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## A Study of Closed Cases of Cerebral Palsied Patients Known to Mercy Cerebral Palsy Clinic

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**A STUDY OF CLOSED CASES OF CEREBRAL PALSID PATIENTS  
KNOWN TO MERCY CEREBRAL PALSY CLINIC**

by

**Rheta M. Collins**

**A Thesis Submitted to the Faculty of the School of  
Social Work of Loyola University in Partial  
Fulfillment of the Requirements for  
the Degree of Master of  
Social Work**

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## CHAPTER I

### INTRODUCTION

#### Purpose and Focus

This study is focused upon ninety closed cases of cerebral palsied children known to Mercy Free Dispensary Palsy Clinic<sup>1</sup> and on the extent to which the recommendations, made after the diagnostic evaluation, were followed by the parents of these children. From this study some common characteristics of the study group may be revealed, indicating what significant factors entered into the failure of the parents to follow through on the Clinic's recommendations.

#### Scope

This thesis is one part of a group project undertaken by five students from the Loyola University School of Social Work whose

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<sup>1</sup>The current title of this medical facility is being used in this thesis instead of the former name, Mercy Free Dispensary Cerebral Palsy Clinic since all of the clinical records had become a part of Mercy Hospital Children's Rehabilitation Center at the time that the study was undertaken.

intention it was to study all of the cases of cerebral palsied children known to Mercy Free Dispensary Cerebral Palsy Clinic anytime between the date of the Clinic's establishment, February 14, 1949, and August 31, 1954. It was decided that only those cases that had been definitely diagnosed as cerebral palsied would be included in the study. There were 329 cases known to the Clinic during the aforementioned time period, but 101 of these were eliminated from the study either because they were not available at the time of the study or had not been conclusively diagnosed as having cerebral palsy or had incomplete diagnostic evaluations. There were 228 cases that met the criteria decided upon for the study. Of this number, 138 were active cases and 90 were closed cases. After the data on these cases were compiled, each of the students engaged in the project selected a specific area for individual concentration and, thereafter, worked independently in analyzing, interpreting, and presenting the material studied. The 90 closed cases on which this particular thesis is focused were selected on the basis that their application for treatment occurred between the periods February 14, 1949, and August 31, 1954. Although it is the policy of the clinic to offer its services to patients from infancy through fifteen years of age, exceptions are occasionally made to accept for care persons over fifteen years of age who are especially in need of the services offered by the clinic. A total of four such patients,

who were beyond the maximum age limit, were included in the study. The age grouping of 86 cases ranged from infancy through fifteen years. This study will concentrate on an analysis of the factors relative to termination of the patients' contact with Mercy Free Dispensary Cerebral Palsy Clinic.

#### Source and Method

The material for this thesis was obtained through a study of the case histories and clinical records of 228 patients known to Mercy Free Dispensary Cerebral Palsy Clinic sometime between the date of its establishment, February 14, 1949, and August 31, 1954. The selection of the material and the general focus were made possible following discussions with the professional clinic personnel, in group sessions and individually, as well as through a study of some of the literature in the field. After a review of several cases was made, a tentative schedule was drafted. This was presented to the professional members of the Clinic staff, who met in a group session to discuss the strengths and weaknesses of the schedule. The clinic personnel indicated areas which needed development and offered suggestions for a more comprehensive study. The schedule was then revised and was tested on a random sample of every tenth case or 30 of the cases in the study group, in order to determine if the schedule were adequately constructed for the purpose of the study. Upon the completion of this preliminary testing, minor

adjustments were made in the schedule. The revised schedule was used as the basis for the collection of uniform pertinent data relevant to the study. This schedule included four broad categories of information: (1) general identifying information; (2) medical history; (3) psychological evaluation; and (4) diagnosis and treatment. The cases were listed alphabetically and placed in numerical sequence. The total number of cases was equally divided among the students for the purpose of completing a schedule on each of the cases. When the study of the individual cases had been completed, the information obtained was transferred to a master schedule and tabulated to facilitate the analysis of the data.

## CHAPTER II

### CEREBRAL PALSY DEFINED

In 1862 an English surgeon, William John Little, wrote a paper in which he described the condition now known as cerebral palsy. Dr. Little gave the inaccurate impression that all cerebral palsied children were the spastic, grimacing, drooling type and were feeble-minded. Today medical doctors no longer use the term Little's disease since it is now known that impaired intelligence does not necessarily always accompany the physical disability which characterizes the illness.<sup>1</sup>

"Cerebral palsy may be defined as a condition characterized by paralysis, paresis, incoordination, dyskinesia or any aberration of motor function that is due to involvement of the motor control centers of the brain."<sup>2</sup> Cerebral palsy is a term used to

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<sup>1</sup>Eugene J. Taylor, Help at Last for Cerebral Palsy, Public Affairs Pamphlet No. 158 (1950), p. 3.

<sup>2</sup>M. A. Perlstein, Infantile Cerebral Palsy: Classifications and Clinical Correlations, published by the American Medical Association (1952), p. 1.

describe conditions resulting from brain injury which occurs before, during or after birth. The brain injury may be the result of an accident or disease.<sup>3</sup> There may be many associated defects or a coexistence of defects in intelligence, personality and sensation in the cerebral palsied person.

As health agencies in most states do not require that cerebral palsy be reported, statistics on its extent are not reliable. The method most commonly used in recent years for estimating the incidence of cerebral palsy is the "Phelps' formula." This is based on the studies of Dr. Winthrop M. Phelps done in several eastern states. According to this formula, it is estimated that seven persons with cerebral palsy are born yearly in every one hundred thousand population. As many of these severely handicapped children are highly susceptible to infections, about fifteen per cent die within the first five years of life. Dr. Phelps estimated that four persons per one thousand population above the age of six were so afflicted. In round numbers, an estimated half million persons in the United States were afflicted with cerebral palsy.<sup>4</sup>

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<sup>3</sup>Give the Forgotten Child a Future, a brochure published by the Cerebral Palsy Foundation of Southern Arizona, Inc. (n.d.)

<sup>4</sup>Taylor, p. 6.

### Classification of Cerebral Palsy According to Clinical Symptoms

1. Spastic: the muscles are tight and tense and free motion is limited and frequently impossible.

2. Athetosis: this type of motion is associated with more tension than of the arms and legs and sometimes the head are in constant uncontrolled motion.

3. Rigidity: the muscles have lost their elasticity and the motion of the joints is blocked. Total motion may be decreased.

4. Ataxic: there is a loss of the sense of relation to space, which makes controlled motion and balance impossible.

5. Tremor: involuntary rhythmical motion is present in one or more joints. These motions are uncontrollable.<sup>5</sup>

### Classification According to Topographical Involvement of Extremities

The terminology employed by Mercy Free Dispensary Cerebral Palsy Clinic to classify patients into specific groups according to the area of involvement are five: (1) paraplegia: this involves the legs only; (2) diplegia: involvement, primarily, of the legs and the arms to a slight extent; (3) quadriplegia; this involves all four extremities; (4) hemiplegia: this condition is lateralized to one half of the body and there is a greater involvement of the

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<sup>5</sup> Give the Forgotten Child a Future.

arm; (5) double hemiplegia: this term is reserved for cases of spastic quadriplegia in which the arms are more involved than the legs.<sup>6</sup>

### Treatment

There is no cure for cerebral palsy, as damaged nerve tissue cannot be replaced or repaired, thereby restoring the normal functions of the nervous system. An objective in treatment is the training of other areas of the brain to take over the function of the damaged centers. Treatment measures include physical, occupational, and speech therapy, surgery, braces, or drug therapy. Treatment is highly individualized and requires skilled personnel. The diagnostic evaluation gives the type of cerebral palsy and the degree of involvement; physical and/or mental. The various types of the handicap require different types of treatment, as well as determining the kind of day-by-day handling. Treatment involves goals; these are indicated at the time of the diagnostic evaluation.<sup>7</sup>

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<sup>6</sup>Perlestein, p. 4.

<sup>7</sup>Information taken from material compiled for publicity purposes for Mercy Free Dispensary Cerebral Palsy Clinic, 1954.

## CHAPTER III

### THE HISTORICAL BACKGROUND OF THE STUDY

In 1847 a charter was obtained for Chicago's first hospital, which was named the Illinois General Hospital of the Lake. The patients were nursed by the Sisters of Mercy who received their training from the staff doctors of the hospital. In 1851 the trustees of the hospital found their funds inadequate and offered the hospital to the Sisters of Mercy. The Sisters took possession on February 27, 1851, and the following year the name was changed to "Mercy" Hospital.<sup>1</sup>

In 1879 the Chicago Medical School was erected on Mercy Hospital property at Twenty-sixth Street and Prairie Avenue. Arrangements were made for the Sisters to conduct a free dispensary for college students' benefit and for the poor of the district.<sup>2</sup>

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<sup>1</sup>Information taken from material compiled for publicity purposes for Mercy Free Dispensary Cerebral Palsy Clinic, 1951, pp. 19-20.

<sup>2</sup>Ibid., p. 20.

Mercy Hospital has continued to grow and expand since its establishment more than a century ago. A flexible program has been directed toward a constant goal of keeping abreast of progress in the medical and scientific world. It has always been a teaching hospital, having been associated with the Rush Medical College, Northwestern School of Medicine, and more recently with the Stritch School of Medicine of Loyola University,<sup>3</sup>

#### Mercy Free Dispensary Clinic

Mercy Free Dispensary Clinic is now in its thirty-seventh year of service to the sick poor. There were no written data to indicate what may have happened in 1914, but the Dispensary was apparently closed from 1914 until July, 1919. The Dispensary was reopened through the support of the Catholic War Council to care for the discharged military personnel and their dependents. When it was found that there was a tremendous need on the part of the general public for out-patient medical care, the Sisters agreed to resume this service. The medical staff of the hospital from that date gave of their time and effort to the Dispensary.<sup>4</sup> Although the Dispensary was a separate unit in 1954, it was administratively an

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<sup>3</sup>Ibid.

<sup>4</sup>Ibid., p. 26.

integral part of Mercy Hospital. Financially, it operated on an independent budget which was met through a three-fold arrangement: the hospital, dispensary fees, and the Community Fund.<sup>5</sup>

### The Cerebral Palsy Clinic

The Mercy Free Dispensary Cerebral Palsy Clinic was established February 14, 1949, and is partially supported by the United Cerebral Palsy Association. The function of the clinic is based on a team-work approach. The medical social worker explains the purpose and function of the clinic to the parents in the initial interview. The medical and social histories are obtained at this time.<sup>6</sup> Every cerebral palsied child is given a complete physical examination. Pediatrics, physical medicine, neurology and orthopedics and the ancillary services of the physical, occupational and speech therapies, the psychology and the social service departments coordinate their activities in a diagnostic study. A diagnostic evaluation is thus established and when completed the recommendations and the type of treatment indicated for the maximum habilitation of the child are discussed with the parents.<sup>7</sup>

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<sup>5</sup>Information taken from material compiled for publicity purposes for Mercy Free Dispensary Cerebral Palsy Clinic, 1954.

<sup>6</sup>"Mummy, I'm Walking," a brochure on the Cerebral Palsy Clinic and the Stritch School of Medicine of Loyola University, Chicago.

<sup>7</sup>Information taken from material compiled for publicity purposes for Mercy Free Dispensary Cerebral Palsy Clinic, 1951.

Affiliation with Martha Washington Home for Crippled Children

As Mercy Cerebral Palsy Clinic was limited largely to diagnostic services because of the lack of space for a treatment center, the Clinic affiliated with the Martha Washington Home for Crippled Children on July 1, 1953. The facilities of the Martha Washington Home were used for in-patient care, and children were admitted for a three-month period and reevaluated every three months. This affiliation was dissolved September 30, 1954, for lack of funds.<sup>8</sup>

The Mercy Hospital Children's Rehabilitation Center

It was decided to continue the Mercy Free Dispensary cerebral palsy diagnostic and rehabilitation services on an out-patient basis only. Space was made available and the Mercy Hospital Children's Rehabilitation Center was officially opened on October 1, 1954. The same specialties of medicine and the ancillary services, with the exception of group therapy, as given previously were continued. A complete diagnostic study is made on all children referred and the most complete rehabilitation plan possible worked out for each child. These services are available to any child through fifteen years of age without regard to race, creed, or

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<sup>8</sup>Ibid.

legal residence. Fees for services are determined on the ability to pay. There are no facilities at present for in-patient care during treatment.<sup>9</sup>

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<sup>9</sup> Ibid.

## CHAPTER III

### THE STUDY GROUP

Of the cerebral palsied patients known to Mercy Free Dispensary Cerebral Palsy Clinic during the period from February 14, 1949, through August 31, 1954, the 90 closed cases were selected for particular study. It is hoped that some concomitant factors may be revealed explaining the reasons for withdrawal of the members of the study group from treatment and supervision of the clinic..

#### Identifying Information

As mentioned previously, occasional exceptions were made to accept for care persons beyond the age of fifteen years who were especially in need of the services offered by the clinic. The diagnostic evaluation occurred when under fifteen years for three of the four patients beyond the usual age limit. The fourth patient was admitted for diagnostic evaluation and potential treatment at the age of twenty-one years. The ages of the remaining 86 children

at the time of admittance to the clinic fell within the age range of infancy to thirteen years inclusively. Private physicians and/or clinics referred 32 children; 21 were referred by community agencies; 21 as the result of radio and newspaper publicity; 7 by friends who were familiar with the services of the clinic; 7 by the immediate family of the cerebral palsied child; and 3 patients applied for services, the source of referral not being indicated on the record.

Certain data relative to the cerebral palsied child's environment and socio-economic stratum seemed to be significant. Forty-eight families were found to rent; 28 owned or were currently buying their own homes; 5 lived with relatives; and the living arrangements of 9 families were not entered in the records. Eighty-two fathers were employed; 3 mothers were public welfare recipients; and the employment status of 5 of the parental wage earners was not recorded. Forty-seven families had hospitalization insurance; 23 were without hospital or medical benefits; and resources of this nature were not indicated for the remaining 20 cases.

Classification by residence revealed that 64 patients were from the city of Chicago; 10 were from suburban areas; 10 were from out-lying parts of the state of Illinois; and 6 were out-of-state residents.

Cerebral palsied children categorized by race and sex revealed that there were 49 white males and 35 white females; 2 negro males and 4 negro females were admitted to the clinic for evaluation and treatment.

Findings as to religious preference pointed out that 51 patients were of the Catholic faith; 30 were of Protestant denominations; four were Jewish; and 5 indicated no religious preference.

#### Social History at Time of Admission

The marital status of the parents of the patients is significant insofar as parental attitudes are instrumental factors in the psycho-social development of the child. Eighty were married; one was divorced; four had remarried; one was a widow; and in four instances the marital status was not known.

The following tables reveal additional informative aspects relative to the child's environment. The age of the parents at the birth of the patient indicates that the concentration of births occurred during the period normally regarded as the child-bearing years.

A total of seven families reported additional cerebral palsied persons in their immediate families. Four parents stated that a niece or nephew had a similar handicap, two reported having two cerebral palsied children, and one family had three cerebral palsied children within the family structure.

TABLE I

## THE AGE OF PARENTS AT BIRTH OF CEREBRAL PALSIED CHILD

Age	Father	Mother
14 to 19	0	2
19 to 24	8	13
24 to 29	14	22
29 to 34	17	20
34 to 39	16	13
39 to 44	11	6
44 to 49	2	0
49 to 54	2	1
54 to 59	3	0
Not reported	17	13

The following table shows a breakdown of the child-bearing histories of the mothers of cerebral palsied children seen at the clinic.

TABLE II

CHILD-BEARING HISTORY OF THE MOTHERS OF CEREBRAL PALSID  
CHILDREN CLASSIFIED BY PARA,<sup>a</sup> GRAVIDA,<sup>b</sup>  
MISCARRIAGES AND BIRTH POSITION  
OF PATIENT

Classi- fication	Pregnancies											
	0	1	2	3	4	5	6	7	8	9	10	Un- known
Para	--	19	32	20	9	4	1	2	0	1	0	2
Gravida	--	23	27	17	11	6	0	0	0	2	4	0
Miscarriages	62	12	7	1	0	5	0	0	0	0	0	0
Cerebral Palsied Child	--	29	28	16	4	4	1	3	0	1	0	4

<sup>a</sup>Total number of live births.

<sup>b</sup>Total number of pregnancies.

A grouping of the number of siblings and the ordinal position of the patient in the family structure emphasizes what difficulties may arise when the mother devotes her time and effort to the demands and specialized needs of the handicapped child.

A social history furnishes data on the pertinent facts in the life and early development of the child and at the same time affords an opportunity to evaluate the attitudes of the significant persons in the life of this type of handicapped child. The environmental atmosphere can be of assistance or hindrance in the treatment

program later planned for the child.

TABLE III  
ORDINAL POSITION OF PATIENT AND  
NUMBER OF SIBLINGS

Ordinal Position of Patient	Number of Cases	Number of Cases	Number of Siblings
Only child	24	24	None
1	21	31	1
2	23	17	2
3	11	12	3
4	5	2	4
5	2	1	5
6	1	1	6
7	2	0	7
8	0	1	8
9	0	1	9
Not recorded	1		
Total	90	90	

The attitudes attributed to the members of the family were those observed by the clinic staff primarily. Three were obtained from reports submitted by the Board of Education, five were from referral agencies, and one as noted by a referring physician.

The attitudes were classified broadly as positive, negative, or undetermined. All members of the clinic team registered their impressions in these broad terms in relation to all significant persons in the life of the child. The importance of these impressions was reflected in the degree of parental cooperation, which

the specialists recognized as being of value or disadvantage to the patient's progress while receiving therapy.

It is important that the family direct its energies toward assisting the child to accept his handicap and his limitations and to encourage him to use to the utmost his capabilities. It is imperative that the cerebral palsied child be treated as much like a normal child as possible. The records revealed that the parental attitudes could be classified as follows: They were overly-protective, fostered dependency, had pronounced feelings of guilt, or were wholly or partially rejecting of the child. A small number of parents were completely accepting of the child and anxious to obtain treatment. In response to the various types of attitudes expressed, the children likewise developed either predominantly positive or negative personalities, and their behavior followed a similar pattern. The handicapped children were also observed during their clinic appointments, and the attitudes and type of behavior they manifested was noted. Twenty-six were decidedly positive in their attitudes, 28 were definitely negative, and the attitudes of 36 were classified as being undetermined. "Others" was used broadly and included relatives, neighbors, and the patient's peer group.

Early recognition of the pathology in the development of the child is important from the point of view of treatment. Medication or orthopedic-surgical appliances give the child an opportunity to

benefit from research in this field providing he has the mental development to assist in the reeducation of his muscles. When cerebral palsy occurs after a child has known the experiences of walking and talking, an added difficulty is introduced in his re-training and rehabilitation. It has been found that a child who lacks experiences in walking and talking is a much more favorable subject for therapy and habilitation than a child who has not had such experiences.

TABLE IV

## ATTITUDES OF FAMILY AND OTHERS TOWARD THE PATIENT\*

Attitude	Father	Mother	Siblings	Other
Positive	25	26	21	7
Negative	22	40	9	5
Undetermined	43	24	36	77

\*Observations made by clinical staff at Mercy Hospital Children's Rehabilitation Center.

The following tables show at what ages the abnormality was observed in the study group and at what age the patients were diagnosed as being cerebral palsied.

TABLE V  
AGE OF PATIENTS WHEN ABNORMALITY  
WAS MANIFESTED

Age Grouping	Number of Patients
Birth to 1 year	55
1 year to 2 years	7
2 years to 3 years	2
3 years to 4 years	1
Mother could not furnish information	27

TABLE VI  
AGE DIAGNOSED AS CEREBRAL PALSY

Age at Diagnosis	Number of Patients
Birth to 6 months	7
7 months to 12 months	20
13 months to 18 months	11
19 months to 24 months	8
25 months to 36 months	11
37 months and over	19
Not recorded	14

Immeasurable contributions have been made to the education of cerebral palsied children by pioneers in the United States who developed the basis for its diagnosis, treatment and estimation of incidence. These pioneers are Doctors Bronson Crothers of Boston, Winthrop M. Phelps of Baltimore, and Earl R. Carlson, who wrote

Born That Way: An Autobiography.<sup>1</sup>

A correlation of the results of their intensive research with the available data from the Center's records may provide some clarification of the existing difference in figures in the above tables for the period from birth to one year. Initially, the manifestation of some abnormality from birth to one in all groups studied revealed that one fourth of cerebral palsied children are so mildly affected that they present no particular problem and such symptoms can be easily and are frequently diagnosed as being a part of or aftermath of the usual childhood diseases.<sup>2</sup>

It has, additionally, been estimated that only seventy-five doctors in the entire United States are sufficiently trained and specifically qualified to accurately diagnose and treat children so afflicted.<sup>3</sup>

As the information for Table V was obtained from the mothers of the patients during the intake interview without benefit of confirmation from previously consulted physicians, clinics, or hospitals, it can be reasonably assumed that parental subjectivity

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<sup>1</sup>Taylor, p. 7.

<sup>2</sup>Ibid., p. 8.

<sup>3</sup>Ibid., p. 2.

may have distorted the accuracy of such data.

As all applicants for clinic services were given a complete physical examination, the clinicians reaffirmed the diagnosis of cerebral palsy when the referral already revealed the same in 43 cases. Twenty-six of the applicants had a differential diagnosis at one time or another prior to clinic registration. This number was confirmed as being definite cerebral palsied children. Initial diagnosis by the clinic occurred in 33 instances. At the time of the study the diagnostic evaluation had not been completed in 14 cases. Ages of the study group at admittance for diagnostic evaluation is shown in Table VII.

TABLE VII  
AGE AT ADMITTANCE OF PATIENT

Age in Years	Number of Patients	Age in Years	Number of Patients
0 to 1	0	8 to 9	5
1 to 2	10	9 to 10	5
2 to 3	13	10 to 11	6
3 to 4	8	11 to 12	3
4 to 5	7	12 to 13	5
5 to 6	5	13 to 14	1
6 to 7	11	14 to 15	1
7 to 8	9	15 to 16	0
		16 and over	1

The proficiency of a cerebral palsied child depends upon the severity of the physical disability and the type and length of

therapy he receives. A variety of factors have important bearing on the ability of this type of child to adjust to his family and the community.<sup>4</sup> Strabismus, deafness, halting speech, stumbling or scissors gait, lack of confidence and other symptoms of the condition will cause the family and members of the community to reject a cerebral palsied child. It is beyond the scope of this paper to present the medical aspects in their entirety, but for reasons of brevity and yet to portray for the reader the extent of this type of handicap, the following table has been employed.

TABLE VIII

## DIAGNOSES BY CLASSIFICATION AND AREA OF INVOLVEMENT

Types of Cerebral Palsy	Area of Involvement					Total
	Not Determined	Quadriplegia	Hemiplegia	Paraplegia	Diplegia	
Spastic	10	10	7	3	3	34
Athetosis	25	7	0	1	1	34
Rigidity	3	2	0	0	0	6
Cerebral Palsy only*	8	0	0	0	0	8
Mixed	4	0	0	0	0	4
Study not completed	4	0	0	0	0	4

\*Classified under general term until further study revealed specific type.

<sup>4</sup>Ibid., p. 8.

### Psychological Evaluation

The psychological examination is a vitally important part of the diagnostic evaluation. A formal psychological test was given to those children whose mental capacity was measurable and who had reached the chronological age when objective testing was feasible on the Revised Stanford-Binet Scale. Generally, the psychologist was able to estimate by observation the approximate mental capacity of those too young to be tested. If the child were largely out of contact and failed to react to visual or auditory stimuli, a recommendation was made for a reexamination in either six months or one year. The mother was then instructed to stimulate the child's curiosity and activity with manipulative toys in the interim.

When formal testing was not feasible, the Vineland Social Maturity Scale, based upon an interview with the mother provided a social quotient. The J. C. Raven Progressive Matrices Test was utilized only rarely. The Ammons Full Range Picture Vocabulary Test was generally utilized in those instances in which the child's intelligence was very obviously measurable, but he was extremely limited as to activity by virtue of the severity of the physical handicap. This test is particularly adaptable for handicapped children as they can make selection and choice of answer by respond-

ing by the simple method of pointing, nodding of the head, or rolling the eyes. This test can be used to test persons from kindergarten to the adult level.

When a child's intelligence was considered measurable and he still failed in test performance as a direct result of physical limitation, some therapy was often recommended. After a period of time, when the therapies had conditioned the child with some modification of the physical limitation, the child was again retested.

Those children who demonstrated the necessary mental ability to profit from formal education at the usual age were classified as having a good outlook for educability.

#### Training and Education

As educability is a very broad term covering the period from primary grade achievement up through the regular grades, the psychologist used the terms poor, fair, and good for a systematic criteria, simplified purposefully for common and unified usage within the clinic. An interpretation of poor meant little chance for qualifying for even an ungraded room. A label of fair meant the patient would qualify for an ungraded room. Good represented normal achievement.

Only 10 children in the study group had a good outlook for educability; the potential educability of 14 was considered fair; the prospect of 48 for educability was rated as poor; and the

educability of 23 was undetermined. Those whose educability was classified as undetermined were so designated either because they were too young for formal testing, had withdrawn from treatment before a psychological examination could be given, or withdrew prior to the completion of the diagnostic evaluation staffing.

Of the total number of patients given psychological tests, only 24 had some type of school experience; and of this number 4 had been withdrawn and 4 had been dismissed from school participation for reasons mental, physical, or behavioral.

Two of the patients had been dismissed from nursery school as they were so mentally retarded they would not have profited from group socialization. One child was dismissed from kindergarten and another from a special school by reason of their overt behavior. One patient was withdrawn from nursery school by virtue of the severity of his physical handicap. One patient was withdrawn from kindergarten and two patients from elementary school for behavioral reasons.

The prognosis for habilitation was correlated with the results of the physical and psychological examinations, which was carefully interpreted to the parents along with recommendations as to potential treatment. Prognostically, 10 cases were considered good; 9 only fair; in 36 cases the patient's prognosis was rated as poor; and 29 were listed as undetermined.

TABLE IX

## PATIENTS WITH FORMAL SCHOOL EXPERIENCE

<u>School Experience</u>	<u>Number of Patients</u>
Nursery . . . . .	3
Kindergarten . . . . .	4
Special school . . . . .	7
Ungraded room . . . . .	1
Elementary school . . . . .	8
Secondary school . . . . .	1
Total . . . . .	24

## CHAPTER V

### THE DISPOSITION OF THE CASES STUDIED

#### Diagnostic Advisory Study

From the cases studied it was found that 15 children had been committed for custodial care; 6 had died while in treatment; 4 were out-of-state residents and 6 were from the out-lying areas of the state of Illinois. The distance involved which the latter would have to travel with a handicapped child was likewise correlated with economic necessity.

Custodial care was recommended in 10 cases. In 17 instances custodial care was not recommended but a clinician had indicated that eventual institutionalization would be necessary; this was not to be verbalized to the parents until they had been counselled by the medical social worker and displayed an acceptance of permanent placement of their child in an institution for mentally defective children. Psychotherapy was recommended for 11 mothers, for 3 fathers, and in 3 instances for both parents. Five children had been placed in custodial care although no such recommendations had been

made by the Clinic to the parents. Four parents refused to accept the decision of the Clinic team regarding the advisability of custodial care for their cerebral palsied child and withdrew from the care and supervision of the Clinic rather than acknowledge the futility of expending money, time and effort to habilitate their children when diagnosed as being mentally defective and largely out-of-contact with reality. The total number committed to custodial care was 15.

Eleven patients withdrew from treatment as their parents preferred placing them under the care of a private physician or other clinic. Of this number, 6 patients were severely retarded mentally and 5 were estimated to have an average or above average intelligence quotient. Nine withdrew from treatment before the diagnostic evaluation was completed. No explanation was given for this action to the Clinic by the parents.

The Clinic was concerned about the large number of patients who withdrew from treatment without giving any explanation of the reasons for this action. When it was noted that the child had not been in the Clinic for a period of time, a letter would be sent to the parents inquiring if they wished to continue receiving service from the Clinic. In most instances there were no replies to the letter of inquiry. There were 29 patients who withdrew from the Clinic, and their reason for doing so was unknown or could not be

ascertained by the Clinic. In the grouping of withdrawals from treatment and/or supervision of the Clinic for unknown reasons, the records revealed that 25 of this number were severely retarded mentally; 5 were mildly to moderately retarded; 6 had been too young to be given a psychological test and could not have benefited greatly from either speech, physical, or occupational therapy until older; and 3 children were of near average mental range.

Treatment recommendations for the entire 90 cases studied included 41 to be treated on a continual out-patient basis pending admittance to an institution for intensive therapy. Five of this number received intensive therapy at the Martha Washington Home for Crippled Children for a three-month period on an in-patient basis.

Some degree of benefit from therapy was recorded for patients while on an active basis with the Clinic, as shown in Table X.

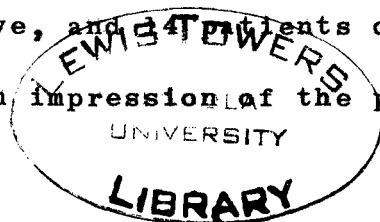
**TABLE X**  
**DEGREE OF THERAPEUTIC SUCCESS**

Type of Therapy	No Improvement	Results of Therapy		Total
		Some Improvement	Marked Improvement	
Occupational Therapy	5	22	3	30
Speech Therapy	6	17	3	26
Physio-therapy	6	21	4	31

Only one third of the study group received this type of treatment. Many were too young to have benefited from this kind of service; 14, as mentioned previously, had been withdrawn from the supervision of the Clinic by their parents before the diagnostic evaluation could be completed; and others failed to return for services after one or more of the therapies was recommended by the Clinic team.

Three children received only one of the above therapies and had been classified as having made some improvement in that area; 6 were the recipients of two therapies and had made some improvement. A total of 22 patients were engaged in all three of the above-mentioned therapies; and of this number 4 were considered to have made no improvement, 15 some improvement, and 3 registered marked improvement in their response to treatment.

Analysis of the case records of the 39 patients who withdrew from treatment, reasons unknown, revealed certain factors may have influenced the parents to remove their child from treatment. Parental attitudes in these specific cases were found to be extremely negative on the part of one or both parents in 17 cases. The attitudes of 7 parents were considered positive, and 14 patients did not remain in treatment long enough for an impression of the parents' attitudes to be noted.



Because of the nature of problems presented by cerebral palsied children, each case seemingly requires individual consideration in order to isolate important factors operating in particular cases. The following cases were selected to point out the adjustments that would be necessary on the part of the patient and members of the immediate family to his particular situation. The cases selected are typical of many in the study group.

The first case is that of a young cerebral palsied boy who, in the opinion of the Clinic, would be able to make only a moderate adjustment on the physical level and possibly some social adjustment through group therapy in the course of treatment.

John A. was a 4½ year old white boy who was admitted for treatment after being referred by a local hospital clinic. John was the youngest of five children. An older brother was married and out of the home. Another brother, age seventeen, lived with an aunt in Texas. Reasons for this arrangement were never known to the Clinic. The patient's female sibling was 20 years of age and described to the clinic as being a mongolian idiot. Another female sibling lived at home. The latter was 12 years of age and was known to have a very poor relationship with the patient. John responded only to the mongolian sister who cared for him. This response, according to the parents, was favorable, meaning he was happy and affectionate when cared for by this sibling, but was irritable and cross toward all others. Parental attitudes were negative and they were non-accepting of plans offered by the clinicians and were unrealistic in viewing the future for the patient.

Although the diagnosis was cerebral palsy, rigidity, the clinic believed that the patient's mental retardation was the main problem. The clinicians agreed that custodial care would be necessary if this child did not develop

mentally by the time he was fourteen years of age. If such development did occur, the patient might benefit from some formal education. It was suggested that John be placed in a nursery or play school of group situation when six or seven years old. Further recommendations included continued therapy on an out-patient basis. John had made "some improvement" as a result of physical and group therapy.

The parents could not accept the diagnosis of mental retardation being the primary problem and withdrew from clinic attendance in order to return to the clinic from which the referral had originally been made.

Because the parents were reluctant to furnish social history and more pertinent data surrounding the composition and intra-familial relationships of the family and a clearer picture of the environment, the parents in the case might be described as unco-operative. A lack of proper understanding of this type of handicap by the parents, their failure to accept the interpretation of an authoritative group of medical specialists, and the resultant initiation of treatment and withdrawal from one clinic to attend another, were more or less typical of a number of the parents of the cerebral palsied children in the study group.

The following case illustrates the behavior of an aggressive, overprotective mother with a severely physically handicapped child whose potential mental ability falls within the average range.

William B. was an 8½ year old white male child who was referred to the clinic by a private physician. William is the only child of his mother's first marriage. His natural father has remarried, but continues to pay for William's support. The type of relationship existing

between the patient and his step-father was never ascertained by the clinic and the mother refused to divulge any information around their relationships or what the attitudes of the natural father and step-father might be.

The mother was described by the Board of Education, the clinic medical social worker, and other members of the clinic team as being overly-protective and overly anxious because William was a "cripple." The occupational therapist at the clinic stated in her report that she had observed that William gets along well with his peer group but felt that he should have some discipline at home. The Board of Education also felt that William sought security from adults and was frustrated and cried frequently when he failed to accomplish some task or assignment.

The mother related to the medical social worker that William would often, when playing with other children, suddenly walk away and play alone. She recognized that William was entirely too dependent upon her and that she had encouraged this to some degree.

The psychologist found William's mental capacity to be fully measurable, and his intelligence ratings showed him to have average mental ability for his age. As the mother displayed her anxiety and need to overly protect this child to a marked degree during the testing situation, the psychologist interviewed the mother in an attempt to help her to discuss the home situation. The mother's constant feelings of guilt caused the psychologist to suspect other unrevealed difficulty in the second marriage. The psychologist recommended counseling for the mother.

William's outlook for educability was good; however, the clinic team agreed that his educability would be only fair if the mother continued to be overly-protective.

Mrs. B. withdrew William from treatment shortly after the diagnostic evaluation. The clinicians felt that counseling proved to be too threatening for this mother.

Although the prognosis in this case may be considered favorable, nevertheless the child's actual potential is not likely to

be developed until some help can be extended to and accepted by the patient's mother. Again, this is not an isolated case but is typical of many in the study group.

The following case illustrates a brief social history of a seemingly normal child, mentally and physically, with only slight muscular involvement.

Patty C. was admitted to the clinic at the age of six years. This was a self-referral in that the parents themselves initiated contact with the clinic for medical service. Patty was diagnosed as being spastic, paraplegia, mild. An older brother, the only sibling, is away from the home, so Patty is treated pretty much like an only child. The brother is a patient in a tubercular sanitarium. When tested psychologically, Patty proved to be well within the average range of intellectual capacity on various tests used. Results of the Revised Stanford-Binet Test, Form L, revealed that Patty was above average for her chronological age. She has no difficulty in school. Her outlook for educability was described as being very good.

According to her mother, Patty managed to get along well with other children and was generally happy, carefree, alert, and of gentle disposition. Mrs. C's primary concern seemed to be concentrated on Patty's poor appetite. All efforts to stimulate or increase her appetite were unsuccessful.

Physio-therapy was recommended in order to modify Patty's physical condition and to provide a greater sense of security of balance.

Mrs. C withdrew Patty from treatment without notifying the clinic of her intentions. There was no response to the clinic's letter offering continued therapy. As Patty was in treatment only for a very brief period of time, parental attitudes were not determined nor entered in the record.

From the clinician's standpoint, Patty received excellent care and attention; she was able to make a satisfactory adjustment at school and probably in the home. However, treatment should have been continued in this specific case as a means of providing for Patty's maximum habilitation.

The following case illustrates rejection of a young cerebral palsied boy, who was the youngest of three children, by his parents and by his older brothers.

Jimmy D. was referred to the clinic by the school nurse when he was 7 years of age. He was diagnosed as being cerebral palsied with mental retardation and congenital cataracts.

Jimmy was refused admission in the regular school system and was at the time of admission to the clinic in attendance at a special school. He had previously been in kindergarten in a public school and had been in one other special school for handicapped children.

Due to gross perceptual difficulty, resulting in or accompanied by mental deficiency, the psychologist was not able to test Jimmy. The Board of Education submitted a report of the estimated mental capacity that might exist and the clinic psychologist concurred with their findings. His chronological age was 6 years and 4 months; his mental age was 2 years and 9 months. With an intelligence quotient of 43, Jimmy's outlook for educability was poor.

Occupational therapy was indicated in Jimmy's case. When he first entered into therapy he refused to play with other children. After two months of therapy he became aggressive and destructive. He learned how to play with other children but sought out the older boys for play.

Jimmy made some improvement while in occupational therapy. It was felt that he should continue on an outpatient basis, but between visits he should be stimulated

to activity with the home-care program.

The D. family had been known to various community agencies over a period of time. The Institute for Juvenile Research reported Mrs. D. as being unaccepting of Jimmy's "slowness" and rejecting of him. It was felt that Mrs. D. might profit from counselling but she objected to counselling from United Charities when referred by the Division of Services for Crippled Children. The clinic described Mrs. D. as overly protective and reported she spoiled the child but admittedly felt badly about his condition. All agencies had recommended casework services with the mother and saw the same as being the initial steps toward resolving some of the child's conflict with his environment.

The patient's oldest sibling has become introverted and refused to play or mingle with his peer group since he had the greater amount of responsibility for care of Jimmy. This male sibling, upon whom the mother has thrust her responsibility, is 16 years of age. His withdrawal from group activity was noticed by the public school teacher, who felt that he, as well as Jimmy, might profit from some type of guidance.

The second male sibling was ten years of age and is totally rejecting of the patient. Parental attitudes and the marital situation were not learned prior to the withdrawal from treatment, the reasons for which were unknown.

The prognosis in the following case was exceptionally good for this type of handicapped child, but it is believed that a language barrier may have induced the parents, who were displaced persons, to withdraw the patient from treatment.

Mark E. was a male white Lithuanian displaced person, who was referred by the Sisters of a local parochial school. Mark was a oldest child in a family of three and had two younger female siblings.

He was diagnosed as having cerebral palsy, athetosis, mild. Due to a language barrier, Mark could not be fully

tested psychologically. More testing would be necessary to obtain an accurate measure of his intelligence. Meanwhile, it was quite reasonable to assume that Mark had above average mental ability. His outlook for educability was estimated to range from good to fair, but this would depend entirely on the rapidity of his mastering the English language.

Familial attitudes were not known or not determined at the time the patient was in treatment at the clinic. The clinic stressed frequent re-evaluation of this child and advised that he continue receiving therapy as he had made "some improvement" in every area.

Mark was placed at the fourth grade level in a parochial school after his parents arrived in this country. It was believed that Mark could be rapidly advanced academically when he has learned English. Because one side of his jaw was smaller than the other and due to ataxia of all five movements, the clinic was desirous of this child remaining under their supervision so as to correct the malfunction of the jaw possibly through surgery, after which it was hoped that Mark might benefit from speech therapy.

The next case presented shows how the deep rejection of the patient by the mother complicates the child's adjustment at home and in the school.

Tony F. was admitted to the clinic at the age of 4 years, the source of referral being a local fraternal organization. Tony was diagnosed as spastic, diplegia.

Tony is the older of two children. The mother explained to the medical social worker that Tony's younger sister is very jealous of him and that he is completely rejected by the father.

Mrs. F. managed to relate some of the family problems, the primary one being the discord that existed in the marital relationship. Mr. F. reportedly abused the mother, drank to excess, and she lived in fear of him. The patient's maternal grandmother also lives with the F's and had con-

tinually ignored the patient. The social worker evaluated Mrs. F's lengthy narration as giving indication that she, too, was wholly rejecting of the patient.

Tony's behavior during the period he was being seen at the clinic was described by members of the clinic team as being negative insofar as his responses affected his treatment. He would bite, kick, scratch, demand attention, and cry, and was generally irritable.

Tony had attended two different nursery schools and had been withdrawn by the parents for the aforementioned behavioral reasons.

The patient's mental capacity was found to be measurable, and he had an intelligence quotient of at least 48. The psychologist believed that Tony possibly had more ability than the tests revealed. The psychologist believed that there was sufficient evidence of family stress and general adverse environmental conditions affecting the patient in the last few years to have an unfavorable influence on the test results and his behavior. Tony was further described as seeming to be basically insecure and rejected and that he apparently felt it deeply.

On the basis of the results of his psychological test, it was decided that this child had a poor outlook for educability. Recommendations were for continued treatment as Tony had benefited from physio-therapy and occupational therapy to some degree.

The prognosis arrived at by the clinic team indicated that eventual custodial care would be necessary as the deep rejection of the patient by his mother blocked even the little improvement that could be made with this child.

Tony was removed from treatment by the mother. Her reasons for doing so were not made known to the Clinic.

Another case which is typical of rejection of the cerebral palsied child is that of Peter G., who was admitted for treatment at the age of 4 years and 2 months.

Peter G., a white male and the second of three children, was referred to the clinic by the United Cerebral Palsy Association. Both of his siblings were males.

The diagnostic evaluation revealed that this patient was afflicted with cerebral palsy, athetosis, severe, and that he was psychologically non-measurable, but in contact. His mental limitations and inability to be tested arose from the severity of his physical disability.

He was described by the medical specialist as being a happy and affectionate child but having more than the normal number of fears.

All team members indicated that Peter's mother was overly-protective, resistive to treatment for the child, and was always tense and emotionally upset when she brought him to the clinic. The father was extremely attached to Peter, and his brothers were very accepting of him and his handicap.

The marital situation was definitely negative as reported by the father, stemming largely from the handicap of the patient.

The outlook for educability for Peter was poor. The clinic recommended home-care for the child and casework services for Mrs. G. The prognosis for physical habilitation was likewise considered as poor.

As Peter had made minimal improvement in speech, the clinic felt that he should have further encouragement under the home-care program and another evaluation of his progress in this area at a later date.

As the emotional stress in the home interfered with the child's improvement, the clinic recommended that the patient be entered into a training center on an in-patient basis so that he could profit from a continual habilitative program even though his response might be at a minimum level.

The child was withdrawn from treatment shortly after casework services were suggested to the mother.

Some of the parents in the study group were described as co-operative. The case of Gerry H. was more or less typical of such parents when such positive attitudes were indicated. Gerry H. was referred to the clinic by the family physician when he was 18 months old.

Gerry was diagnosed as having cerebral palsy, athetosis, mild. He was too young to be psychologically tested.

He was the only child of a young married couple who could not readily accept his handicap, but expended themselves cooperatively in order to provide for the maximum habilitation of their son. When the social worker suggested that the patient needed to be socialized, the H's applied to a local agency and obtained a five-year-old foster-child as a means of providing socialization as the patient was too young to be entered in a nursery school with his handicap. The parents and members of the team noticed great improvement shortly after this arrangement took place.

The outlook for educability was not determined or estimated at the time of the diagnostic study; however, the clinic believed that in Gerry's case the prognosis was good. While receiving physio-therapy, Gerry had made some improvement.

The case of Gerry H. was closed when the parents failed to return the child for additional treatment. A letter from the clinic which encouraged continued treatment did not produce a reply for the reasons for their withdrawal.

These cases as presented in summary form showed some of the individualized needs of this particular type of handicapped child. These patients presented a variety of personal disturbances and situations, but, as a group, they were all in need of continued

medical attention, of clinic supervision, and of the services offered by the Social Service Department of the clinic. These services were available to all the patients and to the responsible members of their families in order to interpret not only the conditions and needs of the patient, but also to promote a better understanding of him as an individual. The clinic team worked together to meet the patient's needs not only on a medical basis but also on an emotional and social level, to prepare and assist the patient or members of his family to make a better adjustment to his environment.

## CHAPTER VI

### SUMMARY

This study consisted of a review of the closed 90 patients known to the Mercy Hospital Children's Rehabilitation Center sometime between the period February 14, 1949, through August 31, 1954. The selection of the 90 cases was based on these criteria: The application for treatment occurred during the period mentioned above; and the age grouping of patients ranged from infancy through fifteen years with the exception of four patients who were beyond the maximum age of children serviced by the Center but who were accepted for care because they were especially in need of the services which the Center had to offer.

The study was focused upon the closed cases of cerebral palsied children known to the Clinic with the purpose of attempting to ascertain the extent to which the recommendations of the medical team were followed by the parents. It was hoped that from this study some common characteristics might be revealed which might indicate what significant factors entered into the failure of the parents to

follow through on the Center's recommendations, as well as the reasons for termination of contact in those particular cases in which maximum treatment benefit had not been attained.

A greater awareness and recognition of cerebral palsy exists in recent years which can be deduced from the source of referrals. Thirty-two children were referred by private physicians and/or clinics, 20 by community agencies, 21 as the result of radio and newspaper publicity, 7 by friends who were familiar with the services of the Clinic, 7 by the immediate family, and the source of referral of 3 patients was not indicated in the record.

Forty-eight families in the study group rented their apartments or homes, 28 owned or were buying their own homes, 5 lived with relatives, and the living arrangements of 9 families were not entered in the records. Eighty-two fathers were employed, 3 mothers were public welfare recipients, and the financial status of 5 of the parental wage earners was not recorded. Forty-seven families had hospitalization insurance, 23 were without hospital or medical benefits, and resources of this nature were not indicated for the remaining 20 cases.

Classification by residence revealed that 64 were from the city of Chicago, 10 were from suburban areas, 10 were from various outlying areas of the state of Illinois, and 6 were out-of-state residents.

The availability of this specialized service for victims of cerebral palsy regardless of creed or race is evident from the findings regarding the religious preference and race of the study group. Fifty-one were of the Catholic faith, 30 were of Protestant denominations, 4 were Jewish, and 5 had no religious preference. Cerebral palsied children categorized by race and sex revealed that 49 white male and 35 white female patients were included; 2 negro males and 4 negro females had been admitted to the Clinic for evaluation and treatment. The disproportionate number of negroes in the study group does not reflect the general Clinic population in attendance at Mercy Free Dispensary Clinic as the ratio is three negroes to every white person in attendance.

The marital status of the parents of the patients is significant as parental attitudes are influential factors in the psychosocial development of the child. Eighty were married, one was divorced, four had remarried, one was a widow, and in four instances the marital status was not recorded.

The ages of the parents at the birth of the patient indicates that the concentration of births occurred during the period normally regarded as the child bearing years and does not lend any support to the hypothesis that cerebral palsied children may be born to older parents.

A total of seven families reported additional cerebral palsied

persons in their immediate families.

The attitudes of the members of the family toward the patient and his handicap were observed by the clinic staff primarily. Three were obtained from reports submitted by the Board of Education, five from referral agencies having a social service department, and one as noted by a referring physician. Positive attitudes toward the patient were recorded for 25 fathers and 26 mothers; for siblings in 21 instances in which the patient had a sibling or siblings; and in 7 cases for the patient's peers in which the patient's relationship with his peer group was known.

Attitudes on the part of 43 fathers and 24 mothers were termed undetermined; there were 36 instances in which the patient's relationship with his sibling(s) was unknown; and in 27 cases the relationship of the patient with his peer group was not known.

The patients were also observed by the Clinic team and their attitudes and the type of behavior they manifested was recorded. The attitudes of 26 patients were decidedly positive; those of 28 were definitely negative; and the attitudes of 36 were grouped under the classification "unknown," as there was no indication of them in the case record.

The age at which the abnormality associated with the cerebral palsy condition was first observed in the members of the study group occurred most frequently in the period from birth to one year. The

ages of the patients when the diagnosis of cerebral palsy was confirmed occurred during the period from birth to three years inclusively in 57 cases, in 19 instances after three years of age, and in 14 cases the diagnostic evaluation had not been completed.

The most common tests used for the psychological evaluation were selected for the individual child, when testing was feasible, and included one or more of the following: The Vineland Social Maturity Scale, the J. C. Raven's Progressive Matrices Test; the Ammons Full Range Picture Vocabulary Test, and the Revised Stanford-Binet Test, Form L.

The psychological evaluation pointed out that only 10 children in the study group had a good outlook for educability; for 14 the prognosis for educability was fair; for 48 the prognosis was poor; and the educability of the remaining 23 cases was undetermined.

The prognosis for the patient's habilitation was based upon the physical and psychological examinations and was carefully interpreted to the parents along with recommendations regarding potential treatment. In 10 cases the prognosis for habilitation was good; in 9 only fair; in 36 cases the prognosis was considered poor; and in 29 cases the prognosis was undetermined.

In the cases studied it was found that 31 cases were closed for the following reasons: 15 children had been committed for custodial care, 6 had died while in treatment, 4 were out-of-state

residents, and 6 were residents of outlying areas of the state of Illinois.

Custodial care was specifically recommended in 10 cases. In 17 additional instances, custodial care was not recommended; however, a clinician had indicated that eventual institutionalization of the patient would be necessary, but that this eventuality should not be verbalized to the parents until some acceptance or suggestion of permanent placement of the child had been expressed by them. For this reason psychotherapy was recommended for 11 mothers, for 3 fathers, and in 3 cases for both parents. Five children had been placed in custodial care although such a recommendation had not been made by the clinicians. Four parents refused to accept the decision of the team as to the advisability of institutionalization and withdrew the patients from treatment when they were diagnosed as being mentally defective and largely out of contact with reality rather than acknowledge the futility of expending money, time and effort to habilitate their children.

Eleven patients withdrew from treatment as their parents preferred placing them under the care of a private physician or another clinic. Fourteen patients were withdrawn from treatment before the diagnostic evaluation was completed and no explanation was given for this action to the clinic by the parents.

Of the 39 patients who were withdrawn from treatment without any explanation being given by the parents as to the reason for this action, the records revealed that 25 of this number were severely mentally retarded, 5 were mildly to moderately retarded, 6 patients had been too young to be tested psychologically and could not have benefited greatly from therapy until older, and only 3 children were of near average mental range. As the majority of the patients were mentally as well as physically handicapped, the interpretation of the facts to the parents of the patients may have been the primary cause for the parents becoming pessimistic about the value of treatment or the continuation of their child under the supervision of the Clinic.

An analysis of the records of the 39 families who "withdrew from treatment, reasons unknown" provided some indication of factors that may have influenced the parents to remove their child from Clinic attendance. Parental attitudes in these specific cases were found to be extremely negative on the part of both parents in 17 cases; 7 were considered positive; and 14 did not remain under the supervision of the Clinic for the period of time required before an impression of parental attitudes could be noted.

Treatment recommendations for the entire 90 cases included 41 to be treated on a continual out-patient basis coupled with home care; 10 could not profit from any treatment and custodial care was

recommended; and 9 were placed on an out-patient basis pending admittance to an institution for intensive therapy. Five of this number received intensive therapy at the Martha Washington Home for Crippled Children for a three-month period on an in-patient basis. As mentioned previously, 5 patients were placed in institutions although not recommended by the Clinic team, 5 had died while under the Clinic's supervision, 4 patients were out-of-state residents, and 6 were from outlying areas of the state of Illinois.

Of the number of children who had entered into occupational, speech, or physio-therapy, only 4 were clasified as having made no improvement, 24 patients had made some improvement, and 3 patients responded with marked improvement physically.

The available data which made this study possible indicated that cerebral palsy was more common in the study group among the white race than among Negroes, among males than females, and among the first-born than among those of subsequent births. Taylor contends that: "There seem to be no other close relationships, however, between the disease and the patient's background. Until further data come to light, it may be assumed that cerebral palsy occurs with almost equal regularity among all classes of people regardless of their socio-economic level, occupation, or location of residence."<sup>1</sup>

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<sup>1</sup>Taylor, p. 4.

This conclusion seems to hold true for the study group in that people from different socio-economic levels and location of residence were represented therein.

The general recognition that environmental and emotional problems are significant and may have an important influence on the patient's ability to sustain treatment until maximum benefit has been attained. It would appear that a greater number of parents should be referred for counseling and casework services as a means of helping them to be more accepting of the patient and his handicap, and more realistic as to the child's potential and type and duration of treatment. In this manner there could be mutual active planning directed toward the maximum habilitation of the child.

Enthusiastic cooperation of the parents might be obtained through a more comprehensive interpretation of the handicap, its effect on the child and the members of the family; the need for a realistic approach as essential in treatment; and the roles of the parents in home-care and helping the child to adjust to the type of education from which he could best benefit if accepted for formal schooling. A program so designed as to emphasize to the parents of the cerebral palsied child the importance of healthy parental attitudes (since negative feelings and attitudes frequently negate the effectiveness of treatment) seems indicated and might induce parents to be more cooperative and help them to view the patient

and his problems more objectively.

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## APPENDIX

### SCHEDULE

#### I. IDENTIFYING INFORMATION

- |   |           |              |            |
|---|-----------|--------------|------------|
| A. Research #                                       |           |              | Clinic #   |
| B. Address  |           |              | Birth date |
| C. Age at admission                                 | Sex       | Race         | Religion   |
| D. Source of referral                               |           |              |            |
| E. Different diagnosis prior to admission           |           |              |            |
| F. Age of child when abnormality was first observed |           |              |            |
| 1. Noted by MD                                      | 2. Mother | 3. Other     |            |
| 4. Diagnosed as CP (age)                            |           | 5. Authority |            |

#### II. SOCIAL HISTORY AT TIME OF ADMISSION

- |  |                             |                                   |
|--|-----------------------------|-----------------------------------|
| A. Constellation   | Age at birth<br>of CP child | Marital Status<br>M D S W U M R M |
| 1. Father  |                             |                                   |
| 2. Mother  |                             |                                   |
| 3. Children  | a. At Home    b. Away       | c. At Home    d. Away             |
| (1)  |                             | (5)                               |
| (2)  |                             | (6)                               |
| (3)  |                             | (7)                               |
| (4)  |                             | (8)                               |
| 4. Other CP members in family  |                             |                                   |
| B. Living arrangements   |                             |                                   |
| 1. Own home  | Rent    With relatives      | Number of rooms                   |
| Floor(s)   |                             |                                   |
| C. Economic Status   |                             |                                   |
| 1.        Employed    Unemployed    Occupation    Income    Fin. Asst. |                             |                                   |
| a. Father  |                             |                                   |
| b. Mother  |                             |                                   |
| c. Siblings  |                             |                                   |
| d. Others  |                             |                                   |
| 2. Insurance: Group Hospital Plan Health Insurance.                    | Yes    No                   |                                   |
| D. Attitudes   | As observed by              |                                   |

- |   | <u>a</u> | <u>b</u> | <u>c</u> | <u>d</u> | <u>a</u> | <u>b</u> | <u>c</u> | <u>d</u> |
|---|----------|----------|----------|----------|----------|----------|----------|----------|
| 1. Mother   |          |          |          |          |          |          |          |          |
| 2. Father   |          |          |          |          |          |          |          |          |
| 3. Siblings   |          |          |          |          |          |          |          |          |
| 4. Peers  |          |          |          |          |          |          |          |          |
| 5. Others   |          |          |          |          |          |          |          |          |
| 6. Marital situation as reported by:                  |          |          |          |          |          |          |          |          |
| a. Father   |          |          |          |          |          |          |          |          |
| b. Mother   |          |          |          |          |          |          |          |          |
| c. Others   |          |          |          |          |          |          |          |          |
| 7. Patient's disposition and behavior as reported by: |          |          |          |          |          |          |          |          |

### III. TRAINING AND EDUCATION

#### A. Level of achievement

Nursery school   kindergarten   grade school   ungraded room  
 special room   special school   high-school

#### B. Number of schools attended

Nursery school   kindergarten   grade school   ungraded room  
 special room   special school   high-school

#### C. Number of dismissals-withdrawals

##### 1. Reasons:

Mental            physical            behavioral

##### 2. Reason not in school

### IV. PSYCHOLOGICAL EVALUATION

#### A. Measurable

##### 1. Fully measurable

- a. Mental age
- b. Intelligence Quotient

##### 2. Practically measurable

- a. Mental age estimated
- b. Intelligence Quotient estimated

#### B. Non-measurable

- 1. In contact
- 2. Largely out of contact

#### C. Test used

- 1. Ammons Full Range Picture Vocabulary Test
- 2. Raven's Progressive Matrices
- 3. Revised Stanford-Binet Form L
- 4. Vineland Social Maturity Scale

#### D. Outlook for educability

- 1. Good
- 2. Fair
- 3. Poor

**V. DIAGNOSTIC ADVISORY STUDY****A. Recommendations**

1. Re-evaluation
2. Treatment
3. Out-patient home-care referral to other institution or clinic
  - a. Speech therapy
  - b. physio-therapy
  - c. occupational therapy
  - d. casework services

**B. Present disposition of case**

1. In treatment institution deceased other
2. Results of treatment
  - a. No improvement
  - b. some improvement
  - c. marked improvement
  - (1) PT
  - (2) OT
  - (3) ST

**C. Prognosis**

1. Good
2. Fair
3. Poor
4. Guarded