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A STUDY OF THE EMOTIONAL PROBLEMS OF A SELECTED
GROUP OF CEREBRAL PALSID CHILDREN

by

James Forkeotes

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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1955

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CHAPTER I

INTRODUCTION

PURPOSE:

This is a study of a group of cerebral palsied children who have been seen at the Mercy Hospital Children's Rehabilitation Center and whose behavior and attitudes suggest emotional problems. It has been recognized by the clinic staff that many of these children are exhibiting emotional problems which prevent or delay the initiation of the therapy program and, therefore, restrict the benefits. This causes modification of therapy until the disturbance is alleviated or other approaches are found. Specifically, therefore, it is hoped that this study will reveal some of the elements of this emotional disturbance and its effect on the results of the recommended therapy program.

SOURCE:

The primary source material for this study is the clinical records of a group of sixty-eight cerebral palsied children known to the Mercy Hospital Children's Rehabilitation Center,* sometime between February 14, 1949 and August 31, 1954. In this group

*The Current title of the medical facility is used in this thesis instead of the former name, Mercy Free Dispensory Cerebral Palsy Clinic.

there were thirty nine active and twenty nine closed cases.

METHOD:

This project was undertaken by a group of five students from the Loyola University School of Social Work. The selection of the material and the general focus was made possible following a discussion with the professional staff of the clinic in group sessions and individually.

The material for this thesis was obtained through a study of available case histories in the master file of the Mercy Hospital Children's Rehabilitation Center. A review of several of these cases was made and resulted in the drafting of a tentative schedule. This schedule was presented to the professional clinic staff, during a group session, for the purpose of discussing 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 tested with a random sample, in which every tenth case was selected for study. Upon completion of the sample study, minor adjustments were made in the schedule. The revised schedule (See Appendix) was the basis for this group study.

The records were alphabetically arranged and placed in numerical sequence. The total number of case histories was divided equally among the students and, upon completion of the study, the information obtained was transferred to a master schedule. The

schedule included four broad categories:

1. general identifying information,
2. medical and social history,
3. psychological evaluation,
4. diagnostic work-up and treatment.

After the data was compiled, each student selected a specific area of concentration. Of the total cases studied, one hundred and thirty-eight cases were active and ninety were closed. Thirty-nine, or approximately twenty-eight percent of the active cases, and twenty-nine, or approximately thirty-two percent of the closed cases were considered by the clinic staff to be exhibiting an emotional problem. This study is, therefore, based on sixty-eight cases or approximately thirty percent of the total number of cases studied by the group.

MERCY HOSPITAL CHILDREN'S REHABILITATION CENTER

HISTORY:

The Mercy Hospital Children's Rehabilitation Center, formerly known as the Cerebral Palsy clinic of Mercy Hospital and Dispensary, has been in existence since February 14, 1949.

Under an affiliation agreement, on March 27, 1953, the services of the Cerebral Palsy Clinic at Mercy Hospital and the facilities of the Martha Washington Home for Crippled Children were united. The facilities of the Martha Washington Home for Crippled Children provided for in-patient care and space for a treatment

center. The Mercy Cerebral Palsy Clinic had been limited largely to diagnostic services. The affiliation, therefore, combined the efforts of these two groups on behalf of cerebral palsied children. The patients were admitted to the clinic for a period of three months, were evaluated during that time, and reevaluated each three months.

Financial difficulties caused the affiliation program to be dissolved on September 30, 1954. Mercy Hospital, however, decided to continue their diagnostic clinic and to initiate a program of rehabilitation on an out-patient basis only.¹

OPERATION OF CLINIC:

The Mercy Hospital Children's Rehabilitation Center treatment program is based on a teamwork approach and incorporates the medical specialties of pediatrics, neurology, orthopedics, and physical medicine, with the auxiliary services of social service; psychology; physical, occupational, and speech therapy to serve the complicated needs of the patient. Consultation in the other specialties of medicine and all laboratory facilities are available through Mercy Free Dispensary. When there is a need for special tests requiring hospitalization, the child is placed in Mercy Hospital.

¹Information taken from material compiled for publicity purposes for Cerebral Palsy Clinic of Mercy Hospital, 1955.

Upon being admitted for evaluation, a history of the birth and development of the child is obtained. The child is then seen by the Medical Director, a pediatrician, who may recommend further examination by the four medical specialists: the physical, occupational, and speech therapists; and the psychologist; or may recommend any other medical and laboratory examinations. The results of these examinations are reviewed by the Medical Director and the other members of the team in a staff discussion, where the rehabilitation plan is worked out.

When intensive treatment appears to be indicated, the child is scheduled for therapy several times weekly on a trial basis and later rechecked; other children, for whom intensive treatment does not appear feasible, are placed on a home program and the parents are given instruction in therapy. A third group of children who enter the clinic for evaluation are referred by private physicians for consultation services and evaluations.

The medical social worker and psychologist provide counseling for parents or older patients when this service is indicated.

Children receiving intensive therapy and those for whom intensive therapy was not feasible at the time of the initial evaluation are rechecked periodically by the team, to evaluate the progress in or results of treatment and to make recommendation accordingly.

Fees for the clinic are based upon the parents' ability to pay. The clinic is being supported by contributions made by various com-

munity organizations and interested individuals.²

Table I shows that twenty-seven, or approximately forty percent of sixty-eight patients were cases initially diagnosed at Mercy Hospital Children's Rehabilitation Center as being children handicapped as a result of Cerebral Palsy. The rest of the cases had been originally diagnosed as Cerebral Palsy by private physicians or other clinics. All were studied in the complete diagnostic process at Mercy, however.

TABLE I

NUMBER OF INITIAL CEREBRAL PALSY DIAGNOSES MADE AT
MHCRC AS COMPARED WITH THOSE MADE BY PRIVATE
PHYSICIANS AND OTHER CLINICS*

<u>Sources</u>	<u>Number of Children</u>
Total	68
Private Physicians and other Clinics	41
MHCRC Hospit	27

Each of the patients known to the clinic has been referred by one of the sources indicated in Table II. The highest percentage of referrals have been made by professional persons. These include physicians, therapists, psychologists, etc. A few referrals have been made by friends of the family. This referral information was

²Ibid.

*From this point on Mercy Hospital Children's Rehabilitation Center will be designated MHCRC.

not recorded in eight of the case histories.

TABLE II
SOURCE OF REFERRALS TO MHCRC

<u>Sources</u>	<u>Number of Children</u>
Total	68
Professional	25
Agency	17
Publicity	12
Friends.	6
Information not recorded	8

WHAT IS CEREBRAL PALSY?

Cerebral Palsy may be defined as "comprising a group of conditions which affect the control of the voluntary motor system and which have their origin in lesions of various parts of the brain."³ Because Cerebral Palsy has its origin in the brain, the child afflicted by this disease may have impaired vision, hearing, or defective speech. Intellectual capacity, upon which so much attention is being focused in recent studies, may also be affected. Some of the causal factors of cerebral palsy are:

1. Prenatal factors recognized as genetic defects or injuries acquired in the uterus. These injuries may be caused by prenatal anoxia, cerebral hemorrhage, or an RH

³Winthrop M. Phelps, The Cerebral Palsies, (Chicago,) p. 1111
1946

factor.

2. Natal factors, which include anoxia due to narcotics, or difficult delivery; and cerebral hemorrhage due to traumas to the head, bleeding tendencies, constitutional factors, or sudden pressure changes.

3. Post-natal factors, which are classified as traumas, infections, toxins, and anoxia.⁴

At times the qualitative nature of Cerebral Palsy may be indicated by the topographical distribution of the involvement. In some instances, legs are more involved than arms, and in others, one side more than the other. The following terms are used in this study and are defined by Dr. Perlstein:⁵

A. Paraplegia involves the legs only.

B. Diplegia involves the legs primarily and the arms to a slight extent.

C. Quadriplegia involves all four extremities.

D. Hemiplegia is a lateralized condition to one-half of the body. Patients with this condition have greater involvement of the arm.

There are five general classifications of Cerebral Palsy based on the observable, outstanding clinical symptoms. These classifi-

⁴M. A. Perlstein, M. D., Infantile Cerebral Palsy, (Chicago, 1952), p. 10-14

⁵Ibid., p. 7, 8

ications are (1) spasticity, which is characterized by a clasp-knife rigidity of muscles resulting in stiffness of movement. There is present an inability to relax muscles which are contracted constantly to their highest degree; (2) athetosis, which is a condition shown by uncontrolled, writhing movements; (3) ataxia, which is a disorder of body balance. In some cases the handicap is apparent only by poor hand and eye coordination, or a staggering walk; (4) rigidity, which is a condition of paralysis of muscles that are very soft;⁶ and (5) tremors, which can be observed in the uncontrollable rhythmic motion of the muscles.⁷

Patients having Cerebral Palsy, formerly known as Spastic Paralysis, represent the second largest group of crippled children, the first being those afflicted with Poliomyelitis. Cerebral Palsy is no longer considered a hopeless condition since some measure of rehabilitation can be achieved by a majority of the patients if the proper facilities are provided. In the past few years diagnostic and treatment centers have been established throughout the country. These centers provide not only medical treatment, but educational, social and family guidance as well.⁸

⁶Ibid., p. 9

⁷M. I. Dunsdon, The Educability of Cerebral Palsy Children, (London,) p. 9, 10
1952

⁸Eric Denhoff, M. D.; Victor N. Smirnoff, M. D.; Raymond H. Holden, M. A., Medical Progress, Cerebral Palsy, (Providence, R. I., n. d.) p. 3

PRESENTATION OF THE STUDY

This study of the case histories of sixty-eight Cerebral Palsied children attempts, in a general way, to consider all possible recorded environmental factors. Specifically, emphasis is focused upon the child's emotional reaction to his condition and his environment, and how his handicap affects his immediate family and peers, and influences his total person.

Chapters II and III give a picture of the environment of these children. The medical problems will be presented in Chapter IV by considering prenatal, natal, and post-natal factors related to the cerebral palsied patient. The physical involvement of the handicap will also be explained in qualitative and quantitative terms. The behavioral problems will be considered in Chapter V and illustrated through case studies. A summary and conclusions will be given in the sixth chapter.

CHAPTER II

AN ANALYSIS OF THE STUDY GROUP

The purpose of this chapter is to describe the sixty-eight patients with information revealed by the face sheet of the clinic record. Identifying data, such as, residence, sex, age at admission, race, religion, education, and number of sibling, will first be presented. Ages of the children's parents, the marital status of the mothers, and occupation of the primary wage earners will be added.

RESIDENCE

There are no residence requirements in the clinic's intake policy. As is shown in Table III, over eighty percent of the Cerebral Palsied children studied at the MHCRC are residents of Chicago. The balance of the study group, with the exception of two patients, live in other areas of the state of Illinois. The fact that two patients are residents of other states would indicate the prestige of the clinic as a diagnostic and treatment center; the lack of facilities to diagnose and treat these children in neighboring states; or the determination by parents to exhaust all possible resources before accepting, with some degree of finality, the diagnosis and treatment plans offered elsewhere.

This last factor will be illustrated in Chapter IV, where consideration is given the disposition of the twenty-nine closed cases.

TABLE III
RESIDENCE OF CEREBRAL PALSED CHILDREN
IN THE STUDY GROUP

<u>Location</u>	<u>Number of Children</u>
City	56
Suburb	3
Other areas of State	7
Out of State	<u>2</u>
	Total 68

SEX AND AGE AT ADMITTANCE

Evidence of the close approximating incidence of Cerebral Palsy in both sexes is found in Table IV. This study of sixty-eight Cerebral Palsied children does show, however, a slight male preponderance.

The majority (forty-three) of the children in this study were under six years of age when admitted to this clinic. The average age was slightly over four years, with the males being slightly older. The age distribution is clearly denoted in Table IV.

TABLE IV

SEX DISTRIBUTION AND AGE AT ADMISSION
OF CEREBRAL PALSIED CHILDREN

Age in years at Admission	Male	Female	Total
Under 1	0	1	1
1 - 2	10	8	18
3 - 4	7	10	17
5 - 6	4	3	7
7 - 8	4	2	6
9 - 10	4	1	5
11 - 12	6	4	10
13 and over	0	2	2
Information not recorded	0	2	2
Total	35	33	68

RACE AND RELIGION

Although MHCRG is under Catholic auspices, there are no religious or racial restrictions in the clinic's intake policy.

Race and religious backgrounds are described in Table V. The majority of children in the study group, approximately eighty-nine percent, were white, with almost an equal distribution of Roman Catholics and Protestants.

TABLE V

RACE AND RELIGION OF CHILDREN IN THE STUDY GROUP

Religion	White	Negro	Total
Catholic	32	2	34
Protestant	28	5	33
Jewish	1	0	1
Total	61	7	68

TRAINING AND EDUCATION

General retardation of the study group is indicated in Table VI, dealing with training and education. Forty-nine of the sixty-eight children studied, were of school age. One child was in an ungraded class. Only seventeen were attending regular classes, and five were in special schools for crippled children. Twenty-four school-age children were not in school.

TABLE VI

EDUCATIONAL STATUS OF THE SCHOOL AGE
CHILDREN IN THE STUDY GROUP

<u>Classification</u>	<u>Number of Children</u>
Graded Classroom	17
Ungraded Classroom	1
Special School	5
Nursery School	2
Not attending School	24
Total	<u>49</u>

AGE OF PARENTS

The mean age of fathers and mothers, at the birth of the patients studied, was thirty-one and twenty-six, respectively. Thirteen of the mothers were under twenty-five years of age at the birth of their Cerebral Palsied child. Twenty-five mothers were between thirty and thirty-nine years of age. The ages of nine fathers and four mothers were not given in the clinic record.

TABLE VII

AGE OF PARENTS AT BIRTH OF CEREBRAL PALSID CHILD

Ages	Father	Mother
15 - 19	0	1
20 - 24	5	12
25 - 29	17	26
30 - 34	14	17
35 - 39	16	8
40 - 44	7	0
Information not recorded	9	4
Total	68	68

NUMBER OF SIBLINGS AND SIBLING POSITION

It is noted in Table VIII that in thirteen of the sixty-eight families, the patient was the only child and that in thirty of the sixty-eight families, he had a younger sibling. These findings

are very similar to those revealed by the Connecticut study.⁹ The table shows that having a cerebral palsied child may have affected the size of many families. There are only six families in which the patient had three siblings and only four families in which he had four siblings. These ten families account for approximately fourteen percent of the families studied. The effect of the cerebral palsied child on the normal siblings is of concern. The child's disability may cause him to receive most of the attention, and this may possibly result in sibling rivalry, which would affect the patient, sibling, or both.

TABLE VIII

NUMBER OF SIBLINGS AND ORDINAL POSITION
OF CEREBRAL PALSIED CHILD

Classification	Number and Position					
	None	1	2	3	4	Not Recorded
Ordinal Position	-	37	19	8	3	1
Patients with sibling	13	28	17	6	4	0

MARITAL STATUS OF MOTHER

Table IX shows that sixty, or approximately eighty-eight percent, of the mothers of the cerebral palsied children were married. Three mothers were remarried, but the records did not show if the

⁹The Study of Cerebral Palsy in Connecticut, (Hartford, Connecticut, 1951,) p. 74

present husbands were the fathers of the patients. At the time of the study one mother was widowed, one had adopted the patient when he was an infant, and one was a foster parent.

TABLE IX
MARITAL STATUS OF MOTHER

<u>Marital Status</u>	<u>Number</u>
Married	60
Separated	1
Remarried	3
Widowed	1
Adoptive Parent	1
Foster Parent	1
Information not recorded	<u>1</u>
	Total 68

OCCUPATION OF PRINCIPAL WAGE EARNER

The occupation of the fathers were of a wide variety as is shown by the distribution of all types of employment catagories, in Table X. Thirty-six fathers were classified as operatives and craftsmen; twelve as engaged in clerical and sales work; four as professional and semi-professional; and seven as service workers. Thus the occupations of the great majority of the group were of a professional or skilled type. One family, in which the father was deceased was receiving old age and survivors insurance. Occupation was not recorded in five case histories.

TABLE X

EMPLOYMENT CLASSIFICATION OF PRINCIPAL WAGE EARNER*

<u>Classification</u>	<u>Number</u>
Professional	2
Semi-Professional	2
Proprietors, Managers, and Officials	3
Clerical, Sales and Kindred	12
Craftsmen, Foremen, and Kindred	24
Operative and Kindred	12
Service Workers Except Domestic	7
Occupation not recorded	<u>5</u>
	Total 67**

*Federal job classification as listed by the Census Bureau.

**One parent was not employed but was supported by old age and survivors insurance.

SUMMARY

Attention may be called to three items presented above as possible factors influencing or aggravating the emotional problems of the Cerebral Palsied child, and affecting the size of the family.

1. The average age of the mothers was twenty-six years. Twenty-five mothers were older than thirty years of age at the birth of their cerebral palsied child. Thirteen of the mothers were under twenty-five years of age and one mother was not yet nineteen years old.
2. The effect of Cerebral Palsy on the size of families

has been noted. In this study, no family consisted of more than four children in addition to the cerebral palsied child. There is a possibility that the emotional life of the parents was affected by the birth of the cerebral palsied child.

3. In thirty-seven cases, the cerebral palsied child was the eldest child in the family. Sibling rivalry, which commonly occurs in various degrees during the development of physically and mentally average children, was considered as an important factor which might have had serious repercussions on the cerebral palsied child's emotional and physical development, possibly adversely affecting the general home atmosphere. The content of sibling rivalry as exhibited in the families of the cerebral palsied patients studied, will be discussed in Chapter IV.

CHAPTER III

MEDICAL PROBLEMS RELATING TO THE CEREBRAL PALSIED PATIENT

This chapter will consider birth history; early development; diagnosis and recommendations; results of treatment; and disposition of cases. The intelligence measurability, general awareness, and educability prognosis of the study group will be considered in effort to present as complete a picture as possible. The psychological evaluations of the patients, which will be reported comprehensively by another member of the group of students engaged in the group project study reflects, to a large degree, the measurability and educability prognosis of the children.

BIRTH HISTORY

The mothers' history of pregnancies, live births, miscarriages, and the ordinal position of the cerebral palsied child are analyzed in Table XI. It is revealed that the number of subsequent pregnancies diminishes after the second. Twenty women each reported two pregnancies. This compilation of figures reveals a high incidence of two pregnancies and two live births, as well as, a high incidence of cases in which the cerebral palsied child was the first born. This indicates that after the birth of the cerebral palsied child, these mothers gave birth to a second child. Although as previously stated, the largest number of living children in the

families studied was five, two mothers reported nine pregnancies each. The following table reveals some of the multiple factors operating in the procreation histories of the mothers of cerebral palsied children. The smaller ratio of multiple births compared with the number of pregnancies seems to be influenced by early miscarriages. Two mothers had nine pregnancies and yet the highest number of live births in the study group was six.

The number of records not reporting some of the above information suggest that in some cases the mother was reluctant to reveal information concerning her pregnancies. Attempts to secure the information may have aroused within some of the mothers many feelings indicating emotional involvement in the areas which created discomfort and requested free expression. The average number of pregnancies, live births, and ordinal position of the patients are 2, 2.7, and 1.7, respectively.

TABLE XI

HISTORY OF PREGNANCIES, MISCARRIAGES, LIVE BIRTHS,
AND ORDINAL POSITION OF PATIENT

Classification	Number and Position										No Record	Total
	0	1	2	3	4	5	6	7	8	9		
Pregnancies	-	12	20	12	10	4	2	-	-	2	6	68
Births	-	12	27	13	6	3	1	-	-	-	4	68
Miscarriages	42	9	5	2	-	-	-	-	-	-	10	68
Ordinal Position	-	26	18	9	6	1	1	1	-	-	6	68

The birth histories of the children studied revealed the following complications associated with, or possibly producing the brain damage: (1) three mothers reported nervousness and depression moods during pregnancy; (2) five reported Rh Blood factor incompatibility; (3) four mothers reported hemorrhaging during pregnancy; (4) placenta previa, and eclampsia was reported in two cases; (5) two cases of hypertension were reported; (6) one accident, and a case of early surgery were considered as aetiological factors. No infectious diseases were reported. Twenty-nine mothers reported no complications during pregnancy. Information was not available regarding this factor in eleven case histories, as shown in Table XII.

TABLE XII
PREGNANCY COMPLICATIONS

Complications	Number	Complications	Number
Psychic Disturbances	3	Traumatic Experiences	2
Hematologic	5	Other	1
Hemorrhage	4	Combination of above	9
Placenta	1	Not recorded	11
Toxemia	1	No complications	29
Chronic Disease	2	Total	68

Information concerning the presentation at birth and prematurity of the Cerebral Palsied child was extremely limited in the case histories. Of the thirty-six in which the presentation of the patient was recorded, only two were breech. The unavailability of data regarding this factor prevents comparison with the number of breech births in the general population. It is known that the breech presentation in the general population is 2.1 percent, as compared with sixteen percent in the cases of the cerebral palsied children studied in Connecticut.¹⁰ Table XIII indicates that one patient in the study group was delivered by Caesarian section.

Birth weight is recognized as the most reliable indication of length of gestation. Any child weighing five pounds, eight ounces or less is classified premature in this study. In the fifty of the sixty-eight cases studied at the MHCRC, in which birth weight was known by the parent, forty-three infants were full term. (See Tables XIII and XIV.) Table XIV shows that seven, or fourteen percent of these fifty infants, weighed between two pounds, nine ounces and five pounds, eight ounces. The incidence of prematurity in cerebral palsied children revealed in this study was also observed in the Connecticut study of 109 Cerebral Palsied children.¹¹

Information concerning the labor process was obtained in all

¹⁰Ibid., p. 44

¹¹Ibid.

the case histories, as is shown in Table XIII. Normal labor was reported in forty-nine or seventy-two percent of the cases, while there was not notable difference in the two extremes of labor; prolonged labor was revealed in nine cases, and ten mothers had short periods of labor.

TABLE XIII
LABOR, PRESENTATION AND PREMATUREITY

<u>Condition</u>	<u>Number</u>
Labor:	
Normal	49
Precipitate	10
Prolonged	9
Total	68
Presentation:	
Head	33
Breech	2
Caesarian Sections	1
Information not recorded	32
Total	68
Prematurity:	
Term	43
Premature	7
Information not recorded	18
Total	68

TABLE XIV
BIRTH WEIGHT OF PATIENTS

<u>Weight</u>	<u>Number</u>
2 lbs., 9 oz. - 5 lbs., 8 oz.	7
5 lbs., 9 oz. - 8 lbs., 8 oz.	44
8 lbs., 9 oz. and over	3
Information not recorded	<u>18</u>
Total	68

In this study an attempt was made to evaluate the information given by parents regarding the presence in the child of findings suggestive of brain damage. Fifty-six of the sixty-eight children, for whom neo-natal history was available, were reported to have had significant difficulties in the neonatorum. The condition reported by the mothers are clearly denoted in Table XV. Thirteen gave histories of moderate to severe anoxia; eight gave histories of convulsions soon after birth; eight gave a history of jaundice at birth; seven indicated feeding problems; and thirteen gave histories of a combination of some of the above difficulties. The neo-natal histories of seven patients indicated a normal physical condition.

The significance of these findings is that a high percentage of children who have Cerebral Palsy present suggestive symptoms in the first four weeks of life. This may point to the advisability of more intensive evaluation of children who present specific

abnormal findings in the neo-natal period with the hope of an earlier diagnosis of Cerebral Palsy.¹² Although it is recognized, of course, that many of these conditions may abate spontaneously and are not necessarily associated with or indicative of cerebral palsy.

TABLE XV

PHYSICAL CONDITION MANIFESTED AT BIRTH OF PATIENTS

<u>Condition</u>	<u>Number</u>
Anoxia	13
Cynosis	9
Convulsions	8
Jaundice	8
Feeding Problem	7
More than one condition manifested	13
Normal condition indicated	7
Information not recorded	3
Total	68

Physical Development

The majority of Cerebral Palsy children in the study group were retarded in their motor development. Many children had a history of marked retardation in achieving head, sitting, and standing balance. Verbal deviations also were noted. The average patient

¹²Ibid., p. 46

walked at thirty-five months, and spoke his first words at 29.5 months. None of the patients could hold their head momentarily erect at the age of one month; and only four could accomplish this task at the end of five months, which according to Gesell¹³, far exceeds the maximum time allowed for the average or normal child to accomplish this phase of physical development. In sixteen cases the patients never held their heads erect. It must be noted, however, that in thirty-seven cases the information contained in Table XVI was not available in the records.

TABLE XVI
PATIENTS HELD HEAD ERECT

<u>Age in Months</u>	<u>Number of Children</u>
Birth - 1	0
2 - 3	2
4 - 5	2
6 - 7	1
8 - 9	5
10 - 11	3
12 - 13	1
14 - 15	0
16 - 17	0

¹³Arnold Gesell, M. D., C. S. Amatruda, M. D., Developmental Diagnosis, (New York, 1941,) p. 427-447

TABLE XVI (continued)
PATIENTS HELD HEAD ERECT

<u>Age in Months</u>	<u>Number of Children</u>
18 and over	1
Never held head erect	16
Information not recorded	<u>37</u>
Total	68

The average patient in this study achieved an unsteady sitting balance at fourteen months, approximately one half year later than the normal child.¹⁴ Thirteen patients were not able to sit alone. The medical histories revealed this information in all but fifteen cases. (See Table XVII.)

TABLE XVII
AGE PATIENTS SAT ALONE

<u>Age in Months</u>	<u>Number of Children</u>
Birth - 5	2
6 - 10	13
11 - 15	8
16 - 20	9
21 - 25	5
26 - 30	0
31 - 35	0

¹⁴Ibid., p. 47

TABLE XVII (continued)

AGE PATIENTS SAT ALONE

<u>Age in Months</u>	<u>Number of Children</u>
36 - 40	1
41 - 45	1
46 - 50	1
Never sat alone	13
Information not recorded	<u>15</u>
Total	68

General retardation among the study group again is evidenced in Table XVIII. The mean age for standing was twenty-four and one-half months; for walking, thirty-five months; for first words, twenty-nine months. Of significance is the fact that, up to the time this study was made, sixteen children in the group had never stood alone, seventeen had never walked alone, and eighteen had never spoken a word. However, the number of cases in which this information was unobtainable should be noted.

TABLE XVIII

AGE PATIENTS STOOD ALONE, WALKED ALONE,
AND SPOKE FIRST WORDS

Age in Months	Stood Alone	Walked Alone	First Words
Birth - 6	0	0	0
7 - 12	3	0	0
13 - 18	7	3	5
19 - 24	1	6	3
25 - 30	6	8	4
31 - 36	1	3	4
37 - 42	1	6	4
43 - 48	0	1	0
49 - 54	1	3	2
55 - 60	0	3	1
61 and over	2	5	2
Never	16	17	18
Not recorded	30	13	22
Total	68	68	68

Dunsden¹⁵ states that a child who is unable to sit independently, does not have the opportunity for the characteristic ex-

¹⁵M. I. Dunsdon, The Educability of Cerebral Palsy Children, Newnes Educational Publishing Company, Ltd., p. 19

ploratory behaviour of the normal child. He says, of the Cerebral Palsied child, "Until he can balance his head and trunk sufficiently to maintain a sitting posture for more than just a few seconds, the normal widening of his interests through visual stimuli is bound to be restricted." Although intellectual development may be directly affected, it would seem that physical retardation also would affect the Cerebral Palsy child emotionally.

DIAGNOSIS

Before a method of treatment is outlined by the doctor, a diagnosis is made. This diagnosis, in addition to defining the condition neurologically, describes the area of motor involvement.¹⁶

In this study, spasticity occurred most frequently, accounting for twenty-four disabled children. Nineteen children were athetoid. One child was diagnosed as having the ataxia type of Cerebral Palsy. Spasticity had afflicted the four extremities in eleven cases. Spastic hemiplegia was next in incidence with seven cases. Four children were listed only as having Cerebral Palsy and the area of involvement was not designated. The incidence rate for areas of involvement in other members of the group were: hemiplegia, nine; paraspastic, four; diplegia, one; and quadriplegia, twenty-four. It may be noted in Table XIX that the area of involvement was not indicated in thirty case histories.

¹⁶ Ibid., p. 20

TABLE XIX

**CORRELATION BETWEEN NEUROLOGICAL DIAGNOSIS AND
LOCALIZATION OF MOTOR INVOLVEMENT**

Diagnosis	Motor Involvement					Total
	Hemi- plegia	Para- plegia	Di- plegia	Quadri- plegia	None Indicated	
Spasticity	7	2	1	11	3	24
Athetosis	-	2	-	6	11	19
Rigidity	2	-	-	3	3	8
Ataxia	-	-	-	-	1	1
Tremor	-	-	-	-	2	2
Mixed Type	-	-	-	3	3	6
Cerebral Palsy only	-	-	-	1	3	4
Evaluations Not Completed	-	-	-	-	4	4
Total	9	4	1	24	30	68

A correlation between the age when an abnormality was manifested and a diagnosis of Cerebral Palsy was made is shown in Table XX. The average age when an abnormality was observed was approximately four months. An abnormality was recognized before the child was six months old in thirty-two or fifty-nine percent of the cases in which this information is known. The average initial diagnosis, however, was made at approximately twenty months. Many case histories indicated that parents were originally told their child would "grow out of it", which probably

accounts for the lapse of time until a definite diagnosis was made. Some of this delay in early diagnosis and treatment of Cerebral Palsy may indicate that Cerebral Palsy is still regarded as a condition of which to be ashamed and, therefore, hidden.¹⁷ Also the parents may find it difficult to face the possibility of having their fears confirmed by medical diagnosis.

TABLE XX

CORRELATION BETWEEN AGE ABNORMALITY MANIFESTED AND
AGE DIAGNOSIS OF CEREBRAL PALSY COMPLETED

Age in Months	Abnormality Manifested	Diagnosis Completed
Birth through 6	32	9
7 through 12	16	13
13 through 18	4	6
19 through 24	1	13
25 through 30	1	5
31 through 36	0	6
37 through 42	0	12
Information not recorded	14	4
Total	68	68



¹⁷ Peggy Derse, "The Emotional Problems of ~~the~~ the Spastic, Athetoid and Ataxia Type of Cerebral Palsy Child," The American Journal of Occupational Therapy, IV, (November-December, 1950), p.252

PROGNOSIS AND RECOMMENDATIONS

The prognosis of the Cerebral Palsy children who were seen at MHCRC is shown in Table XXI. The medical histories revealed that, upon completion of the evaluations, it was felt that ten patients could, after intensive treatment, lead relatively normal lives. A prognosis of "fair" was made in nine cases. Of significance is the fact that a prognosis of "poor" was made in twenty-seven cases. It was determined, at the time of evaluation, that many of the latter patients could not profit from treatment because of an emotional disturbance which interfered with and, in a few cases, prevented the initiation of treatment. A few of these children had been helped through the immediate utilization of service offered by the Mercy Child Guidance Clinic.

TABLE XXI

PROGNOSIS OF CEREBRAL PALSID CHILDREN

<u>Classification</u>	<u>Number of Children</u>
Good	10
Fair	9
Poor	27
Guarded	8
Evaluation not completed	4
Prognosis not recorded	<u>10</u>
Total	68

Treatment recommendations were made immediately upon completion of the evaluation. The following table illustrates these recommendations. Placement in special institutions, such as, a convalescent custodial hospital, or a treatment home for crippled children, was recommended for eleven children. It was recommended, however, clinic services be extended to fifty-three children of the study group. Four children were still being evaluated at the time information for this study was being compiled.

TABLE XXII

TREATMENT RECOMMENDATIONS

<u>Recommendation</u>	<u>Number of Children</u>
Special Institutions	11
Clinic treatment	53
Evaluations not completed	<u>4</u>
Total	68

RESULTS OF THERAPY

The fifty-three patients, who accepted the services of the clinic, received one type of therapy or combination of types of therapies. There were three children who received only one type of therapy. One of the patients received occupational therapy, in which an evaluation of some improvement was reported; and the two other children received only physical therapy, in which an evaluation of some improvement also was entered. Nine children received the services of both the physical and occupational ther-

apists. One of these patients received an evaluation of no improvement from both therapists. Eight children received an evaluation of some improvement. Each of the remaining four patients received speech therapy in addition to the two mentioned before. Those children who do not respond to treatment, and in some cases have regressed, are evaluated as having shown "no improvement". A child who makes any positive response to treatment is evaluated as having made "some improvement", while "marked" is definite.

The treatment results of the children who received occupational, physical, and speech therapy are illustrated in Table XXIII.

TABLE XXIII

TREATMENT RESULTS FOR FORTY-ONE CHILDREN
WHO RECEIVED OCCUPATIONAL, PHYSICAL,
AND SPEECH THERAPY

Type of Therapy	Improvement			Evaluation Not completed	Total
	Marked	Some	No		
Occupational	3	16	8	14	41
Physical	3	9	9	20	41
Speech	3	11	8	19	41

It is significant that only three patients had responded to treatment with "marked improvement".

An attempt is made by the psychologist to evaluate the intellectual capacity of all children known to the MHCRC. However, many of the children are inaccessible, because of the severity of the

physical condition, or hyperactivity and uncooperativeness. Therefore, modifications of the standardized test material or procedure must be made. In many cases even segments of standardized tests cannot be applied. Case records reveal, as is shown in Table XXIV, that the intellectual capacity of twenty-five children was measurable according to standard procedures and test materials. The mental ability of nine patients was partially measurable and some modifications were made to accomodate these children. The intellectual capacity of twenty patients, who were in contact (socially alert), was, however, not measurable. The children comprising this non-measurable group were observed as not being meaningfully aware of the world about them. They were, however, aware of their environment. This information reveals the extent of mental and emotional retardation of these children.

Table XXV illustrates the educability prognosis of the Cerebral Palsy patients studied. This prognosis was made by the psychologist after the psychological evaluation of each child was completed. The table shows clearly that forty-three, or approximately sixty-three percent of the children have little chance for qualifying for even an ungraded classroom. Eleven patients are capable of qualifying for an ungraded class, and ten patients probably will attain normal achievement. The prognosis of four patients was undetermined.

TABLE XXIV
INTELLIGENT MEASURABILITY AND GENERAL AWARENESS OF PATIENTS

Measurability	Awareness		Total
	In contact	Out of contact	
Measurable	25	-	25
Partially Measurable	9	-	9
Non Measurable	20	14	34
Total	54	14	68

TABLE XXV
EDUCABILITY PROGNOSIS OF CEREBRAL PALSY PATIENTS

<u>Prognosis</u>	<u>Number of Patients</u>
Good	10
Fair	11
Poor	43
Undetermined	<u>4</u>
Total	68

DISPOSITION

In the first chapter it was explained that twenty-nine of the sixty-eight cases studied were closed at the time this material was being compiled. It is significant to consider the disposition of these cases. Table XXVI shows that four of these children are receiving custodial care. One child returned to his out-of-state home after receiving the full benefits of the diagnostic evalua-

tion and treatment recommendation. The child's parents originally requested this service. Five children expired; four while receiving custodial care, and the other child while a patient in a hospital. The medical records of nineteen children revealed no information concerning disposition other than "no return". A study of these records indicated that there were a few "uncooperative" parents. Among these were some who could not accept the diagnosis and, therefore, sought the services of other clinics and private physicians. The emotional components of these people will be considered in the following chapter.

TABLE XXVI

DISPOSITION OF TWENTY-NINE CLOSED CASES

<u>Disposition</u>	<u>Number of Closed Cases</u>
Custodial Care	4
Out-of-State Residence	1
Deceased	5
Contact Terminated-No reason given .	<u>19</u>
Total	29

SUMMARY

A descriptive picture of data from medical histories was presented in this chapter. Table XI revealed that although the incidence was greater for the children born first, or at least second, the greater incidence of mothers with more than one pregnancy and birth would indicate the birth of younger siblings in some of these

cases. Although there is a lower incidence of prematurity in this study group, as compared with the Connecticut study, this factor does not have much significance, since this information was not obtained in eighteen cases. The high incidence of unrecorded information regarding the type of birth presentation precludes any definite conclusions.

The study of the physical development of the children indicated that many have a history of marked physical retardation. For this reason we can assume that exploratory behavior of many of these Cerebral Palsy children was restricted and, therefore, the possibility of emotional involvement was very great.

The delay in early diagnosis and treatment is illustrated in Table XX. A comparison of Tables XX and XXI indicates that, in spite of the fact that many prognoses of "poor" were made, most of the children, nevertheless, were recommended for treatment. The importance of early diagnosis is made obvious by considering the information revealed in Table XX.

The difficulties encountered in evaluating the patient psychologically were considered briefly in this chapter. In the paragraph dealing with the procedure on psychological testing of Cerebral Palsied children, an attempt was made to show why it is necessary to be flexible in this evaluation.

CHAPTER IV

EMOTIONAL PROBLEMS

Until very recently, physicians, teachers, and parents, treating or living with handicapped children, were engaged in searching for and primarily concerned with corrective measures along physical or medical lines. Little, if any, attention was given to the emotional implications of the handicap. The effect that the disability has upon the emotional growth and development of the child or the many complex mechanisms employed by the child to overcome his handicap and gratify his emotional needs was overlooked.¹⁸

The emotional life of the handicapped child recently has become an important subject for study and research. Attempts, therefore, are being made to look upon the emotional life of the handicapped child as a vital link in the difficult task of treating and rehabilitating the patient.¹⁹

The fact that emotional disturbances can be diverted into physical channels is explained in the psychosematic concept concerning the body-mind relationship. Conversely, physical symp-

¹⁸Marcus Guensberg, M. D., Emotional Implication of Handicaps, reprinted from the February, 1950 issue of the Crippled Child, p.1

¹⁹Ibid.

toms, and organic conditions, have emotional concomitants. These emotional repercussions could be of greater significance to the patient than the physical manifestations of the illness. The mental attitude one develops towards a physical illness or a handicap plays as vital a part in the course of the illness as the purely physical and medical aspects of it. Our ability to overcome an illness does not depend exclusively on the results of the medical therapeutic recommendations of the physician.²⁰

This chapter will consider the etiological factors and symptoms indicating possible emotional disturbances. In addition to studying the nature of the patient's emotional problem, attention will be given the emotional climate in which the child lives. This emotional climate, possibly the most important aspect of the child's life, includes the attitudes and feelings of his parents and siblings.

ATTITUDE OF PARENTS

The attitude of the parents as an influencing factor in the habilitation or rehabilitation of the Cerebral Palsied child has been emphasized by Dr. Sherman Little:

No treatment program for children with Cerebral Palsy is complete unless there is available trained personnel to work with the parents and children around the emotional reactions which are an inevitable part of the picture and

²⁰Ibid., . . .

which may severely interfere with the response to medical and eventual general adjustment.²¹

The case records of sixty-four of the sixty-eight patients in this study revealed a definite description of the mother's personality or emotional stability as a possible etiological factor of the child's emotional disturbance.

Overprotection was recognized as the major unfavorable parental attitude by the clinic staff. Twenty-one or approximately thirty-two percent of the mothers were considered over-protective. Although it was recognized that this attitude was associated with other psychic components, overprotection was a possible major personality trait. In these cases the parents were so profoundly aware of their child's limitations and greater needs for affection and security that they developed this over-protective attitude. It also was found that in many of these instances, the parents assumed an attitude of martyrdom and heaped an excessive amount of love, devotion and care on the defective or handicapped child. The consequences of this type of parental attitude will be considered later in this chapter when the emotional disturbances of the patients are discussed.

Ten mothers were described as being extremely demanding of the clinic. These parents were almost hostile in their attitudes and

²¹Sherman Little, "The Psychosomatic Aspect", Spastic Review, vol. X no. 4 (April 1949)

demands for therapeutic results. Lack of cooperation and insight also were characteristic of these demanding mothers. One mother was described as very bitter towards the clinic staff because she considered the treatment resulted in insufficient improvement in her child. These parents had found it extremely difficult to accept the physical diagnosis of their child. This non-accepting attitude was especially strong when mental retardation was indicated.

Rejection of the child by the mother was detected in eighteen cases. This attitude ranged from open rejection toward the child, in about four cases, to an unrealistic approach toward the child's limitations in the balance of the cases. The majority of these mothers had seen many physicians in the hope of obtaining a favorable evaluation. An impression was created in the records that the mothers had never reached a true understanding of what the child could or could not do. In considering the cases of open rejection not much more can be added to Dr. Guensberg's explanation:

The mother of a feebleminded or deaf-mute child will show a much greater readiness to accept a post-natal injury, an insignificant fall or illness as the cause of her child's mental retardation or deafness rather than to admit an inherent defect in the child's brain, which she is inclined to identify with a defect within herself. In extreme cases, such an attitude may eventually lead to utter rejection of the defective or handicapped child with all the tragic consequences that such a rejection may generate for the child and mother alike.²²

²²Guensberg, p. 3

Although there were only four specific cases of mothers with guilt feelings, it was suspected that this problem was a casual factor in many of the above discussed emotional manifestations. Therefore, the incidence of guilt feelings in parents who have Cerebral Palsied children may be fairly large.

The profound feelings of guilt may be evidenced by self-condemnation and self-punishment, in that the thought of having created something defective may produce feelings of failure and frustration. To relieve these guilt feelings, the mother often may resort to an unwillingness to face and accept the harsh reality by over protection and infantilization.²³

Six mothers were described in the case histories as being "fearful" and "dependent". One mother revealed that she felt she was being neglected by her husband. The problem of alcoholism was indicated for one mother. Another had been in a mental hospital. Only two mothers were recognized in the medical histories as being "mature".

The fathers' attitude toward the patients was generally similar to the mothers. Alcoholism in the father was reported in three cases. Total rejection of the patient and partiality toward a younger sibling was revealed in one case history. Four fathers were described in the records as "not willing to assume

²³Ibid.

any responsibility" for the welfare of the child. Two fathers reported that the spouse gave too much time to the patient and, therefore, they felt neglected. One father was described as receiving a deep satisfaction in caring for the child. The balance of the thirty cases, in which some information about the fathers could be obtained, revealed that unrealistic attitudes, overprotection, rejection, guilt feelings, and insecurity were, as in the mothers, similarly distributed in frequency.

THE CHILD

The psycho-sexual development of the Cerebral Palsied child is basically the same as in the normal child. However, since the period of dependency is related to his physical disability, he may seem to have a longer period of dependency. Activity, the normal means for a child to learn about the world, is definitely limited in the Cerebral Palsied child. The limitation of his activities, the slowness of performance and all the other difficulties which limit activity definitely affect the emotional stability of the child. Frustrations are greater and more frequent. Anxiety, when it does appear, tends to be more intense. The child may choose to escape from reality or may be openly aggressive and hostile. Rehabilitation, in the latter stage, is extremely difficult.²⁴

²⁴The Psychiatrist's Role in Treatment of Cerebral Palsy, by Edward D. Greenwood, M. D. Reprinted from the (December, 1951) issue of The Crippled Child.

With each of the patients studied, the attitude, behavior, or disposition, which indicates a possible emotional problem, is presented according to whether child's emotional reaction is aggressive and negativistic or one of withdrawal. The terms used in the clinic records describe the predominant behavior pattern or reaction to a situation.

Thirty-eight children were recognized by the staff as being aggressively negativistic. Nine of these patients demanded an excessive amount of attention from either the parents or the therapists. Enuresis was regarded as a definite symptom of an emotional disturbance in the medical histories of two patients. Eighteen patients were described as "uncooperative, hyper-active, inattentive, or easily distracted". Seven cases of temper tantrums, and associated feeding problems were reported. The mother's of two patients reported that their children were very disobedient in the home. One child was described as being a "school behavior problem".

Twenty-one patients were considered by the clinic staff to be quite withdrawn. Fourteen patients were observed specifically as being very passive and dependent. Eight children revealed apprehensiveness when encountering new situations or activities.

The case histories revealed very little information concerning the relationship between patients and siblings. Information regarding the matter was available in only thirty-two percent of the records studied. The mothers of eight patients reported that a

good, accepting relationship existed between the patient and siblings. A tendency, by the siblings, to overprotect the Cerebral Palsied patient was reported in two cases. Sibling rivalry was suggested in twelve histories. Many of these parents felt that the patient's siblings were hostile and rejecting because of the additional attention given to the patients, by the parents. For one sibling truancy was a problem.

CASE A

This is the case of Mary M, two year old female, whose condition was diagnosed as athetoid quadriplegia. This patient was described as highly distractible, hyper-active, and very dependent. It was felt that the mother was overprotective.

The parents first realized the presence of a medical problem when the patient, at the age of eight months, could not sit up. The mother had had four pregnancies. The first and third pregnancies resulted in miscarriages. The patient was the first live birth. A sibling was born as a result of the fourth pregnancy.

During the evaluation and the three month treatment period which followed, the patient preferred to be alone. When the mother attempted to touch a toy, the child cried and screamed. It was extremely difficult for the clinic staff to get sustained interest from the patient. The psychologist felt that the outlook for educability was good, but that the emotional component might interfere with treatment and thus result in a regressive pattern.

After the three month period of treatment the physical therapist reported no improvement. The occupational therapist reported a decrease in the patient's attention span. The clinic staff recommended treatment for another three month period, and suggested that the mother be offered casework services.

CASE B

George, a two year old white male, who was admitted to the clinic for evaluation and treatment recommendations, presented another type of emotional problem. The clinic staff reported the problem of temper tantrums in this child, and that both parents seemed quite immature.

The area of physical involvement was not indicated in any of the individual staff reports. A final diagnosis was not made, since the initial evaluation process was not completed. The medical report indicated a normal birth history.

The physical therapist reported that the patient was capable of performing many functional activities but felt that the mother was frustrating him, resulting in the temper tantrums. The occupational therapist pointed out that when the child was allowed some freedom, he would take a cup of water, which was placed in front of him, in both hands and drink from it. The therapist also advised that much more could be accomplished with the boy when given an opportunity for independent activity. The mother informed the staff that many of the activities which were performed in the clinic

were not accomplished in the home. The psychologist noted a near normal level of mental ability, however, because of the child's disturbed background and lack of stimulation, it was doubtful that the test results gave a valid measure of ability. The neurologist recognized the problem of hyper-activity and ruled out mental retardation.

CASE C

Mary, age fourteen, was admitted to the clinic for counseling service because of a school adjustment problem. The patient's condition was diagnosed as spastic quadriplegia.

The mother told of how she had been concerned about Mary since the child's birth, but had been told by her physician that she was overly concerned. The doctor advised the mother not to worry. Mary's mother gave the following birth and developmental history: Mary had convulsions approximately two weeks after birth and was given oxygen. Soon after, she developed an acute digestive condition which lasted for approximately three years. When Mary was three years old, her mother began to feel that the vomiting "was used against me". She noticed that the child walked on the tips of her toes, stiff legged, with her arms up and head down. The mother expressed the feeling that Mary could have walked correctly if she wanted to. She was a feeding problem until she reached the age of five. Her manner of eating disturbed her father to the extent that he would turn his head in another direction.

As Mary approached adolescence, her inability for form satisfying relationships with her peers became more of a problem for her.

Intensive counseling for Mary and her mother was the prominent recommendation.

SUMMARY

It has been the purpose of this chapter to present the emotional problems of the Cerebral Palsied children studied from and described in the case records.

The high incidence of rejection, over-protection, and infantilization suggests the probably cause of emotional dependence and various behavior problems in these children. These parental attitudes and problems add a handicap of emotional dependency to the existing physical handicap of the child, thus prolonging and complicating the process of treatment.

CHAPTER V

SUMMARY AND CONCLUSIONS

The purpose of this study is to reveal some of the emotional elements which the staff of the MHCRC have recognized as Negatively affecting results of medical treatment.

Two items were pertinent in the thesis as possible factors influencing the emotional problems of the cerebral palsied children in the study; age of mother and ordinal position of cerebral palsied child. Although the average age of the mothers was twenty-six years, twenty-five of the sixty-eight mothers were older than thirty years of age at the birth of their cerebral palsied child. Eight mothers were between thirty-five and forty years of age.

Thirty-seven patients are first born. In thirteen of these cases the patient^s had no siblings. Thus, it seems that having a cerebral palsied child may have affected the size of many families.

Sibling rivalry was recognized as an important factor which had serious repercussions on some of the children.

A study of the physical development of the children indicated

that many had a history of marked physical retardation. Because of this, it was assumed that exploratory behavior of many of these cerebral palsied children was restricted, and therefore, the possibility of emotional involvement was very great.

The high incidence of rejection, over-protection, and infantilization suggests the proximate reason for these children being emotionally dependent and for their various behavior problems. It seems, therefore, that these parental attitudes and behaviorisms had added an emotional handicap to the existing physical handicap of the child, thus prolonging and complicating the process of treatment.

The case records indicate the need to take into account and deal with parental attitudes, so that better medical results could be achieved. It is conceivable that since the parent-child relationship is essentially a process of interaction of the personalities of parent and child, the emotional attitude of the parent profoundly affects the cerebral palsied child's emotional life.

BIBLIOGRAPHY

A. BOOKS

Connecticut State Department of Health. The Study of Cerebral Palsy in Connecticut, Hartford, 1951.

Dunsdon, M. I., The Educability of Cerebral Palsied Children. Tower House, Southampton Street, London, 1952.

Gessell, Arnold., M. D., and Amatruda, C. S., M. D., Developmental Diagnosis: Normal and Abnormal Child Development. New York, 1941.

Hopkins, Thomas W., Bice, H. V., Colton, K. C., Evaluation and Education of the Cerebral Palsied Child: New Jersey Study. Washington, D. C., 1954.

B. ARTICLES

Denhoff, Eric, M. D., Smirnoff, Victor N., M. D., Holden, R. H., M. D., Medical Progress, Cerebral Palsy. (Providence, Rhode Island.)

Derse, Peggy. "The Emotional Problems of Behavior in the Spastic, Athetoid and Spastic Type of Cerebral Palsy Child", The American Journal of Occupational Therapy, IV (November-December 1950), 252-260.

Greenwood, Edward D., M. D., "The psychiatrist's Role in Treatment of Cerebral Palsy," Reprint from The Crippled Child, (December, 1951.)

Guensberg, Marcus., M. D., "Emotional Implications of Handicaps", Reprint from The Crippled Child, (February, 1950.)

Little, Sherman., "The Psychosomatic Aspect", Spastic Review, Vol. 10, No. 4. (April, 1949).

Perlstein, Meyer D., M. D., "Infantile Cerebral Palsy - Classification and Clinical Correlations", Reprinted with additions

from The Journal of the American Medical Association, (May, 1952.)

-----, "Mature and Recognition of Cerebral Palsy in Infancy",
Reprint from The Journal of the American Medical Association,
(April, 1952.)

Phelps, Winthrop M., "The Cerebral Palsies", Mitchel Nelson Text Book of Pediatrics. 4th Edition, 1946,

C. UNPUBLISHED MATERIAL

Information taken from material compiled for publicity purposes
for Mercy Free Dispensary, Cerebral Palsy Clinic, revised,
1955.

APPENDIX

SCHEDULE

Identifying Information:

- I. Birth Date _____ Age at Admission _____ Height _____ Weight _____
Sex _____ Race _____ Religion _____
- II. Source of Referral _____
- III. Different Diagnosis Prior to Admission
Treatment: OT _____ PT _____ ST _____ Surgery _____ Medication _____
- IV. Age of Child when Abnormality was first Observed _____
Noted by: a) MD _____ b) Mother _____ c) Other _____
Diagnosed as Cerebral Palsy: Type _____ Involvement _____
Age _____

Social History:

- I. Family Constellation: Age at birth _____ Marital Status: _____
of CP child: M, D, S, W, RM.
a) Father _____
b) Mother _____
c) Children: at home _____ away _____
- II. Patient: Other Placement Prior to Admission
a) Foster Home _____ b) Institution _____
Reason for Placement _____
Number of Placements _____
- III. Other CP members in the family _____
- IV. Others with illnesses in the family _____
- V. Others in the home _____
- VI. Living arrangements:
a) Own Home _____ b) Rent _____ c) With Relatives _____
d) Number of Rooms _____ e) Floor _____

VII. Economic Status:		Employed	Unemployed	Occupation	Income
a)	Father	_____	_____	_____	_____
b)	Mother	_____	_____	_____	_____
c)	Siblings	_____	_____	_____	_____
d)	Others	_____	_____	_____	_____

Group Hospital Plan Insurance: Yes No

VIII. Attitudes: As Observed by:

a) Mother _____

b) Father _____

c) Siblings _____

d) Others _____

IX. Marital Situation as reported by: _____
 Father Mother Others

Health

I. Mother:

a) Complications During Pregnancy _____

b) History of Accident, Physical disability, or Serious Illness During Pregnancy _____

c) Labor: Normal _____ Prolonged _____ Other _____

d) Delivery: Breech _____ Footling _____ Head _____ Transverse _____
Versional and Extraction _____ Instrument _____

d) Birth: Caesarian Section _____ Normal _____ Premature _____
Delayed _____ Other _____

f) Para _____ Gravida _____ Which Pregnancy CP _____ Miscarriage _____

(s)

II. Child:
a) Birth: Normal _____ Anoxia _____ Cyanosis _____ Jaundice _____
Resuscitation _____ Convulsions _____ Birth Weight _____ Feeding
Method _____
b) Mother's Account of Early Symptoms: _____
c) Physical Development: Held Head Erect _____ Sat Alone _____
Stood Alone _____ Walked _____ First Words _____ Toilet
Trained _____
d) Illness or Accident During Childhood _____

III. Training and Education

a) Level of Achievement: Nursery School _____ Kindergarten _____
Grade School _____ Ungraded Room _____ Special Room _____
Special School _____ High School _____

b) Reason not in School _____

IV. Social Activity: Spectator _____ Participant _____

V. Present Behavior _____

Psychological Evaluation

Measurable _____ Non-measurable _____ Fully Measurable _____
 Practically Measurable _____ In Contact _____ Largely Out of
 Contact _____
 Outlook for Educability _____ (good, fair, poor)

Diagnostic Advisory Study

I. Recommendations:

a) Re-evaluation _____

b) Treatment _____

1) Out Patient _____ Home Care _____ Institution _____

2) OT _____ PT _____ ST _____ Casework services _____

II. Results of Treatment: Marked _____ Some _____ No _____
 Improvement Improvement Improvement

PT _____

OT _____

ST _____

Case work Treatment _____