies, and its links with unconscious fantasies.

Another problem not attempted is that of the solution of the Oedipus Complex in the blind boy, owing to the fact that he has identification difficulties if he cannot live otherwise than castrated in the fantasy of others.

3. In practice, it is a complex problem to define to what extent this affective development underlies the integration of the blind in the society of the sighted. If the high quality of early development is a necessary condition of that of later development, it is certainly not sufficient, and we know how few people born blind in our country achieve proper socioprofessional and affective integration.

Lukoff and Whiteman (1970), studying the means of adaptation and their determining social factors in 500 blind adults, conclude that the degree and level of independence which they attain answers the expectations of the environment. This environment obviously covers the family, which is of course granted a dominant role, but it is widened to include the whole of society, and this poses again on a different level the problem of the attitude of the sighted towards the blind. It must be remembered that the contradictory fantasies of the impotent-omnipotent blind person are universal, and that they determine equally contradictory stereotypes (from the pathetic beggar to the blind genius). It is thus conceivable that certain educational and social structures intended for the blind reflect the ambivalences described for the microcosm of the family and in some way give them the force of law.

Hence, the "normal" blind child brought up to school age without particular overprotection most frequently finds himself segregated in an institution among blind children only, where learning clearly will take precedence over the blossoming of the personality. Despite the very favorable results of attempts at early integration of the blind child into schools for sighted children carried out in other countries, it should be noted here that in France no educational integration of blind children is provided for by law before the end of secondary schooling. This means that a

very small number of them benefit (the "blind geniuses") and that the great majority remain dependent on protected surroundings of assistance or attain professional autonomy only at a mediocre level (traditional trades). Hence, one of the essential functions of these closed and protected circles designed by the sighted appears to be that of protecting the latter from the phobogenic object, blindness, by freeing themselves from guilt through the rationalization of technical obligations.

4. In conclusion, we think it important to qualify the very general claim put forth in our introduction, that accordingly it is the inadequate attitude of the environment, and primarily of the family, which is responsible for the failure to adapt to blindness. Whereas one may give the family credit for the good adaptation of a blind child, one cannot invert the proposition without underestimating the complex elements which come into play. The absence of sight makes the child's upbringing genuinely difficult; it demands much greater virtues in the mother than those required for bringing up a sighted child. The necessity to adapt to the special needs of the blind child should not overlook the fact that these needs remain unknown. The quality of performance which some blind children achieve bears witness to very remarkable ingenuity on their part, but leaves untouched the profound lack of comprehension of the compensatory mechanisms which they bring into play. To our knowledge, only W. Brodey (1969) has attempted a comprehensive study of these mechanisms by placing himself in a group of blind students as an ethnologist faced with an unknown world, the blind students acting as informers. By living blindfolded for long periods he was able to experience at first hand to what extent the hypercathexis of sight in every sighted person suppressed (in the physiological sense of the term) the relevant information conveyed by the other sensory channels, and to measure the quality of this information. This writer reached the conclusion that while the sensory world of well-adapted blind people is different, it is in fact infinitely more rich and varied than the world of those with sight. However deserving of criticism the methodology may be, this path of study among others seems to be likely to lead to a more positive understanding of blindness, and to a demystification of that which, in familial educational, and social attitudes, is merely a projection of this *lack* which is in ourselves.

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APPENDIX

SCALE OF DEVELOPMENT FOR PRESCHOOL BLIND CHILDREN

The numbers alone refer to corresponding items of the Social Maturity Scale of Maxfield-Bucholz.

Maxfield, K. and S. Bucholz. *A Social Maturity Scale for Blind Preschool Children.* New York: American Foundation for the Blind, 1957.

The letters P, S, C, or L followed by a number and the age in months refer to the corresponding items of the Brunet-Lezine test.

Brunet, O. et I. Lezine. *Le Developpement Psychologique de la Premiere Enfance.* Paris: PUF, 1951, 129 pp.

The numbers preceded by HB refer to the corresponding items of the Hayes-Binet test.

Hayes, S. P. "Alternative Scales for the Mental Measurement of the Visually Handicapped," *Outlook for the Blind*, 1942, Vol. 36, pp. 225-30.

Hayes, S. P. "A Second Test Scale for the Mental Measurement of the Visually Handicapped," *Outlook for the Blind*, 1943, Vol. 37, pp. 37-41.

In the scale, First, Second... year refers to the real age of the child to be tested.

The number of months indicated after the items of Brunet-Lezine refer to the age at which there was successful performance by sighted children. (This explains why the second year of real age in the blind child may correspond to performance during the first year by sighted children.)

First Year

Postural	Sensory-Motor	Sociability	Language	Autonomy
1 -	2 -	S9 1 month	L8 1 month	
				S10 7 months
P3 2 months	C4 1 month	S10 1 month	C8 2 months	
				S10 10 months
P7 2 months	4 -	3 -	L8 3 months	
P1 4 months	C3 4 months	S9 2 months	L8 4 months	
				P7 9 months
P2 4 months	C6 4 months	S10 2 months	L8 4 months	
P1 5 months	C3 5 months	S9 3 months	L8 5 months	
P1 6 months	6 -	S9 4 months	L8 6 months	
P1 7 months	7 -	S9 5 months	L8 7 months	

First Year (Continued)

Postural	Sensory-Motor	Sociability	Language	Autonomy
P1 8 months	C3 7 months	S10 6 months	15 -	
5 -	C6 9 months	12 -	L8 10 months	
P1 9 months	8 -	S9 9 months	16 -	
11 -	9 -		L8 12 months	
19 -	10 -			
P7 9 months	13 -			
	14 -			
	17 -			
	20 -			

Second Year

25	29	S9 10 months	22	27
P1 10 months	C2 10 months	S9 12 months	32	PL 12 months
26	C2 10 months	S10 12 months	37	31
P1 12 months	C5 10 months	34	L8 15 months	33
P7 12 months	C6 10 months	24	L8 18 months	35
P1 18 months	C2 12 months	S9 6 months	L9 21 months	P1 15 months
P1 21 months	C5 12 months	S9 7 months	L8 24 months	P7 15 months
	C2 15 months			P7 18 months
	C3 15 months			P7 21 months
	C4 15 months			
				23
	C5 15 months			
				28
	30			
				38
	C2 18 months			
				S9 18 months
	36			
				39
				21
				40

Third Year

Postural	Sensory-Motor	Sociability	Language	Autonomy
P1 24 months	42	45	44	
				50
P1 30 months	46	HB3	51	
				41
	47	HB4	L9 24 months	
				43
	48	S10 24 months	L8 20 months	
				49
	54	S10	HB6	
				55
	HB2			
				P7 24 months
	C2 24 months			
				P7 30 months
	C2 24 months			
				52
				53
				S9 30 months

Fourth Year

	69	62	61
			57
	HB6	69	64
			56
		HB1	66
			65
		HB6	70
			67
		HB5	HB4
			60
			68
			58

Fifth Year

Postural	Sensory-Motor	Sociability	Language	Autonomy
	79	71	81	
				74
	80	72	83	
				78
	85	77	HB1	
		82	HB2	75
				76
				84
				73

Sixth Year

	86		HB1	
				93
	94			
				90
	95			
				87
				89
				88
				91
				92

First Year

Postural

P3 - 2 months Lying on back, holds head erect when pulled by the forearms to a seated position

P7 - 2 months Turns self from side to back

P1 - 4 months When lying on stomach, keeps legs extended

P2 - 4 months Lying on back, lifts head and shoulders when gently pulled by the forearms

P1 - 5 months Stays seated with slight support

P1 - 6 months Held vertically, supports part of own weight on feet

P7 - 7 months Passes toys from one hand to the other

P1 - 8 months Lifts self to a seated position when slightly pulled by the forearms

P1 - 9 months Can remain standing with support

P7 - 9 months When held under the arms, makes walking movements

Sensory-Motor

C4 - 1 month Reacts to bell

C4 - 3 months Holds a rattle firmly and shakes it with sudden, involuntary movements

C3 - 4 months When seated at the table, fingers the edge of the table

C6 - 4 months While lying on back, shakes the rattle placed in hand and listens to it

C3 - 5 months Grasps a block when it is placed in contact with hand

C3 - 7 months Grasps two blocks, one in each hand

C6 - 9 months Rings the bell

Sociability

S9 - 1 month Ceases crying when approached or spoken to

S10 - 1 month Begins sucking reaction in anticipation of feeding

S9 - 2 months Stops moving or turns his head when spoken to

S10 - 2 months Smiles at familiar voices

S9 - 3 months Becomes animated at the perception of feeding preparations

S9 - 4 months Laughs out loud

S9 - 5 months Uncovers self by articulated kicking; grasps own thigh or knee

S10 - 6 months Distinguishes between familiar and strange voices

S9 - 9 months Reacts to certain familiar words

Language

L8 - 1 month Emits small guttural noises

L8 - 2 months Emits several vocalizations

L8 - 3 months Babbling: prolonged vocalization

L8 - 4 months Vocalizes when spoken to

L8 - 5 months Utters cries of joy

L8 - 6 months Makes trills

L8 - 7 months Vocalizes several well-defined syllables

L8 - 10 months Repeats a sound that has been heard

L8 - 12 months Can say three words

Autonomy

S10 - 7 months Can eat a thick cereal with a spoon

S10 - 10 months Drinks from a cup or a glass

P7 - 9 months When held under the arms, makes walking movements

Second Year

Postural

P1 - 10 months When standing with support, lifts one foot and puts it down

P1 - 12 months Walks with help when someone holds hand

P7 - 12 months When standing, bends to pick up a toy

P1 - 18 months Pushes a ball with foot

P1 - 21 months Kicks the ball, after demonstration

Sensory-Motor

C2 - 10 months Finds a toy hidden under a napkin

C3 - 10 months After demonstration, puts a block in a cup without releasing it (or takes it out of the cup)

C5 - 10 months Takes the round form from the board

C6 - 10 months Looks for the clapper of the bell

C2 - 12 months Picks up a third block while keeping the two already in possession

C5 - 12 months Puts the round form back into the hole on the board

C2 - 15 months Constructs a tower with two blocks

C3 - 15 months Fills a cup with blocks

C4 - 15 months Introduces a tiny object into a bottle

C5 - 15 months Puts the round form into the hole on the board when requested

C2 - 18 months Constructs a tower with three blocks

Sociability

S9 - 10 months Understands an interdiction, stops doing something when requested

S9 - 12 months Gives an object by request

S10 - 12 months Repeats actions which have provoked laughter

S9 - 6 months Takes own feet in hands

S9 - 7 months Puts feet in mouth

Language

L8 - 15 months Can say five words

L8 - 18 months Says at least eight words

L9 - 21 months Asks for food and drink

L8 - 24 months Makes sentences of several words

Autonomy

P1 - 12 months Walks with help when someone holds hand

P1 - 15 months Walks alone

P7 - 15 months Climbs stairs on all fours

P7 - 18 months Climbs stairs standing when someone holds hand

P7 - 21 months Descends stairs when someone holds hand

S9 - 18 months Feeds self with a spoon

Third Year

Postural

P1 - 24 months Kicks a ball on request

P1 - 30 months Tries to stand on one foot

Sensory-Motor

C2 - 24 months Constructs a tower with at least six blocks

C5 - 24 months Puts all three forms in the board

Sociability

S10 - 24 months Helps to set own things in order

S10 - 30 months Does not wet bed at night

Language

L9 - 24 months Calls self by own name

L8 - 30 months Says "I"

Autonomy

P7 - 24 months Climbs and descends stairs alone

P7 - 30 months Can carry a glass of water without spilling

S9 - 30 months Puts on own slippers