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**CASEWORK COUNSELING WITH PARENTS OF
CEREBRAL PALSID CHILDREN**

by

Bennette L. Herrera

**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**

June

1955

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CHAPTER I

INTRODUCTION

As the parents of the child afflicted with cerebral palsy gradually recover from the shock and disillusionment of discovery that their child is handicapped and begin to contemplate the child's future, they are faced with the challenge of helping the child to make the best use of his abilities. The child's physical and emotional adjustment to his handicap starts with the parents' acceptance of him as one who needs to be loved and wanted for what he is, a child--not a handicapped child, but a child with normal feelings, desires, and ambitions, who is also handicapped. It has long been an established fact that, in order for a handicapped child to adjust successfully, it is necessary that there be a positive relationship with the parents.¹

Purpose

This study is concerned with casework counseling with parents

¹Edith Meyer, Ph.D., "Role of Psychology in the Cerebral Palsy Training Unit," reprint from The Crippled Child (August 1953).

of children with cerebral palsy and the manner in which parents accepted casework counseling. It is hoped that this study might uncover some factors that might assist the parents in meeting this problem with more courage.

Scope and Focus

This thesis is part of a group project undertaken by five students from Loyola University School of Social Work, whose purpose it was to study the case histories and clinical records of 221 patients known to the Mercy Hospital Children's Rehabilitation Center sometime between the date of the establishment of the Center, February 14, 1949, and August 31, 1954. (The current title of the medical facility is being used in this thesis instead of the former name, Mercy Free Dispensary Cerebral Palsy Clinic.) Only those cases definitely diagnosed as cerebral palsy were included in the study. Of the total number of cases studied (221), 138 were active cases and 90 were closed cases.

Method

The selection of the material for the study and the general focus was made possible following a discussion with the professional clinic personnel. Additional information was obtained through group and individual sessions with clinic specialists in this field as well as by a review of pertinent literature related to this problem. A schedule (see Appendix) was devised by the five students engaged in this group project; it was then presented to the pro-

professional members of the clinic staff who met in a group session to discuss with the students the strengths and weaknesses of the schedule. The schedule was revised, and minor adjustments were made. After a preliminary testing on a sampling of 30 cases, the total number of cases was then divided equally among the students for the completion of the schedules from the case material. After this, the information obtained was transferred to a master schedule and tabulated to facilitate analysis of the data. This schedule covered four broad categories of information: (1) general identifying information, (2) medical history, (3) psychological evaluation, and (4) diagnosis and treatment. Following the completion of the collection of data on the total number of cases studied, each member of the group project then selected an area of individual concentration.

This particular study will focus on a selected group of 44 cases that had been receiving intensive casework services from the Social Service Department of the clinic. These cases were arbitrarily selected by one of the social workers on the clinic staff. The selection included only those cases that had a number of interviews and had received intensive casework service. The cases in the study group represent a trend on the part of the clinic to make casework service available to more parents of cerebral palsied children.

The Setting

Mercy Hospital was established in 1849 by the Sisters of Mercy, who had come to Chicago in 1846. The original name of the hospital was Illinois General Hospital of the Lakes. After a charter was secured in 1852, the name of the hospital was changed to Mercy Hospital. The hospital has been at the present location since 1855. The dispensary was added to the hospital in 1889. The dispensary is a very vital part of the hospital and is financed through the Community Fund, hospital and clinic fees.²

The Mercy Cerebral Palsy Clinic was not established until February 14, 1949. This additional clinic was established as a result of the urgent need for such a medical facility in the community. It was estimated that there were from four to five thousand children afflicted with cerebral palsy in the Chicago area. These children were under twenty years of age. Treatment and rehabilitation resources in the community for children with this disability were almost nil.

Establishment of Mercy Free Dispensary Cerebral Palsy Clinic

The administrator of Mercy Hospital met with the Pediatrician and the Director of Social Service of the hospital staff in November

²Information taken from material compiled for publicity purposes for Mercy Free Dispensary Cerebral Palsy Center, 1951.

of 1948. The purpose of this meeting was to develop an advisory board that would represent all of the specialties interested in and connected with cerebral palsy. All social agencies in the city interested in developing resources for meeting the problem of cerebral palsy were invited to attend and participate in this meeting. At the meeting consideration was given to potential treatment facilities at Mercy Hospital and the kind of cooperation that could be offered by outside agencies.³

After the clinic was opened, a fund-raising drive was started in order to purchase much needed equipment and to procure staff. The physicians donated their services and the hospital provided the physical plant. The limited amount of space and money available made it necessary for the clinic to operate on a part-time basis. In December of 1950 the clinic received an allocation from the United Cerebral Palsy Association which allowed the clinic to expand its facilities.

Operation of the Cerebral Palsy Clinic

The parents of the cerebral palsied child apply for admission or are referred by physicians or other professional persons or by other agencies. These applications for the clinic services are received by the medical social worker who conducts the first interview

³Ibid.

with the applicant. At that time, some interpretation of the clinic program is given to the parent. A history of the child's birth and other pertinent information is obtained and a clinic appointment is made. The information secured by the social worker is made available to the physician in charge and other staff members before the child is seen in the clinic. When the patient is brought to the clinic, he is examined by the physician in charge, who also interviews the parents. Clinic appointments are arranged as indicated for further examination and laboratory tests. Afterwards a diagnostic evaluation is made based upon the findings of the various specialties in the clinic. All of this information is pooled and treatment plans are outlined. These recommendations are given to the parents.⁴

The clinic has developed with the philosophy that problems of a handicapped child can best be met with a team work approach. The team includes the medical specialties of pediatrics, physical medicine, orthopedics, and neuro-psychiatry. The team also calls into consultation the other specialties of medicine available in the total clinic program. Other professionals represented in the team are psychologists, medical social workers, physical therapists,

⁴Ibid.

occupational therapists, and speech therapists. Contact is maintained with schools for handicapped children and other resources in the community.⁵

Presentation of Material

In Chapter II a definition of cerebral palsy will be given along with an explanation of the treatment process. An attempt will be made to present a picture of the physical and intellectual development in including identifying information relating to their physical and intellectual development. The material for this study will be presented from case data and case illustrations will be made to show problems presented by the families of cerebral palsied children and the nature of the casework service rendered these families.

⁵Ibid.

CHAPTER II

A STUDY OF FORTY CHILDREN DIAGNOSED AS CEREBRAL PALSY

Cerebral palsy is a condition characterized by paralysis, weakness, or incoordination occasioned by any other abnormality of the motor center of the brain. Surveys have revealed that the incidence of cerebral palsy is approximately one in every two hundred births. However, there is a wide variation in the character of the disability and the degree of motor involvement observed in various palsied patients. These are five types of cerebral palsy. These types are based upon the area of the brain that is damaged, thus rendering a distinctive pattern. Spasticity is characterized by involuntary tightening of the muscles, which slows motion and makes it ungainly and stiff. Athetosis is characterized by involuntary purposeless muscle movement. In ataxia there is a lack of balance, and the conception of bodily position in space is damaged or destroyed. The next type of palsy, tremor, is characterized by irregular rhythmic motion which ranges from a fine tremor to a gross one. This type is usually found in the post-natal type of cerebral palsy.

following a brain infection such as encephilitis. Rigidity is a paralysis of the musculature. In this condition the muscles are decidedly soft and putty-like.

Eye defects occur in about 50 per cent of the patients with cerebral palsy.¹ An examination of the intrinsic muscles of the eyes of infants may produce presumptive evidence of cerebral palsy. Strabismus, nystagmus, and paralysis of gaze (i.e., "loss of conjugate movement") are likely to occur with organic brain damage. Strabismus associated with cerebral palsy is characterized by a pronounced variability in the degree of the squint that can be detected in patients on repeated clinical examinations. Paralysis of gaze is frequently associated with the Rh type of athetosis. The motions may be illicited by so-called synkinetic, which are defined as involuntary muscle actions due to voluntary movements of another muscle or in response to a reflex.

It has been estimated that 75 per cent of all children with cerebral palsy have speech defects and that from 50 to 75 per cent of these children can benefit from speech training. Speech disabilities may be due to a lack of control of the tongue, the lips, or the breathing mechanism. There may also be speech defects

¹Mary Louise Burton, "General Implications of Cerebral Palsy," Journal of Social Casework, XXVII (March 1947), 91.

secondary to hearing loss or to perceptual defects in hearing.

Treatment

There is no cure as such for cerebral palsy since damage to the nerve tissue of the brain cannot be replaced, thereby restoring the normal function of the nervous system. Therefore, one objective in treatment is the training of other areas of the brain to take over the function of the damaged centers. Training or retraining of the muscles and the application of this training to vocational skills are the functions of the physical and occupational therapists. Other treatment measures include speech therapy, surgery, drug therapy, and fitting with braces. In all instances, treatment is highly individualized and requires skilled personnel. In the diagnostic evaluation a determination is made as to the type of cerebral palsy and the degree of involvement, whether physical or mental. Appropriate treatment is then prescribed including the different types of treatment as well as day-by-day handling of the patient. Treatment goals are decided upon at the time of the diagnostic evaluation. Emphasis is placed on the importance of a high degree of integration of the different phases of the treatment program and the value of individual members of the team.

²Noah D. Fabricant, "Clinic of the Month," Eye, Nose and Throat, XXXII (August 1953), 18.

Sometimes in the treatment process it becomes rather difficult to evaluate the child's potentialities for training because of the parents' extreme overprotectiveness. This situation was being met to some extent by the clinic becoming affiliated with the Martha Washington Home for Crippled Children program, established July 1, 1953. The facilities of this children's home were used for in-patient care. Children were admitted for a period of three months and their potentialities for training and rehabilitation evaluated. According to the agreement made at the time of this affiliation, the board of the Martha Washington Home was to meet the financial cost of this program, and Mercy Hospital was responsible for the supervision and the administration and was given professional direction to the program. This affiliation ended September 30, 1954. The Martha Washington Home was closed for a lack of sufficient funds to meet operating costs. The coordinated program of the Mercy Hospital Children's Rehabilitation Center now includes the home, clinic, school, and the community at large in the rehabilitation of the cerebral palsied child.³

Children are accepted for treatment at the Center from three to fifteen years of age. There are no restrictions because of race.

³ Information taken from material compiled for publicity purposes for Mercy Free Dispensary Cerebral Palsy Center, 1951.

color, or religion. Exceptions are occasionally made to accept for care persons over sixteen who are especially in need of the services offered. Fees for services are flexible and are determined on the ability of the patient to pay. No child is ever denied services because of the family's inability to pay.

Before discussing the casework counseling services provided the parents of the children studied, it was deemed advisable to present a picture as to the intellectual and physical development of the children who make up this group. This picture helps point the need for casework counselling to sustain interest and to help resolve any unsatisfactory child-parent relationship arising because of the cerebral palsied condition.

Of the 44 cases selected for this study, there were 25 females and 19 males. The ages of these children varied greatly, from two years, three months, to sixteen years, six months. The median age was fourteen years, two months. It should be mentioned that the median age of the children studied is not the same as the average age. The mean age of the total study group was four. There were 8 Negro children among this group, 5 girls and 3 boys. All but 6 of these children were living with both parents. In these 6 cases there were 3 divorces and 3 separations; there was 1 case of divorce and remarriage. In this case the father retained custody of the child and had since remarried.

Table I shows the religious affiliation of the study group.

TABLE I

RELIGIOUS AFFILIATION OF THE STUDY GROUP

<u>Religion</u>	<u>Number</u>
Catholic	24
Baptist	6
Lutheran	5
Methodist	6
Jewish	3
Total	44

The range of intelligence among this group varies from non-measurable to an I.Q. of 113. The term "non-measurable" has a two-fold meaning in the clinic. It can mean that the child is too severely handicapped for testing or that the subject is too young for testing, not yet having developed a "yes" or "no" response. In this study, nineteen children were considered by the psychologist to be non-measurable; six were too young for testing, eight were too severely handicapped, and in one case the child was blind and the hearing ability was questionable. The I.Q. of four children could not be measured because of their hyper activity and short attention span. Establishing a definite intelligence quotient for children with cerebral palsy is extremely difficult. There was considerable variation among the cerebral palsy patients in the degree

of muscular involvement which is related to the amount of brain damage. Because of the child's physical handicap, he may not have had the normal experiences of life to deal with the questions of the test adequately.

Other factors that may affect test results are the many defects in hearing, seeing, and sensory perception that cerebral palsied children frequently have. Finally, the greatest single factor influencing the child's performance on the test is his inability to learn because of damage to the learning centers of the brain. The differential in learning rate varies greatly in cerebral palsied children. Because of this, the tests must be so structured as to take into consideration the child's individual difficulties, before even a rough estimate of intelligence can be obtained.⁴

The psychological department of Mercy Free Dispensary uses the Revised Stanford Binet, Form L, test to establish an I.Q. Other tests used are the Vineland Social Matrices and the J. C. Raven's "Progressive Matrices." Raven's "Progressive Matrices" test is used quite often and with great success. This test makes an attempt to measure the child's ability to observe relationships, make comparisons, and develop a logical method of reasoning. The test is

⁴Edith Meyer, The Role of Psychology in the Cerebral Palsy Training Unit, Reprint from the October 1950 issue of The Crippled Child.

presented in book or block form and requires an inductive and deductive approach to the problem.

Table II shows the I.Q.s of the study group:

TABLE II
INTELLIGENCE QUOTIENT OF FORTY-FOUR
CEREBRAL PALSID CHILDREN

<u>Intelligence Rating</u>	<u>Number</u>
High average	3
Average	9
Dull normal	5
Borderline	8
Non-measurable	19
Total	44

Various studies and research indicate that spasticity and athetosis type cerebral palsy make up about 80 per cent of all cases of cerebral palsy.⁵ In this study there were twenty-one spastics, seventeen athetoid types, and two mixed types. One mixed type was diagnosed as athetosis and spasticity; the other was diagnosed as rigidity, and five cases were diagnosed as cerebral palsy, but the type had not then been determined. The spastic and athetoid

⁵Mary Louise Burton, "General Implications of Cerebral Palsy," The Journal of Social Casework, XXVII (March 1947), 94.

type of cerebral palsy made up 97 per cent of this study. Cerebral palsy rigidity and some cases in which no definite type of palsy was established accounted for the remaining 3 per cent of the cases in the study group. Spasticity is characterized by involuntary tightening of the muscles which slows down the motion and makes it ungainly and stiff. Athetosis is characterized by involuntary purposeless muscle movement and an inability to control proper motion in the extremities.

TABLE III

DIAGNOSIS ACCORDING TO TYPE OF PALSY

<u>Type of Cerebral Palsy</u>	<u>Number</u>
Spastic	21
Athetoid	10
Mixed type	2
Rigidity	6
Type not determined	5
Total	44

In most cases in which it has been impossible to measure the child's intellectual capacity at the time the initial test is administered, arrangements are made for a retest and revaluation within six months to a year.

TABLE IV

REASONS FOR NON-MEASURABILITY IN NINETEEN CASES

<u>Reasons</u>	<u>Number</u>
Too young	6
Severely handicapped	8
Blind, poor hearing	1
Short attention span, hyper activity	4
Total	19

The area of involvement as a result of the cerebral palsy condition varied for the members of the study group. Involvement of the head area was at a minimum. Only five children had poor vision although the hearing ability was considered only fair in four additional cases. However, there was no child in the group who was totally deaf. There were three children with defective vision and one who was blind. The speech of six children in the study group was considered poor, but none was too handicapped to talk or make his needs known. A normal child of two would have an adequate vocabulary that could be evaluated, but with a cerebral palsied child, the speech may be a major accomplishment. Sometimes many months are spent in physical and occupational therapy before the cerebral palsied child can develop sufficient coordination to button and unbutton or to lace shoes properly.

TABLE V
SENSORY PERCEPTION

	Hearing	Vision	Speech
Good	35	40	38
Fair	4	2	0
Poor	5	1	6
Complete disability	0	1	0
Total	44	44	44

This study included a great number of children that were self-sufficient in that most of them were able to do tasks such as comb their hair, dress and undress themselves. All but eight children were toilet trained.

TABLE VI

DEGREE OF HANDICAP IN THE STUDY GROUP

<u>Degree of Handicap</u>	<u>Number</u>
Mild	14
Moderate	24
Severe	6
Total	44

TABLE VII

SELF CARE

Self Care	Yes	No	Partially	Total
Comb hair	26	8	10	44
Wash	28	9	7	44
Dress self	20	10	14	44
Undress self	17	13	15	44
Toilet trained	36	8	0	44

Feeding presents a very challenging problem to parents of cerebral palsied children. Because of the child's lack of coordination, it is rather easy for him to injure himself with the eating utensils. Many parents circumvent this by feeding the children themselves, thus avoiding the danger of injury. In summary, it may be said that cerebral palsied children need constant attention because seemingly simple tasks, such as eating or drinking can prove to be very laborious and even hazardous.

In Chapter III, an attempt will be made to examine the case-work process with the parents of the children in the study group and case illustrations will be presented.

CHAPTER III

CASEWORK COUNSELING WITH PARENTS OF CEREBRAL PALSID CHILDREN

A social worker offering service to persons afflicted with cerebral palsy and their families deal with a variety of problems. The emphasis may vary according to the setting in which the worker functions. Within the medical framework, the social worker makes a unique contribution in helping to achieve the goals of the professional team in assisting with problems of the family and of the child that affect the child's habilitation and adjustment.

The social worker is used to help plan appropriately for the child in terms of training, education, and recreational facilities. To do this, it is necessary that the parents be helped and, wherever possible, the child to evaluate his status and clarify goals on a realistic basis.

It was stated in Chapter II that in order for a handicapped child to adjust successfully, it is necessary that there be a positive relationship with the parents.

It is one of the goals of the worker to help the cerebral palsied child and his parents achieve a satisfactory and positive parent-child relationship. Before discussing the process of casework counseling with parents of cerebral palsied children, it would be well to look at the group of parents who comprised the study group. This was a diversified group of parents with three major religious sects and several nationalities represented in the group. In educational attainment, the mothers ranged from seventh grade to the completion of college, with the average mother completing the equivalent of a high-school course. Information regarding the educational attainment of the fathers was not available in a sufficient number of cases to warrant statistical tabulation. The occupations of the fathers varied from truck driver to that of electrical engineer.

Casework counseling is an extremely individual one at the Center. This becomes necessary because each parent, for the most part, is acquainted with only one type of cerebral palsy. The social worker's first job is to give the parent an interpretation of the type of cerebral palsy that his child has. The following real situation is typical of the type of interpretation that the worker may have to give and the positive that this may have for both the parents and child is evident in this real situation.

The feeling of guilt is a problem that the social worker often

encounters." One mother in the study group labored under this feeling for many years until the social worker introduced this topic. It was pointed out to this parent that many parents whose children were "different" in any way had some feelings of guilt for what had happened to their children. Perhaps in her own case this notion had been entertained or implied: that either she or her husband were at fault, and that they should have married other partners, in which case this tragedy might not have occurred. It was further pointed out that in this feeling of guilt there was often a vacillation between self-blame and voiced or unvoiced suspicion that it was the other person's fault. Because the mother was deeply involved in this problem, the social worker emphasized the scientific findings that had been established as facts in the study of cerebral palsy; namely that there is absolutely no evidence that cerebral palsy is an inherited condition, and that in most cases there is no evidence that either parent is in any way responsible for the condition. It was quite evident that this mother was very relieved in hearing this statement. She has been a different person since this was explained to her and has now begun to accept her child's limitations and realistically plan for the future. The treatment center soon observed marked improvement in the child.

Among the problems that occur within the family circle, none appeared as urgent as that of discipline. A mother who had used

spanking as a means of securing the child's obedience had tremendous feelings about having to resort to this measure. She admitted that spanking is ineffective but that she had been unable to devise a more satisfactory method. This mother's child had the athetoid type of cerebral palsy. As a result of punishment, the child became more tense and nervous. This mother disapproved of disciplinary measures that would cause pain. She acknowledged that her purpose in administering corporal punishment seemed defeated by the feeling of resentment and humiliation that it provoked in the child. More satisfactory disciplinary measures discussed with the parent included isolation, diverting attention, making a game of attaining the desired end, giving praise and rewards for good behavior, and when possible ignoring the bad, avoiding threats that could not be carried out, and making certain that the child did not gain his goal by unsatisfactory behavior. Consistency on the part of the entire household in the handling of the child was stressed as essential if discipline was to be effective.

Discussion with various mothers who had expressed difficulty in applying discipline led to the following conclusions: many parents make an ineffective start, father and mother may not agree on what to demand, either parent may be inconsistent in the application of the means used, or may be swayed by too much sentiment.

One mother said, "The trouble with mothers is that they can't

stand to discipline these children." Another parent said, "They can wind you around their fingers and you give in." At the outset, because of the palsied child's disabilities, parents have to do more for him than for the child of normal physical development. The line of demarcation between what the mother must do for the child and what she should expect him to do for himself is a difficult one to determine. Solicitude, care, service, and protection beyond what is actually needed give so much satisfaction to the child (and the mother) that he demands that they be continued. The parents knowing the child must lead a circumscribed life find it hard to take anything from him or deny him anything because his disability has already robbed him of so much. Discipline may deprive him even of his sense of security. The social worker admitted to the parents that there was much truth in their point of view. However, in the sessions of casework counseling, efforts were made to help the parents realize that a failure to do all that is possible to develop desirable personality traits only adds one more liability to the already handicapped child. The worker stressed the fact that the mother need not fear that her child will lose his sense of security if disciplined; like other children he will learn to accept discipline from those he loves and the spirit in which the parent does so many things for the child will leave no doubt that the parents love him.

Attitudes of these parents varied as the problems of the children were presented. One mother expressed to the social worker that too much demand was placed upon her by doctors, nurses, and social workers; that it was impossible for her to remain patient all of the time with the child. This mother was greatly relieved when it was explained by the social worker that it wasn't expected that she be eternally patient; this would not be normal. It was explained that sometimes parents' impatience must well up and spill over; and that they might grab and push their children and afterwards remember the admonitions of doctors and nurses and feel guilty. It is easy to understand that, having to live with handicapped children made tremendous demands on these parents, both physically and psychologically. Empathy and support given by the social worker relieved these parents a great deal.

TABLE VIII

ATTITUDES OF PARENTS TOWARD THE CEREBRAL PALSIED CHILD
AS OBSERVED BY THE PROFESSIONAL STAFF OF
MERCY FREE REHABILITATION CENTER

<u>Attitudes toward Child</u>	<u>Number</u>
Positive	20
Negative	15
Ambivalent	6
Unknown	3
Total	44

This case illustration shows the social worker in a supportive role:

This is the case of a fourteen-year-old spastic child who has been receiving treatment from the Center since 1947. This child's handicap is moderate. In the treatment center, she was thought to be nervous and withdrawn and not profiting completely from therapy. Various interviews with the child's mother indicated that the mother needed help in working with the problems involved in handling the child's handicap. This parent had a tendency to over-protect the child coupled with the failure to realistically understand the child's need for independence and growth.

In the initial interview, it was learned that the child was seeking independence and was reacting as any normal adolescent in many areas. For instance, she had her hair styled in a short haircut and she wanted to choose her own clothes whereas previously her mother had done this. The worker pointed out to the parent the importance of allowing the child to do things that would give her some feeling of independence and responsibility.

The mother of this child gained quick insight into this situation and soon reported changes. The child is now answering the telephone at home whereas previously she was too shy to do this. The worker helped the parent realize that her child is shy and that the parent should not stress the shyness or make an issue of it. It was suggested that the child should be allowed to do things without feeling she was being forced to do them.

Both parents have shown understanding in handling the child's problem of shyness and her feelings of insecurity. The child is now able to go alone on the streetcar to visit her friend whereas previously the child had been taken by her mother.

This change in the home situation has caused the child's father to show interest in the child. Previously he seemed to be disinterested in the child. He has now been helping the child with her homework and, in general, spending more time with her.

The father has also been very encouraging to the child and offered her stimulation in a way that has not been too threatening to her. He does not force things upon the child, but rather, makes suggestions and does things with her. The mother has reported a great change in the child because of the close relationship that exists between father and child.

Praise and encouragement was discussed and how greatly the child needed this. She needed the feeling of being able to do things well and also needed to accept some responsibility. It was emphasized by the social worker that the child should be included in things that were important to her and the family, and she needed to feel a part of the family group.

In more recent interviews, the parents stated proudly that the child had purchased a record for her phonograph. This choice was decidedly one that she had made independently. This was thought of as being great progress for the child.

She has also been able to meet her mother at the bus stop near school when she comes to the treatment center for therapy. Previously the mother would call for her at school and bring her to the center. The mother now shows evidence of understanding and realistic thinking. She no longer emphasizes the child's shyness as she had previously done. She has been trying to give her daughter more responsibility by allowing her to do things for herself, without being obvious.

This case is typical of many of those in the study group in that through the casework process of supportive help and clarification these parents arrived at a better understanding of the child's needs, which in turn allowed the child to become more self sufficient in spite of his handicap through the casework service. The child is better able to accept the handicap and the parents better able to plan realistically for the child.

In Chapter IV a case will be cited that differs from that described in the present chapter in that it illustrates the rejection of a cerebral palsied child by the mother because of her inability to cope with a child who is handicapped. The mother had contemplated giving the child in adoption to her mother.

CHAPTER IV

CASEWORK COUNSELING WITH PARENTS OF CEREBRAL PALSID CHILDREN

Attitudes of parents of cerebral palsied children vary greatly. Some parents who were seen at the Center are well adjusted and accept the child's handicap fully and in every way have given their fullest cooperation to the various disciplines involved in the treatment. There have been parents who have seen cerebral palsy as a challenge, working responsibly toward improving through group action the pitifully inadequate facilities for children with cerebral palsy. At the other extreme was one mother so completely overwhelmed that she had turned over most of the care of the child to a relative and had herself become increasingly dependent on the relative. This mother felt extremely frustrated because of her inability to cope with the child, and as a result had much guilt because of her feelings of inadequacy as a parent. This guilt was caused by the mother's feelings about the child's having been born out of wedlock. The mother had since married but felt that this

child was in some way a punishment for her once promiscuous life.

This case illustration shows how casework counseling cleared a highly emotional block and assisted the mother toward acceptance of the child.

This is a five-year-old Negro child with spastic quadriplegia type cerebral palsy. Quadriplegia means the child has involvement in all four extremities. In the diagnostic evaluation, the case was thought to be moderately severe.

The initial contact with Mrs. S. revealed that she was desperately in need of help in supervising the child, along with an interpretation of the existing handicap.

The child has been seen in the treatment center since February 1, 1954. The opinion of the therapist was that the child was rather negativistic and declined to use words. She responded to everything with a grin.

Testing was attempted but the psychologist found it impossible to gain the child's attention or interest in any testing situation. She is very affectionate and wandered happily around the room, coming back to the examiner to be held and cuddled.

In order to obtain some measure of development, the grandmother of the child was interviewed and a Vineland test was administered. A social age equivalent of one year and nine months was obtained. A corresponding social quotient of thirty-three was obtained, which would indicate very serious retardation in all areas of social development.

The grandmother of the child has assumed the greatest portion of the responsibility for her care and has stated that her daughter wants her to legally adopt the child. The grandmother also indicated that her daughter was a very immature person and that she feels that the responsibility and care of Mary has become too difficult for her. The grandmother elaborated in great detail about how the mother constantly brings

Mary over to her home and never follows through with any appointments for the child at the clinic.

The grandmother's thoughts of adoption were very practical. Were it not for her advanced age and the fact that she is receiving assistance from the City Welfare Department, she would very much like to adopt Mary.

From the information received, Mary seems to be rejected by the mother. The mother of the child was given regular appointments by Social Service.

The mother informed Social Service that the housing conditions were very bad; the living room had collapsed and there were no bathing facilities. The family has registered with the housing authority but the mother was quite discouraged, indicating that there does not seem to be any possibility for more adequate housing.

Mrs. S. stated that the poor housing situation necessitated allowing her mother to keep the child. In subsequent interviews, Mrs. S. was thought to be completely confused and lacking in any understanding of the child's needs. It was further observed that Mrs. S. was not disinterested in the child, but helpless and felt rather guilty in not being able to care for Mary properly. Mrs. S. admitted that she becomes very discouraged when she sees very little progress in Mary's condition. When the worker told Mrs. S. that she probably feels uncomfortable with the child, she admitted that this was true and indicated a desire to receive help from Social Service in this area. The social worker told Mrs. S. that some people found it very difficult to adjust to handicapped children and that the worker would be willing to help her in the care of the child. Mrs. S. elaborated on Mary's demand for love and attention; Mary constantly wants to be held on her mother's lap and follows her about the house.

The social worker pointed out to Mrs. S. that Mary could receive attention in other ways, such as performing little tasks or helping mother with the cleaning. In subsequent interviews, Mrs. S. reported that she had tried this and found it very successful. She now permits Mary to dust.

The worker stated that no doubt Mary takes up a great deal of her mother's time and suggested that maybe a schedule could be worked out for Mary. She could receive attention in other ways than by being held on her mother's lap. Also Mary needs some independence and some responsibility which is very important for her growth.

Mrs. S. explained that her husband showed increased interest in Mary when he learned that Mrs. S. wanted her mother to adopt the child. It was pointed out during counseling how Mary could feel rejected being placed outside of her own home, even with her grandmother. Mrs. S. stated that she had never thought of this but could see how upsetting this could be to Mary.

After approximately ten interviews, Mrs. S. grew in her interest in Mary and the treatment center. She has kept all appointments and is very cooperative. The housing situation is still critical; however, Mrs. S. has been placed on the waiting list of the housing authority. Social service department has written letters to the housing authority, explaining Mrs. S.'s dire need for more adequate housing and responses have been encouraging.

Mary has shown improvement at the treatment center. With the prospect of better housing, Mary is expected to show marked improvement. Mrs. S. is very much interested now in keeping her child, and has shown a willingness to plan for her future realistically. This case is still receiving extensive casework counseling in order to sustain continued interest on the part of the parents.

In a number of cases in the study group, progression could be observed in which parents move from a negative point of view to a positive one in which their conflicts were resolved. One mother said, "You can't keep on feeling sorry for yourself; I'm not going to sit at home and cry over it." Another said: "Both my husband and I come from large families. I have thought about the different brothers and sisters and decided that it is good that I am the one

with the cerebral palsied child. I am better able than any of the others to bear this burden." "We ought to look at it this way," said another, "there are other handicaps besides cerebral palsy; it must be a lot worse for the parent who has a child who has been normal for years and then suffers a crippling condition such as polio or an accident." Still another comment was, "I went in circles for a year after I found out he was a cerebral palsy; then I realized that the child is the one who has the real struggle and I should not take it as a personal hurt." Several mothers were helped by their religious beliefs. One said, "The counselor will probably think this is silly but I can understand this experience only by relating it to religious convictions. There is a reason for everything that happens. . . . If we and our friends come to understand better and do something about the cerebral palsied, good will be accomplished that otherwise never would have been."

The social aspects of the handicapped child in relation to himself and to his family have been studied and reported upon comprehensively in social-work literature and elsewhere. We know that many physical abnormalities require an adjustment on the part of the patient, in varying degrees--socially, emotionally, and often educationally and vocationally. We know also that the child's success in achieving a satisfactory adjustment is determined primarily by the quality of the parent-child relationship which gives him



a feeling of being loved and secure and of having approval and social and emotional growth opportunities in a happy home environment.

Parents who can provide a healthy emotional climate and opportunities for their handicapped child are usually themselves mature, compatible, and well-adjusted individuals who have succeeded in resolving many of their feelings about having had a handicapped child. The capacities of parents for "the long pull" which having a handicapped child requires of them is rather generally underestimated, perhaps because the force of the expression of their emotional anxieties and fears are magnified at the time of the first awareness of the abnormality of their child. The fact is also overlooked that it is normal for most parents to have some anxiety in relation to becoming parents and especially concerning the first born. If the first child is born abnormal, even very slightly, the initial anxiety of the parents becomes intensified.¹

A chronic handicapping illness of a child requires a permanent adjustment by all members of the family. Parents often have future goals outlined for their children, the extent and type of which depend somewhat upon the social and cultural pattern of the parents,

¹Rosita H. Hansen, "Second Child," The Crippled Child, (February, 1954).

and their conscious or unconscious desires to fulfill through their children their own denied achievements. Normal children often disappoint parents in this respect, but the parents have had at least a rather prolonged period of wishful planning. The handicapped child brings disappointment very early. These come when friends and neighbors discuss their children and when neighborhood children first start off to school. Anticipation of prolonged financial and physical dependency of the child may create within the parents anxiety over their own current and future financial status, ability to maintain financial care and physical support indefinitely.²

What social aspects, therefore, seem specific to the cerebral palsied? Cerebral palsied children seldom have one handicap. Instead their handicaps may be many and may include all or several of the following: motor handicaps in the legs and arms, feet and hands, and speech; defects of sight, hearing, and intelligence; convulsive seizures; lack of bowel and bladder control. The impact of multiple handicaps and the parents' beginning awareness of the physical and intellectual involvement arouses intense anxiety and fear. They look hopefully for one area in which the cerebral-palsied child can demonstrate some degree of normalcy while denying or ignoring the presence of others that may be more obvious and more severe. Parents

²Ibid., p. 17.

often attribute to the child many more capacities than he actually has. For example, a mother might describe the facility for speech when actually in objective observation by a professional person the child may lack intelligible speech and articulate only a few words which are more mimicry than verbalization. Parents also stress certain physical functions and focus their efforts and anxiety upon one area, which may be the one in which the child may never have successful function. One frequently hears the parents say: "If he could only talk," "If he could only walk," or "If he could only feed himself."³

The relationship between parents and the social worker which starts in the intake interview hopefully is strengthened as the social worker and parents plan for the child's future care.

An admission to in-patient service often represents the first separation of the child from the parents and inevitably there is anxiety both for the parents and the child, with adjustment to the separation for both. The social worker helps the parents interpret the separation and the new experience to the child so that his fears are reduced.⁴ Thus acceptance of the new situation is more quickly

³Margaret Toune, Social Service Vital to Cerebral Palsy, Reprint from the April 1951 issue of The Crippled Child.

⁴Ibid., p. 5.

achieved. The continuity of the worker's relationship with the child is sustained through this period and gives the child a feeling of security when he is separated from daily life with his parents by knowing a familiar person.

The social worker's services to the children may not be direct. She may reach the children through the parents by enabling them to be the kind of parents these children need. The social worker in her relationship with the child supplements, but does not replace, the parent. The social worker can also reach the child through the teachers and therapist.

If a child attends an out-patient center, the social worker continues the relationship with the parents, offering the same kind of casework services and orientation to the setting. Home visits are an important aspect of social service. Home visits are sometimes made in order to assess the progress of the child. These visits are an important aspect of the social service department. Many parents do not seek help, seldom recognizing that they have problems or that social casework is available to them. They need to be encouraged to use the services of the social worker, and the home visit provides this opportunity.

Because the cerebral palsied often have more than one handicap, many now are, and perhaps always will be, dependent upon an adult. The child's continuing need for care arouses the parents'

fears regarding the child's future and the possibility of institutional care. Parents usually have goals for their children which, as we know, may be somewhat unrealistic but often can be achieved. Institutional care as an ultimate future for children born or yet to be born is not one of these planned goals. Facing this possibility early is extremely difficult as it is complicated by opposing feelings of love and rejection for the child, guilt conscious or unconscious, and conflicting loyalties to the father, to the mother, and to other children. Fortunately for these parents, there is usually a time element which provides them with an opportunity for resolving some of their conflicts in this area, because treatment usually extends over a long period of time and the moment for a decision regarding institutionalization can be deferred, thus cushioning the shock. During this interval, however, the social worker can provide help by giving the parents an opportunity to talk out their conflicting feelings and their problems.⁵

The social worker in a cerebral palsy program encounters many problems similar to those associated with other handicaps, but because of the multiplicity of physical involvement of the cerebral palsied, the emotional stresses may be more complicated, more in-

⁵Edward D. Greenwood, "The Psychiatrist's Role in the Treatment of Cerebral Palsy," The Crippled Child (December 1951), 5.

intense, and more prolonged. Many of these parents have need for some type of social casework services, especially at the beginning and termination of therapy. Services may also be needed intermittently, with the need fluctuating with the changing medical and treatment developments and shifting social situation.

The average parent, troubled in the planning for his handicapped child, has little knowledge of the kinds of help that are available to him through family service, child guidance clinics, and other comparable agencies. Those who are working in the interest of cerebral palsied patients should reaffirm their obligation to explore every possible resource and to make help available if they are not unable to provide such service themselves or within their agency setting.

The social worker's knowledge and understanding of the parents and of the children under treatment should be shared with and utilized by all of the professional associates in planning for these children. The social worker's job is manifold, the human need is great, and it is through such team work that maximum goals may be achieved in the physical and social rehabilitation of the cerebral palsied child.

CHAPTER V

SUMMARY AND CONCLUSIONS

It has been stated in previous chapters that the physical abnormalities require an adjustment for the patient, in varying degrees, socially, emotionally, and often educationally and vocationally. It was pointed out also that the child's success in achieving a satisfactory adjustment is determined primarily by the quality of the parent-child relationship, which if positive gives the child the feeling of being loved and secure and of having approval and social and emotional growth opportunities in a happy home environment. The degree of successful adaptation of the handicapped child is dependent not upon the severity of the condition but rather upon the immediate security gained from the good relationship that exists with the parents and from having opportunities for appropriate educational and social participation and successful achievement, however modest, in his experiences in and outside of the family group. The child's physical and emotional adjustment to his handicap starts with the parents' acceptance of him as one who needs to be loved and wanted for what he is, a child, not a handicapped child but a

child with normal feelings, desires, and ambitions, who is also handicapped.¹

Cerebral palsy was defined as a condition characterized by paralysis, weakness in coordination, or any other abnormality of the motor center of the brain. There are five types of cerebral palsy. These types are based upon the area of the brain that is damaged, thus rendering a rather distinctive pattern in the physical symptoms. The types of cerebral palsy mentioned were as follows:

Spasticity is characterized by involuntary tightening of the muscles and makes the muscles stiff and ungainly. Athetosis has a distinctive involuntary purposeless muscle movement. There is no ability to control or direct proper motion in the extremities.

Ataxia is manifested by lack of conception of balance and directional control. Tremor has a distinctive regular rhythmic motion that runs from gross to fine. Rigidity is a type of cerebral palsy where paralysis or rigidity of the musculature is pronounced. The muscles are not tense and hyperactive but soft and putty like.

Social workers in the field of cerebral palsy deal with a variety of specific problems depending on the setting in which they function. Within the medical framework the social worker makes a

¹Edith Meyers, The Role of Psychology in the Cerebral Palsy Training Unit, Reprint from the October 1950 issue of The Crippled Child

unique contribution to the goals of the professional team. He is called upon for assistance in cases in which the problems of the family or of the child affect the child's habilitation and adjustment. The social worker is used to help plan appropriately for the child in terms of training, educational, and recreational facilities. To do this, it is necessary that parents are helped and, where possible, the child, to evaluate his status and clarify goals on a realistic basis.²

Of the forty-four cases selected for this study, there were twenty-five females and nineteen males. The ages of the children varied greatly, from three years, three months, to sixteen years, six months, with a median age of fourteen years, two months. There were eight Negro children among this group, five boys and three girls. All but six of these children were living with both parents. In these six cases there were three divorces and three separations. In one case of divorce a remarriage followed. Of these six cases, all but one were living with the mother. In this one case, the father had retained custody of the child and had since remarried.

The range of intelligence among the group varied from non-measurable to an I.Q. of 113. It was pointed out that the term "non-

²Mary Louise Burton, "General Implications of Cerebral Palsy," Journal of Social Casework, XXVII (March 1947).

measurable" has a two-fold meaning in the clinic. It can mean that the child is too severely handicapped for testing or that the subject is too young for testing, not yet having developed a "yes" or "no" response. In this study the intellectual ability of nineteen children was considered to be non-measurable. Six of these children were too young for testing and eight were too severely handicapped. One child was blind and the hearing ability was in great question. The intelligence of four children could not be measured because of their short attention span. Very often the intelligence is considered non-measurable and an attempt is made to retest the child within six months to a year.

It was important to note that establishing an I.Q. for cerebral palsied patients is a very difficult thing to do. Cerebral palsy varies quite a bit in the degree of muscular involvement and according to the amount of brain damage. Because of the child's physical handicap, he may not have had the experiences of life to deal with the questions of the test adequately. Other factors that may affect test results are the many defects in hearing, seeing, and sensory perception. Finally, the greatest single factor influencing the child's performance on the test might be his inability to learn because of damage to the learning centers of the brain. The differential in learning rate varies greatly in cerebral palsied children. Because of this, the test must be structured to meet the child's

individual difficulty, before even a rough estimate of intelligence can be obtained.

The characteristics of the parents of the children in the study group were very diversified. Three major religious groups and several nationalities were represented in this group of parents. In educational attainment the parents ranged from seventh grade to the completion of college, with an average parent having the equivalent of a high-school education. The occupations of the fathers varied from that of truck driver to that of electrical engineer.

Casework counseling was noted as being an extremely individual one at the Center. This becomes necessary because each parent for the most part is acquainted with only one type of cerebral palsy. The social worker's first job is to give the parents an interpretation of the type of cerebral palsy the child has. Other interpretations and feelings are handled early. It was observed that typical of the feelings that the social worker has to help the parents with is one of guilt. Parents labor under these feelings for some time and have some trouble bringing these feelings to the surface. The workers become highly intuitive and for the most part introduce this focus quite early in the interviewing sessions. The social workers point out to these parents that very often many parents who have children who are "different" in any way had some feeling of guilt for what had happened to their children. Very often this

notion has been implied, that either the mother or the father was in some way at fault. This notion can become so implanted that each parent shifts the blame from one to the other, and in some cases they think that this tragedy could have been avoided if they had married other partners. In these types of situations the social worker emphasizes what has been established as scientific findings. It is pointed out to these parents that contrary to some of the things that are generally said, there is absolutely no evidence that cerebral palsy is inherited. Evidence seldom points to the fact that either parent was in any way responsible. However this being generally true, this study did include a couple who did have some responsibility for what had happened to their child. During the mother's pregnancy, she and the husband became engaged in a rather heated argument, as a result of which an altercation started and the mother was stabbed in the stomach. The child was born with a slight paralysis that was classified as a moderate case of cerebral palsy. This case of cerebral was thought to be unusual and was in no way representative of the majority of cases in treatment at the Center.

The problems that some of the parents were experiencing were examined. Among the problems was that of discipline. Some of the parents had used spanking as a means of securing the child's obedience. These parents admitted that spanking was ineffective but were

at a loss regarding other means of coping with the child. Interpretations were given to the parents that spanking should be discontinued. It was pointed out to these parents that if physical punishment were used with children with athetoid type of cerebral palsy, such punishment might cause them to be more nervous and tense. More satisfactory disciplinary measures included isolation, diverting attention, making a game of attaining the desired end, giving praise and reward for good behavior and when possible ignoring the bad, avoiding threats that could not be carried out, and making certain that the child does not gain his goal through unsatisfactory behavior. Consistency on the part of the entire household was considered most essential if discipline were to be effective.

Quite a few of the parents are swayed by too much sentiment. They related how these children are able to wind them around their fingers. In talking over these feelings with the parents concerning these sentiments, the facts in the matter were that because of the cerebral palsied child's disabilities, parents at the outset had to do more for these children than for a child of normal development. In spite of this, the line of demarcation between what the mother should do for the child and what she expects him to do for himself is a difficult one to determine. Solicitude, care, service, and protection beyond what is actually needed gives so much satis-

faction to the child and often to the mother that the child demands that they be continued. The parents know that the child must lead a rather circumscribed life and that it is hard to take something away from them because the disability has already robbed the child of so much. The social workers handled these feelings by interpreting to the parents that a failure to do all that is possible to develop a desirable personality trait only adds one more liability to the already badly handicapped child.

The attitudes of the parents varied as to the problems of the children presented. It was noted that one parent told the worker that too many demands were placed upon her by the doctors, nurses, and social worker, and that it was impossible for her to remain patient all of the time with the child. The social worker is able to relieve such feelings by explaining to the parents that it is not expected that they should be eternally patient since this would not be normal. It was pointed out that sometimes their patience must be exhausted and that they "might grab the child and give him a push, later remembering the admonitions of doctors and nurses and feel guilty. Empathy and support relieve these parents a great deal. It was certainly understandable that having to live with a handicapped child made tremendous demands on parents physically and psychologically.³

³Meyers.

In conclusion, we are able to see that social service is vital to cerebral palsy and that social service helps coordinate community programs for the cerebral palsied. Attention is now being focused on the need for including in professional training and experience provision for specific medical and social orientation to meet the challenge that cerebral palsy offers. With many new treatment centers being established throughout the country and the "team" approach becoming the pattern of organization for treatment, the services of the social worker are being sought along with those of the other professional personnel such as the medical specialists, psychologists, physical therapist, occupational therapist, speech therapist, nurses and educators. Included in this team working in the interests of the cerebral palsied child are the parents themselves.

Basic social casework knowledge and skills must be supplemented by those of the medical and psychiatric social worker and of the social workers trained in group work and in child placement for successful operation of a treatment program for cerebral palsied children, which may include diagnostic clinics, out-patient and in-patient centers, school clinics, hospital units, and recreation programs.

Through the social worker's understanding of the problem, it is possible to make a variety of contributions to the cerebral

palsy program. The social worker is always basically concerned with the patient as a person and must work toward utilizing whatever skills are necessary to better understand the patient in relation to his illness, his environment, his total situation. Whether the social worker works directly with patient and parents or in a consultative capacity with others more directly associated with the child, the focus remains the same: better understanding of the multiple social and emotional factors that need to be reckoned with in a plan for total treatment. Equally important as arriving at this understanding is the interpretation of it to various people to whom it will have importance in planning.

If the social worker is to fulfill his function in these many settings, both to the agency he serves and to the cerebral palsied and their parents, he must offer many types of casework services. He must also be flexible and imaginative and must hold a steady course focusing always upon the social needs of the cerebral palsied children.

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APPENDIX

SCHEDULE

I. Identifying Information:

- A. Research # Clinic #
B. Address Birth date
C. Age at admission height weight sex race religion
D. Source of referral
E. Different diagnosis prior to admission

Treatment: OT ____ PT ____ ST ____ Surgery ____ Medication ____

F. Age of child when abnormality was first observed

Noted by: 1) MD 2 Mother 3) Other

Diagnosed as Cp (age) Authority

II. Social History at Time of Admission:

- A. Constellation age at birth Marital status
of CP child M D S W UM RM

1. Father

2. Mother

3. Children a. at home b. away at home away

(1) (5)

(2) (6)

(3) (7)

(4) (8)

4. Pt: Other placement prior to admission:

a. foster-home b. institution c. adopted

(1) Reason for placement:

(2) Number of placements: (3) Other:

5. Other CP members in family

6. Other illnesses in family

7. Others in the home

B. Living arrangements:

1. Own home rent with relatives number of rooms floor

C. Economic Status:

Financial

1. Employed Unemployed Occupation Income Assistance

a. Father

b. Mother

c. Siblings

d. Others

2. Insurance: Group Hospital Plan Health Insurance: Yes No

D. Attitudes:

As observed by:

a b c d

a b c d

1. Mother:

2. Father:

3. Siblings:

4. Peers:

5. Others:

6. Marital situation as reported by father:

Mother:

Others:

III. Health**A. Mother:**

1. Complications during pregnancy:

2. History of accident, physical disability or other serious illness during pregnancy:

3. Labor: Normal prolonged other

4. Breech footling head transverse versional and
extraction instrument anesthesia analgesia

5. Birth:

Caesarian section normal premature precipitate
delayed other

6. Para gravida which pregnancy CP miscarriage(s)

B. Child:

1. Birth

Normal anoxia cyanosis jaundice resuscitation
convulsions

- a. birth weight b. feeding method
- 2. Mother's account of early symptoms:
- 3. Physical development
 - Head held erect sat alone stood alone walked first words
 - Convulsions onset frequency medication
 - Strabismus toilet trained
- 4. Patient's disposition as reported by:
- 5. Illness or accident during childhood after first month:

IV. 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: reasons
 - Mental physical behavioral
- D. Reason not in school:

V. Social Activity:

- A. Spectator B. Participant:

VI. Present Behavior (as described by):

VII. Clinical Observations:

- | A. Physical examination: | Good | Fair | Poor |
|------------------------------------|------|------|------|
| General appearance | | | |
| Nutrition | | | |
| Muscular development | | | |
| Voluntary motion | | | |
| Coordination | | | |
| Trunk function | | | |
| Balance | | | |
| Leg function | | | |
| Arm function | | | |
| Speech | | | |
| Facial control | | | |
| Sight hearing | | | |

B. E.E.G. Report:

C. Psychological Evaluation

Measurable _____	Non-Measurable _____
Fully measurable _____	In contact _____
MA _____ IQ _____	
Practically measurable _____	Largely out of contact _____
_____	_____
_____	_____

Test used:

Ammons Full Range Picture Vocabulary Test _____
 Raven's Progressive Matrices _____
 Revised Stanford-Binet Form L _____
 Modifications of 1) Procedure _____
 2) Material _____

Outlook for educability:

Good _____ Fair _____ Poor _____

III. Diagnostic Advisory Study:

A. Recommendations:

1. Re-evaluation

2. Treatment:

Out-patient home-care referral to other institutions/
 clinic speech therapy physio-therapy occupational
 therapy casework services

B. Present disposition of case:

1. In treatment institution deceased other

2. Result of treatment: no improvement some improvement
marked improvement

Physio-therapy:

Occupational therapy:

Speech therapy:

C. Prognosis