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A Study of Cerebral Palsied Children Who Have Been Dismissed from School

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A STUDY OF CEREBRAL PALSID CHILDREN
WHO HAVE BEEN DISMISSED
FROM SCHOOL

by
Winifred Hill Jones

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

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CHAPTER I

INTRODUCTION

HISTORY AND DEFINITION

There has been increased interest by lay and professional groups in cerebral palsy within the last two decades. Investigation and research have resulted in furthering knowledge, understanding, and the application of skills from various disciplines in the treatment of the cerebral palsied person.

Originally this condition was known as Little's Disease when its recognition and description were given by an English surgeon, Dr. William John Little in 1862. At that time individuals so afflicted were considered feebleminded and untreatable. Much of this impression was due to his description which was that of a grimacing, drooling spastic child. All of these children were considered to be of one type. The negative outlook as to treatability was due to a multiple handicap frequently present, involving speech, hearing or sight; as a consequence there may be a difficulty in expression. This, too, was interpreted as a lack of intelligence. Since there was no hope of amelioration these children were hidden away at home or institutionalized.

Cerebral palsy is now defined as a neuromuscular disability resulting from brain injury or malformation. "Cerebral" refers to any part of the brain within the skeletal border and "palsy" is the term used to describe the condition of the muscles. It is now known that intellectual impairment does not always accompany the physical disability. When intelligence is affected, the range may be from slight mental retardation to the severely handicapped. The term now includes five major types of palsies; different sites of brain damage produce different conditions. Dr. Phelps¹ has stated that in any discussion of cerebral palsy a certain number of fundamental definitions should be given, because the term "cerebral palsy" is used to connote a group of conditions. The five main groups of cerebral palsy are: spastic paralysis, athetosis, ataxia, rigidity and tremor.

ETIOLOGY

Spasticity is due to a damage located directly behind the frontal area of the brain which affects the muscles directly. The stretch reflex is a special characteristic of this condition. That is, when a muscle is moved, it contracts, thereby preventing the normal performance of the intended motion. Athetosis is a condition resulting from damage to the basal ganglia and involves the joints of the body. A child so disabled is unable to control

¹ Winthrop M. Phelps, Let's Define Cerebral Palsy, Chicago, 1946, 1.

the directions of his motions; therefore the movement is purposeless and involuntary. This patient cannot direct his extremities, lips, or tongue, nor is he able to stop undesired movements.

Ataxia is caused by damage to the cerebellum, the center which controls balance. This results in a disturbance of the ability to control posture and balance. The child may not know the position of joints in relation to other parts of the body. The child who has stiffness of arm muscles and legs, without involuntary motions and the stretch reflex, may be classified as having the rigidity type of cerebral palsy. Tremor is described as involuntary motion that is reciprocal. There may be variance in speed and range of the tremor in different joints of the body. There are two types of tremor: the intention tremor that occurs during involuntary attempts to move, and the non-intention tremor which is more or less constant.² Approximately eighty-five per cent of the cerebral palsied children are in the spastic and athetoid groups.³

The causes of cerebral palsy are grouped according to the time that the damage occurs. These periods are: gestation, during birth or after birth. In reference to pre-natal causes there are many possibilities as to formation of brain structure and development because of the complexity of the nervous system.

2 Pauline F. Egel, Technique of Treatment for the Cerebral Palsied Child, St. Louis, 1948, 21-22.

3 Winthrop M. Phelps, The Farthest Corner, Chicago, 1947, 3.

Other factors which may affect the development of the embryo are infective conditions in the mother, nutritional defects in the mother and the child, a condition known as erythroblastosis foetalis in which a disparity between maternal and foetal blood results in a type of infantile jaundice and anaemia, cerebral hemorrhage or anoxia (a lack of oxygen to nervous tissue for a prolonged period). During birth, damage to brain tissue may result in hemorrhage or anoxia. Other causes which have been attributed to the natal period are prolonged labor, precipitate delivery, breech birth, forceps delivery, etc. However, there is increasing evidence that the preponderance of these cases are a result of cerebral palsy rather than a cause of the disability. That is, a child may be born prematurely, or the delivery may be more difficult because of the pre-existing condition. Trauma or mechanical injury to the skull and brain caused by the obstetrician as distinguished from natural obstetrical trauma is considered as probably less than five per cent of all cases of cerebral palsy.⁴ After birth, cerebral palsy may result from infection such as whooping cough or polio-encephalitis or from injury to the brain or a tumor.

Research has revealed that an average of seven cases of cerebral palsy are born each year in every one hundred thousand population. Of these seven children one dies before reaching the

⁴ Meyer A. Perlstein, Medical Aspects of Cerebral Palsy, Chicago, 1950, 5.

age of six years.⁵ This method of estimation is known as the "Phelps Formula". This recurrence of cases despite progress in health measures and preventive medicine has further contributed to the conclusion that factors, other than birth injury, are responsible for the greater number of these cases. With reference to the etiology of cerebral palsy, Dr. Perlstein⁶ has stated that:

There are some factors which predispose to the occurrence of cerebral palsy. It is more common among premature than among full-term infants. Likewise, it is more common among first-born children and those with heavy birthweights where prolonged labor is frequent. It occurs more frequently in children born to older women, who have on the average heavier babies, and in boys, who on the average, weigh more than girls at birth.

This occurrence of cerebral palsy also seems to be higher among white children than among colored. This may be due in part to the average smaller size of the colored newborn infant and in part to a lower incidence of Rh negativity among this race. A racial factor may also possibly exist. With these exceptions there seems to be no economic, social or geographic predilection for cerebral palsy.

Cerebral palsy is a chronic disability; therefore work with this group has centered around rehabilitation instead of cure and it involves consideration of the individual as a whole. Effective treatment requires an integrated program which includes medical, social, psychological and educational aspects. Knowledge of family relationship and home environment may be of great significance in the treatment process.

5 Phelps, Farthest Corner, 9.

6 Perlstein, Medical, 1.

PURPOSE OF STUDY

This study is focused upon a small segment of the program for the rehabilitation or habilitation of these children; that of education, and specifically the problems of those who have been dismissed from school. This is an important consideration inasmuch as there are special values involved in the education of these children because it affords, aside from academic training, opportunities for a social experience which is of inestimable value in developing emotional life and attitudes. Therapy in these schools is directed toward the re-training of muscles and general motor improvement; speech therapy is also provided. The mother is thus relieved from giving constant care during the hours that the child is out of the home. Not the least benefit to the parents is the hope and encouragement that through continuance in school the child might make progress. Dr. Earl Carlson,⁷ himself cerebral palsied, and one who has made outstanding contributions to the study of cerebral palsy, emphasizes the importance of training and education early in life. The therapeutic effects are likely to be greater when started early and followed consistently. In special schools the child's educational needs may be met on an individual basis since there are varying degrees and combinations of intelligence and physical handicap. The nature and severity of the handicap will determine whether instruction

7 Earl R. Carlson, Born That Way, New York, 1941.

will be received in regular classes, special schools, classes for the physically handicapped or classes for the mentally retarded.

SIGNIFICANCE

The study was made at the Cerebral Palsy clinic of Mercy Hospital where recommendations to patients for school placement were considered in the treatment process. There has been recognition of the effects of school dismissal upon the child and the family as a whole, since it poses problems of a social and emotional nature arising out of this rejection. It also raises the question as to the alternatives and the availability of resources in the community. An analysis of the clinic charts of the patients who have been dismissed from school may point up ways in which the staff could be of further assistance to these families and also help to evaluate recommendations for school placement, thus reducing the number of children having this experience.

SOURCES

In preparation for the study, all of the charts of such children known to the clinic within its two years of operation were reviewed. There were twenty children in this group. Of this number, three cases were not used in the study because information relative to reasons for dismissal and other data were incomplete. The schedule was used in gathering information (see Appendix). Sources of information included the clinic charts, conferences with members of the clinic staff, minutes of staff meetings and clinic records. Further insight was gained in the

nature of the handicap and its many ramifications through participation-observation in the cerebral palsy clinic, and current literature on the subject.

ACTIVITIES IN THE CEREBRAL PALSY CLINIC

The Cerebral Palsy clinic of Mercy Hospital and Dispensary has been in operation since February 14, 1949. It was established through the efforts of the Sisters of the Hospital, the clinic, the medical staff, and interested community organizations. The clinic serves the community regardless of the client's religious affiliations. Represented in the study were nine Catholic families, six protestants, including Methodist, Presbyterian and Lutheran families and one Jewish family. The religious faith of one family was not recorded. A program for the parent group in connection with the clinic had been developed and the first meeting was held at the clinic in February 1952. This was a recognition of the value of parents in the treatment of the cerebral palsied child; their understanding and intelligent cooperation are assets to the team relationship. It is recognized, too, that association with other parents with a common problem helps them to accept their responsibilities, and encourages them to healthful attitudes.

In the out-patient clinic the team approach is used in the diagnostic and treatment program in which there is a close working relationship between doctors representing the specialties of pediatrics, physical medicine, neurology and orthopedics.

Other professions represented in the clinic are the psychologist, medical social worker, physical therapist, occupational therapist and speech therapist. Contact is maintained with the schools for handicapped children and other resources in the community.

The procedure used in the clinic is as follows: applications for clinic services are received by the medical social worker who conducts the first interview. 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 for further examinations and laboratory tests. Afterwards a diagnostic evaluation is made upon the findings of the various specialties in the clinic, the information is pooled, and treatment plans are outlined. These recommendations are given to the parents.

TREATMENT

There is no cure, as such, for this condition, since damage to the nerve tissue cannot be replaced thereby restoring the normal functions of the nervous system. Therefore one objective in treatment actually 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 given by the physical and occupational therapists. Other treatment measures include speech therapy, surgery, braces or drug therapy. In all instances treatment is highly individualized and requires skilled personnel. The diagnostic evaluation gives the type of cerebral palsy and the degree of involvement, whether physical or mental. The different types of cerebral palsy require different types of treatment, as well as the kind of day by day handling. Treatment always involves goals; these are indicated at the time of the diagnostic evaluation.

Emphasis, again, is placed on the importance of a high degree of integration of these different phases of the treatment program, and the value of individual members of the team. The co-ordinated program includes the home, clinic, school and community at large, in the habilitation or rehabilitation of the cerebral palsied child.

OUTLINE OF FOLLOWING CHAPTERS

An adequate treatment program is directed toward a two-fold problem, consisting of the parent and the child. The two-fold aspects of the program will be considered in the chapters which follow. Some of the resources utilized in the treatment of these handicapped children will be examined in the second chapter. These resources consist of schools, families and the handicapped children. Emphasis will be placed on the quality of

the mother-child relationship, and the reasons for the dismissals from school.

Case studies will be presented in the third chapter to show the strengths and weaknesses of individual families and the effects of these upon the children. Availability of resources will be pointed up through an examination of the actions or plans of the parents for the children. A summary and conclusions will be given in the fourth chapter.

CHAPTER II

AN ANALYSIS OF THE STUDY GROUP

In the seventeen cases there were four girls and thirteen boys. That the larger number of this group were boys may be explained by the fact that more males than females are afflicted with cerebral palsy, rather than by the conclusion that girls make better adjustments in schools than boys. All children in this study were of the white race. The ages of these children ranged from five years and three months to thirteen years, at the time of the dismissals from school. The mean age was seven years and three months.

It is understandable that the parents should become concerned about plans for the formal training of their children at this time, because, normally, entrance into the first grade occurs in the child's sixth year. The majority of the children who had passed their sixth birthday had been previously enrolled in school. Usually the school experience was at the nursery school or kindergarten level. Although some of these children made a satisfactory adjustment in the pre-academic classes, they could not remain at this level because they were beyond the age limit.

SCHOOLS

Represented in this study are five different schools, of which four are public schools for the physically handicapped. The other school is a private school for mentally retarded boys. A uniform requirement for all schools is referral for admission from a doctor or a clinic. A requirement for attendance in the public schools is that the child has an I.Q. over fifty. Those children having this qualification are described as educable. A child with an I.Q. under fifty may be considered trainable but not educable, along academic lines. Children scoring between fifty and eighty are assigned to ungraded classes. None of the children in this group were known to have an intelligence quotient over eighty.

The private school for mentally retarded boys accepts pupils with an I.Q. ranging from fifty to eighty. Although the school is not for physically handicapped children, the school does make exceptions should the handicap be mild. Fees at this school are based on a sliding scale, but no one is refused admittance because of his inability to pay.

NUMBER OF DISMISSALS

The study was limited to one dismissal from school although some of the children had been sent home from school more than once. The records indicated that two children had been dismissed twice from school, and that three children had been dismissed from school three times. Eleven children had been reported as having had only one dismissal. Yet some of them had been

transferred from one division to another within the same school, while other children had been refused admittance to schools in a different district.

REFERRAL TO CLINIC

All the children came to the cerebral palsy clinic through referrals. An examination of these referrals revealed a variety of contacts with agencies and workers who were interested in the cerebral palsied child.

TABLE I

REFERRALS TO CLINIC

<u>Sources</u>	<u>Number of Children</u>
Total	17
Spastic Aid Foundation	6
Clinic Staff	3
Public Welfare Personnel	3
Private School	1
Civic Organization	1
Radio	1
Information not on record	2

The largest number of referrals to the clinic came from the Spastic Aid Foundation at which four parents had participated in the parent group connected with the organization. Two of the six parents referred from the Foundation specified that a professional member of the Foundation had directed them to the clinic.

Staff members of the cerebral palsy clinic recommended the clinic to three parents, and three parents received information about the cerebral palsy clinic through public welfare workers. These workers represented the public schools and the University of Illinois Division of Services for Crippled Children. One parent heard of the clinic from a radio broadcast; another parent was sent to the clinic by a staff member of a private residential school for cerebral palsied children. Two clinic charts did not contain the source of referral.

FAMILY FINANCIAL STATUS

Adequate treatment of the cerebral palsied child requires the integrated services of specialists as described in Chapter I.¹ The cost of these services is prohibitive for a family of moderate means, when rendered on a private basis. Treatment is a long, slow process for these children. This adds to the physical and financial strain on the family. Therefore, consideration was given to the incomes of the families represented in the study, and to the members of the families who were gainfully employed. Twelve of the fathers were the only members employed in their respective families. This number included the majority of the group. In two families the mother worked on part-time jobs to supplement the earnings of the father. In two families the mothers were the only members working; one of these

mothers was the only employable member of the family since the father had died. The other employed mother had taken a job rather than stay in the home with the children. The father in this family stayed at home to keep the children and the house.

TABLE II
ANNUAL INCOME OF FAMILIES

<u>Earnings</u>	<u>Number of families</u>
Total	17
\$1,000 - \$2,000	1
2,000 - 3,000	4
3,000 - 4,000	5
4,000 - 5,000	3
5,000 - 6,000	1
6,000 - 7,000	1
Information not recorded	2

The income bracket from \$3,000 to \$4,000 contained five families, which was the largest number falling within one group. Ten families, representing over one-half of the group had an income of less than four thousand dollars annually. In the upper range of incomes recorded, there were only two families with an annual income of \$5,000 and over. Three families had an annual income between \$4,000 and \$5,000.

FAMILY COMPOSITION

There were five families consisting of both parents and

two children; and five families of two parents and one child. These two categories represent over one-half of the group. Two families consisted of only one parent and one child. In each of these families the spouse was deceased. Since both of the deaths occurred after the child had been treated in the clinic, information regarding these parents was recorded on the clinic charts.

TABLE III
FAMILY COMPOSITIONS

Parents present	Number of children					
	1	2	3	4	5	6
Total 17	7	5	3	1	0	1
Mother and father	5	5	3	1	0	1
Mother only	1	0	0	0	0	0
Father only	1	0	0	0	0	0

Five of the cerebral palsied children were also the oldest of the sibling group. Five of the handicapped children occupied the third position among his siblings. There were no families in the study with more than one child having cerebral palsy. Five children were the only child in the family. These statements are in reference to living children only.

TABLE IV
SIBLING POSITION OF THE CEREBRAL
PALSIED CHILD

<u>Position</u>	<u>Number of children</u>
Total	17
Only child	5
First child	5
Second child	2
Third child	5

DESCRIPTION OF CHILDREN

TABLE V
DIAGNOSTIC CLASSIFICATIONS

<u>Diagnosis</u>	<u>Number of children</u>
Total	17
Spastic	8
quadriplegia	2
paraplegia	2
diplegia	1
hemiplegia	1
unclassified	2
Athetoid	6
quadriplegia	2
unclassified	4
Cerebral palsied without reference to type	3

An important consideration in the treatment of the cerebral palsied patients is the diagnosis. In addition to classifying patients according to the five major groups described in Chapter I,² the location of the effected parts of the body is classified. The spastic type of handicap occurred more frequently in the group, and it accounts for eight disabled children. Six children were athetoid, and three children were recorded only as cerebral palsied. The extent of the injury was designated by the clinical terms of quadriplegia, which refers to the involvement of all four extremities; paraplegia, which indicates that only the legs are effected; diplegia, that refers to like parts on both sides of the body; and hemiplegia, which indicates that one side of the body is involved.

Other defects were present which added to the difficulty that the children had in the learning situation. The multiple handicaps were present in various degrees; in some instances the defects were considered to be major problems. There was doubt, in some cases, whether the disability could be overcome. On the other hand, it was certain that some defects could be improved through corrective measures recommended in the clinic. In relatively few instances were the handicaps mentioned as the primary reason for the dismissal.

TABLE VI
SENSORY DEFECTS

<u>Impairment</u>	<u>Number of children</u>
Total	17
Speech	7
Visual	4
Visual and speech	2
Visual and hearing	1
No severe problem	3

Speech ranked highest among the sensory disabilities of these children. There were nine children with a severe speech problem, two of them had a visual problem also. Seven children had impaired vision, three of these had either speech or hearing defects. Only three children had no serious problem in these areas.

TABLE VII
PHYSICAL EVALUATION: MOTOR

Activity	Yes	No	Partial	No record	Total
Sit alone	9	3	1	4	17
Stand alone	6	7	0	4	17
Walk alone	6	7	0	4	17
Run	4	9	0	4	17

TABLE VIII

PHYSICAL EVALUATION: SELF CARE

Activity	Yes	No	Partial	No record	Total
Wash hands	5	6	2	4	17
Wash face	5	6	2	4	17
Brush teeth	3	7	3	4	17
Comb hair	1	10	2	4	17
Undress self	2	10	1	4	17
Toilet trained	10	0	3	4	17

TABLE IX

PHYSICAL EVALUATION: FEEDING

Activity	Yes	No	Partial	No record	Total
Get bread to mouth	11	1	1	4	17
Raise spoon and eat	10	3	0	4	17
Use fork	7	5	1	4	17
Raise cup to mouth	9	4	0	4	17
Use knife	0	13	0	4	17

The preceding tables illustrate some of the problems encountered in the care of these children in school and at home. Generally, the children were more proficient in feeding themselves than in the self-care activities. The highest number of children could get bread to their mouths, which is a less complicated action than raising a spoon to the mouth. Ten children were toilet trained; however, the same number could not dress themselves nor comb their hair. The children, as a group, were more advanced in muscle co-ordination than they were in self-care. Only six children could stand and walk alone. It may be observed from the tabulations, that the skill of feeding, muscle co-ordination and self-care are developed in the normal sequence. That is, children normally have achieved a certain amount of skill in the feeding performance before they are able to walk alone. Although the children are physically handicapped, as a group, their abilities have developed in the same order.

REASONS FOR DISMISSAL

The reasons given by the schools for dismissing the children were classified under five main problems. The five major problems were mental retardation or deficiency, behavior problems, physical handicaps, combinations of physical and mental problems, or mental and behavior problems.

Two children were dismissed because they were mentally retarded, with the qualification that they were too immature then for school activities. In this qualification was the

TABLE X
REASONS FOR DISMISSAL

<u>Problems</u>	<u>Number of children</u>
Total	17
Mental retardation or deficiency	5
Too immature at this time	2
Lack of progress	2
Uneducable	1
Behavior problems	4
Anti-social behavior	2
Lack of toilet training	2
Physical handicaps	2
Lack of self-expression	2
Physical and mental problems	4
Mental and behavior problems	2
Negativistic, crying	1
Masturbation, retarded	1

implication that these two children would be expected to reach a level of maturity which would allow them to re-enter school. Two children were excused because they did not make progress in school and one child was considered uneducable. The difference in terminology used to describe the children in this first group suggests a difference in their intellectual impairment and potentialities to profit by the school program. Four children were primarily considered behavior problems. Two of these children displayed anti-social behavior, which was described as destructive, fighting and hyperactive. Their problems were such as to compel the full attention of one teacher. There were not enough teachers to provide this type of care in the schools. Two children were not toilet-trained, although this is an entrance requirement. Therefore the question could be raised whether the wetting was due to a lack of training or whether it was a symptom of an emotional disturbance. Two children had gross physical handicaps, which made self-expression extremely difficult for them. These two children needed more special attention than the school was equipped to offer. Two children were in the problem classifications of both mental and behavior problems. One of these children was described by a school staff member as crying most of the time. This behavior was disturbing to the other children. The child was negative and self-willed in his relationship with the teachers. In addition to the unsatisfactory behavior, the child did not accomplish anything. The second child in the mental retarda-

tion-behavior problem group was capable of very little self-help. This child also masturbated in the presence of other children.

TABLE XI

CORRELATION OF THE ATTITUDES OF THE MOTHER
AND REASONS FOR DISMISSAL

Attitude of the mother in relation to the child	Reasons for dismissal				
	Mental	Mental and Physical	Physical	Behavior	Mental and Behavior
Total 17	5	4	2	4	2
Accepting 4	1	2	1		
Aggressive 1	1				
Resentful 1					1
Patient, over-esti- mating abilities 1			1		
Discouraged 2	1	1			
Disgusted, nervous 2				2	
Over-protective 4	2			1	1
Ambivalent, self-pity- ing 1				1	
Information not on record 1		1			

The mothers whose attitudes were questionable or unaccepting were described in the clinic charts as follows: (1) The mother is ambivalent. She is loving and devoted, yet anxious to be relieved of the responsibility for care, supervision and training of the child. She feels keenly that she is unfortunate in having to accept this burden. (2) The mother is nervous and resents having the child around. She blames the father for the child's handicap. In turn, the father blames the mother and accuses her of neglecting the child.

Two of the four mothers who were considered accepting of their children were recorded as follows: (1) The parents are pleasant and cooperative. They are exceptionally devoted, solicitous and protective in the care of the child. (2) The child is well-regarded by both parents and siblings. They are interested in the child and appear to love her very much. The mother spends much time reading and playing with the child.

The attitudes of the mothers and their emotional reactions to their children were examined in connection with the reasons for their children's dismissals from school. It was found that four mothers were considered to have healthy attitudes toward their children. These attitudes were described as (1) loving, (2) understanding, and (3) interested. Moreover, these children were well regarded by other members of their families, and the children appeared to be happy. Their problems in school were mental retardation and physical disabilities. Two mothers

were discouraged over the condition of their children. One of these mothers felt defeated, since the evaluations on the child were largely negative. This mother did not find it easy to accept the child's limitations. One mother was outstandingly aggressive; she had a tendency to exaggerate the child's abilities. This child was mentally retarded.

Ten mothers were considered to have faulty attitudes regarding their children. One of these mothers expressed resentment over having the responsibility for the handicapped child. This mother and the father blamed each other for the child's condition. The child was dismissed from school because of a combination of mental retardation and behavior difficulties. Two mothers complained of physical symptoms which probably had some relation to their negative feelings about their children. One of these mothers was nervous; the other mother became deaf at times, particularly when the child was annoying her. Both of these children were dismissed from school because they were not toilet trained. The second largest group of mothers was listed as over-protective of their children. Two of these children were mentally retarded; one was mentally retarded and had behavior problems, and one of them was a behavior problem. There was one mother who was ambivalent in her feeling toward the child. The child presented a behavior problem.

This breakdown reveals that the four children whose mothers were accepting, had no behavior problems. The two mothers

who were so affected by their handicapped children as to have physical symptoms themselves, had children with the same type of problem. Two children who had rejecting parents, also had behavior problems. The third child manifesting behavior difficulties had an over-protective mother. This may be a more subtle form of rejection. Both mothers who were discouraged had children who were mentally retarded; in addition to the mental retardation, one of these children was physically handicapped. Apparently mental limitations were more difficult for the mothers to accept than some of the other handicaps. And seemingly, there was a high correlation between the presence of unaccepting attitudes of the mother toward the child, and the manifestation of behavior problems in the child.

SUMMARY

The educational program for the cerebral palsied child should include special methods and techniques which may be different from those used in the education of the orthopedically handicapped child. In the discussion here of the types of schools attended by the members of the study group, it was stated that the public schools were open to the physically handicapped child who has an I.Q. over fifty. Some of the children in the study did not fit into these classifications; neither did some of the children meet the requirements for the private schools. All children of this group were physically handicapped in varying degrees, and some had sensory defects. The reasons for the dismissals from

school indicated that the schools were not geared to meet the individual educational needs. Yet, efforts were made by the teachers to help the child adjust to the school program. In some instances the children had been transferred from one division within the school to another, prior to the dismissal from school. Three children in the group had experienced three dismissals.

Dismissals from these schools were based upon the child's inability to profit from, or to adapt to that particular school program. It was not established that all the children excused from school attendance could not profit from a program better suited to their needs.

The incomes of these families were included in this chapter. When public educational facilities are not available for these children, the parents are confronted with the need to consider private care for the child over a long period of time. The annual income of these families, as a group, ranged from \$1,000 to \$7,000 in round figures. The lower and higher figures were the extremes in which only two families were represented. Two families were not entirely self-supporting.

Information was given about the size of the families and the sibling position of the brain-injured children, since the family can be an asset in the treatment of these children. Positive family relationships can help to reduce the social deprivation experienced by these children, who are restricted by severe physical handicaps. However, positive relationships are not

always predominant in these homes.

Ten mothers had attitudes toward their children which were questionable; the reactions were indicative of the mother's need for help around an emotional problem. Some of these mothers gave evidence of such deep feelings about their children that intensive casework services were indicated. The negative attitudes of the mothers seemed to have been a significant factor in the child's inability to adapt to the school setting.

CHAPTER III

PRESENTATION OF CASES: WAYS OF HELPING THE CEREBRAL PALSID CHILD

PHILOSOPHY OF EDUCATION

That every child has certain inherent rights is generally accepted in this country. Within the heritage of each child is the right to an opportunity for an education or training commensurate with the child's needs and capacities. The cerebral palsied child is no exception. Basically, the needs and rights of this child are no different from those of any other child. The difference, however, may be in the planning or the approach to meet his needs. Especially is this true in the provision for the educational needs of the cerebral palsied child, since he presents unique problems in the learning situation.

For many years very little was done in the interest of cerebral palsied children, because such cases were considered to be hopeless. Within recent years the philosophy regarding their training and education has changed. This philosophy is set forth in the following statements:

The aim of a sound educational program for cerebral palsied children is to provide the amount of education

for which each child can profit most. This means giving consideration to the needs inherent in all children, because they are children. Then the limitations upon normal potentialities for achievement and the other obstacles imposed by each individual particular cerebral involvement must be recognized, evaluated and provided for as well.

Every handicap must be minimized to the greatest extent possible or removed. Medical care, education and training consistent with each child's specific needs must begin as early as the handicap is diagnosed and continued as long as gains are being made. For those whose handicap cannot be removed, ways of working through them, around them, and desirable ways of compensating for them must be found.¹

The increase in public interest, the advancements in medical science, and improvements in the educational methods and techniques for other handicapped children, have given new hope for the brain-injured child. As a result of this progress more of these children have received education and training, thereby realizing social adjustment, economic independence and personal happiness. On the whole, however, these have been the achievements of cerebral palsied children who were of normal or superior intelligence. The focus here is upon children that have not been so endowed, and those who have had difficulty in remaining in school. This group of children has been found to have varying degrees of mental impairment, as well as other multiple handicaps. In some cases the physical handicaps were so severe as to prevent a specific determination of the potential mental capacity.

1 Maurice H. Fouracre, Realistic Educational Planning for Children with Cerebral Palsy, New York, 1951, 2.

PROBLEMS

The reasons for the dismissal as given by the schools were listed under five main categories, namely: mental retardation, physical handicaps, behavior difficulties, or a combination of physical handicap and mental retardation, and a combination of behavior problem and mental retardation. All of these children were either mentally deficient or retarded to some degree; or there was some question as to their potential mental capacity. Yet, other factors operated against these children making their adaptation to the school setting, since less than one-third of them were dismissed because of mental limitations. Of course, mental retardation in combination with other handicaps would increase this percentage. Another factor in the school dismissals was the improper school placement for the children. In many instances the school facilities were not suited to the needs of the child.

Notwithstanding, placements in these schools continue for several reasons. One reason is the scarcity of schools open to the children; another reason is that parents are not always willing to accept certain limitations in their children. These parents select the school with requirements which are more acceptable to them. Recommendations for a certain school placement may be predicated upon medical, physical, social and psychological findings; yet, this information does not benefit the child if the parent does not act upon it. Sometimes the parents need to be

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helped to follow through on such recommendations. Emotional and personality conflicts within the family have to be worked through by long term social casework services. This is an indirect way of helping the handicapped child. Examples of these problems are given in the next two cases.

CASE PRESENTATION

Case A

This is the case of John Z, eight year old athetoid, mentally retarded boy, who was dismissed from a special orthopedic public school because of his behavior difficulty.

Family

In the family were both parents and three children, a son, age twenty-two; daughter, age nine, and the patient. Mr. Z. age fifty-two, was a self-employed man, owned his home, which was mortgaged. He was born in Germany and came to this country as a young adult. He later became a naturalized citizen.

Mr. Z. seemed more willing to accept John's handicap and consequently had less difficulty in managing the boy.

Mrs. Z., age forty-three, was also born in Germany and came to this country at the same time as her husband. She, too, became a naturalized citizen.

Mrs. Z. was able to accept John's physical handicap, but she was not able to accept his mental retardation. She compared him unfavorably with his sister, who was a bright, attractive child. Mrs. Z. was impatient with John's slowness. She

expressed disgust with some of his habits and mannerisms, especially his drooling. She had been troubled with deafness that seemed to have no organic basis. It was interesting to note that on one occasion when she became totally deaf, she had enough insight into the situation to say that this deafness came after a particularly trying day with John. She also said that she was not surprised.

Social Relationships

John had little opportunity for group participation. The children in the community were impatient with his physical slowness. He seemed to make a good social adjustment at the school for retarded boys during his brief stay there, prior to the placement in the public school. He was liked by the other children; and he cooperated with the teachers. He played well with his sister, who is one year older than he. His mother described him as giddy, active, and very demanding in his relationship to her and other adults.

School History

John was enrolled at the special orthopedic public school, nursery division, at three years of age. However, he was not completely toilet trained, and the mother was asked to take him home. At six years of age, John was admitted to the private school for mentally retarded boys. After the initial adjustment John got along well there. The mother did not feel satisfied about having him in this school because she felt that he was not

as mentally retarded as the other children. She said that he cried to come home and that he was not happy there.

She removed him from this school. He remained at home for one semester. Then John was re-admitted to the public school, but he was dismissed because of behavior difficulties.

Clinic Psychological Findings

John was found to be within a range of intelligence which was short of normal. Mental deficiency was given as the primary factor for his inability to adjust in the special public school classes. Secondary factors were emotional, due to the mother's lack of success in handling the child.

Social Service

John was referred to social service because of behavior problems at home. The impression was that the mother's nervousness was affecting John's behavior and that through home visits by the caseworker, she might be helped to handle John more effectively.

It was found that Mrs. Z. wanted a school placement for John outside of the home. The father would not agree to have the child a long distance from the home, and Mrs. Z. did not want him placed among other mentally retarded children. Neither parent would consider an expensive school. Casework services with Mrs. Z. continued for over a year, except for an interval after the first caseworker left the agency. During this period Mrs. Z. became a little more tolerant in her attitude toward her son's

mental impairment. Finally, she and her husband decided to send John back to the private school for mentally retarded boys.

The problems in this case included limited social experiences for the child; tension in the home resulting from the mother's negative, unaccepting attitudes; lack of agreement between parents regarding plans for school; and the child's improper school placement. It is obvious that the mother needed help in accepting more realistic educational goals for her child, which was only an index of a deeper feeling that this mother had for her child.

It may be added that casework services should be started early in an attempt to avoid the repetitions of such experiences. Some type of service from the social caseworker is given on all of the cases in the clinic; intensive casework is offered on a selective basis.

Another example of need for social casework services is seen in the next case.

Case B

The problems in this family included tensions in the home, lack of agreement between parents as to the future plans for the child, and his rejection by both parents. The child was not in a school placement which was suitable for his needs, and he was dismissed because his activities and crying were disturbing to the other children. His school work was poor.

Family Relationships

It was the impression of the caseworker that Mr. L., the father of Terry, never received any love and security as a child. Hence, he was unable to give love. Mr. L. was disgusted by Terry's actions, and the mother believed that the father's flare-ups resulted from this. An example was Terry's eating habits. The child seemed to feel that if he did not eat fast he would not get enough; consequently, he frequently regurgitated. He could not get away from the table when this happened and Mr. L. would be furious and take it out on all of the family. Neither parent could agree upon a plan for Terry.

Social Service Contacts

Terry was first seen in social service in March 1949. The mother was seeking a place where she could place the patient for training so that he could better fit into the home situation. It seemed that the patient was the reason for many disagreements between the parents and as Mr. and Mrs. L. expressed it, "the child was a cause of nothing but trouble since his birth". It was partly because of Mr. L.'s complaints that Mrs. L. had hoped to place the child in the Illinois Children's Hospital.

Because of his mental condition and the fact that he could probably learn to walk, the patient was not eligible for Children's Hospital. The patient was immediately referred to Visiting Nurses Orthopedic Division for training in balance and gait. The child improved a great deal in the next few months.

The patient was also referred to the Board of Education for testing and nursery school placement. After the child began attending the special orthopedic school, the home situation improved some. Mrs. L. began to feel that the father liked the patient better.

Terry was again referred to social service in February 1951, because he was having difficulty in the public school placement. The school was planning to expel him in June and had suggested commitment to a state institution. Mr. and Mrs. L. needed help in working through a plan for the child.

During a three-month period, the parents were seen together and separately. It was learned from them that there had been marital tension from the beginning of their marriage. They had been separated a number of times and had been given the permission of the Chancery Office for a legal separation. Terry seemed to be a source of irritation to both parents. Since they were planning a final separation, a place was found among relatives for the other children, but no one was willing to care for Terry. For this reason the L.'s had to make plans for him immediately.

The worker talked through with the L.'s the recommendation of the school. They were helped to understand that there were no schools open to Terry since he was not only physically handicapped, but mentally handicapped as well. The decision as to Terry's care was left to the parents who decided that commit-

ment would best meet Terry's needs. Terry was committed to Dixon State Hospital in May, 1951. The case was closed in social service, since no further help was requested.

It is not unusual for these parents to react with anxiety, fear, and hostility over the responsibility of caring for the children. Yet, these feelings do not prevent the parents from accepting their responsibility when they have the cooperation of professional groups. These parents may gain the necessary support from contacts with other members of the team, as well as from short contacts with the social caseworker. A case of this type follows:

Case C

Carl, age six years, was diagnosed as spastic quadriplegia, mild. He was further handicapped by bilateral cataracts. Carl was dismissed from school because he was not able to cooperate with the group, and he masturbated. He was also considered to be retarded and capable of very little self-help.

The parents attempted to have Carl enrolled in another public school for crippled children, but he was refused admittance. The psychological re-examination, which was made on Carl as a preliminary to an application for enrollment in school, indicated mental retardation. Another problem in this case was in the inter-personal relationships involving the mother, siblings and the patient.

Family

Both parents were in the home. In addition to Carl there were two other boys in the family. One of these brothers was five years older than the patient; the second brother was two years older than Carl.

The father was employed while the mother stayed at home with the children. The father was thought to be more objective about the situation than his wife. Her feelings about the child might have been stronger because of her own suffering from osteomyelitis for twenty-two years. She was inclined to feel bad about Carl and had spoiled him. She thought that Carl was brighter than the other boys, but she could not explain this specifically or in detail. She was inclined to be over-protective. Both parents were reported as having feelings of guilt over the child's handicap. Siblings: The older boy was upset and became introverted since he had to help with Carl. The second son was happy-go-lucky, and he did not appear to be affected.

Social Relationships

The child played with his brothers and with the children in the neighborhood. Although his span of attention was below average, he was reported to be at ease with strangers.

Clinic Psychological Findings

Carl was found to have gross perceptual difficulty, resulting in or accompanied by mental deficiency. The impairment was thought to be the results of a cortical disturbance rather than peripheral, i.e. although his vision might have been impaired

the way he interpreted the things he perceived indicated that the damage to the cortical area of the brain, perhaps, accounted for the distortion.

Previous test results of the Bureau of Child Study tended to confirm the above impression of severe retardation in mental development.

Social Information from the School

Carl's older brother, Phillip, had been taking Carl to school. This brother began to resent the other children poking fun at his handicapped brother. Although the parents seemed to have accepted the child's mental immaturity, the mother explained many times that she thought the child's greatest problem was that he was spoiled. Also, she believed that his poor vision was responsible for his inattentiveness. The parents were resigned to placing Carl out of the home, since they felt that such placement would be better for the two normal boys. The child was not a candidate for a school for crippled children, inasmuch as he was not severely physically handicapped except by defective vision. He was not eligible for placement in the public school's regular classes because of his low mental age and low I.Q. Placement in a private boarding school seemed to be the best solution. The plans were discussed with the parents, who said that they would make an appointment to see the admittance officer at the school for mentally retarded children.

The following two cases illustrate the problem of

finding suitable school placements. These children had positive relationships with the family members. The parents were able to take independent action in planning for the children after they were evaluated in the clinic. Re-evaluations and counseling are continuous throughout the patients contact in the clinic.

Case D

Lawrence, age six years and two months, was dismissed from school because he was not ready for the activities at the first grade level. He had an exceptionally limited possibility for self-expression, and his mental status was estimated to be lower than the average.

Family

When the family was registered in the clinic both parents were in the home. The mother died during the time that the case was active in the clinic. Lawrence was an only child. Both parents were considered accepting in their attitudes toward the child. They were reported as dealing with Lawrence in a patient, intelligent, and understanding manner; and they apparently were realistic about his physical and mental status. Lawrence appeared happy and alert.

School History

Lawrence entered the nursery division for spastics in one of the public orthopedic schools when he was four years old. He spent two years in this division before he entered kindergarten. During these years his teachers thought that his progress

in all areas was exceptionally meager. It was reported that he made no improvement in self-help; he could not walk; and he could not use his hands. Lawrence was strapped in a wheel chair. He was socially alert.

In the testing situation at the school, it was difficult to ascertain his mental age on any scale, because of his limitations in self-expression. His mental growth was estimated to be probably eighty-five per cent of the average rate.

Clinic Psychological Findings

An accurate estimate of Lawrence's mental ability could not be obtained as his speech was not understandable, and the examiner could not be certain of his responses when he used his hands.

A month later it was recorded that the child's performance in speech therapy indicated that he could profit by a definite learning situation. The occupational therapist described Lawrence as cooperative, persistent, determined, and capable of learning. Lawrence also showed independence and initiative. The recommendations were that Lawrence could be started at the first grade level, provided the program was adjusted to his needs and limitations.

Action of the Parent

After the mother's death the same year, the father moved with the child to a distant city. The father wrote to the clinic asking for transcripts of the records on Lawrence who was being

enrolled in a school. The correspondence from this father did not indicate the type of school selected, nor whether the child was accepted.

The implications from the clinic records in the above case are that with an adequate treatment program the child would make definite progress. Apparently the major problem would be the placing of the child in a school program designed to meet his physical and mental requirements.

Case E

This is the case of a six year old child who had been diagnosed as spastic hemiplegia. Frank was dismissed from school because he was too mentally retarded to make progress. The teachers reported that Frank lacked in concentration, that he showed no noticeable improvement, and that he did not participate in any group activities at any time. A recommendation was made for a re-examination in two years, at which time he would be considered for an un-graded division of the public school.

Family

Both parents were in the home. The father was the only member of the family employed; the mother stayed at home to care for the children. Frank was the older of the two boys in the family. There were no problems reported in the family relationships. The two children got along well together, with the usual fights. The mother did indicate that the younger boy may have been a bit jealous of Frank.

School Attendance

Frank entered the nursery division of the public school for crippled children when he was two years and ten months of age. He continued in the nursery until he was six years old. The mother did not agree with the report of Frank's progress in the school. She thought that the other children were so much more handicapped than her child that he had no one to help stimulate his speech.

After Frank was dismissed from the school he went to a summer camp. The next fall he was enrolled in a private residential school for cerebral palsied children. The mother was advised that the residential school was not a good placement for Frank, so he was withdrawn. Later, the mother was successful in entering Frank in a parochial school. From the last report he was making good progress toward an adjustment. In making application for this school placement, however, the mother did not tell the authorities that Frank was a cerebral palsied child. She thought that his position there might be jeopardized by the information.

ACTION TAKEN BY PARENTS AFTER DISMISSALS

All parents of the children are upset by the dismissals from school; often they have feelings of frustration. They are confronted with the problems of finding another school that will accept the child; this may entail additional expenses. The alternatives may be care for the child in the home or placement in an institution. The parents have strong feelings about the latter

TABLE XII
ACTION TAKEN FOR FUTURE CARE

Problem		School for Retarded Children	Private school for Cerebral Palsied Children	State Institution	Paro- chial	Home	Not Recorded
Total	17	3	2	2	1	3	6
Mental retarda- tion	5		1		1	2	1
Behavior	4	1		1			2
Physical	2		1				1*
Physical and Mental	4	1				1	2
Mental and Behavior	2	1		1			

* School placement planned by father, but the type of school is unknown to clinic.

plan, since there is a stigma attached to state hospitals. Some parents think that the state institution is a poor substitute for the care which can be given in the home.

After their dismissal from school three children were sent to a school for retarded children. Two children were enrolled in a private residential school for cerebral palsied children. The enrollment of this school is limited to fourteen children. The parents of two children had decided upon commitment to state hospitals. The final arrangements for one of these children had been completed. Three children in the group remained at home. In each of these cases the child was able to continue the contact with the clinic for therapy. Institutional care had been recommended by the school for one of the children in the home, but the parents were not willing to follow the plan. Six records did not contain information about plans for the future. Among these six was the child who had moved to another state. The father was interested in having the child placed in school, but he did not state the type of school where he sought admittance for the child. Hence, this record was included among those whose plans were not recorded.

CHAPTER IV

SUMMARY AND CONCLUSIONS

The purpose of the study was to examine the problems of those cerebral palsied children who had been dismissed from school.

The reasons given by the schools for the dismissals were listed under five main problems. Of these main reasons for the dismissals, mental retardation or mental deficiency comprised the larger group. This group was sub-divided into three categories because of the terminology used to describe their mental status, thus indicating that some children were less retarded than others. Indications were that some of them might be expected to reach a level of maturity which would allow them to re-enter school; others were considered to be deficient in mentality, and uneducable.

Two children had gross physical handicaps, which made self-expression extremely difficult for them; therefore, progress was immeasurable. Four children were primarily considered behavior problems. Six children were either a combination of physical and mental problems, or mental and behavior problems.

Further analysis of the group pointed up the more obvious underlying problems affecting the adjustment of these children to the primary disciplines. These problems are as follows:

- (1) The mental and physical limitations of the brain-injured child.
- (2) The lack of adequate school facilities for dealing with the limitations presented by this particular group.
- (3) The emotional tensions and personality conflicts within the home environment which were reflected in the children's behavior in the school setting.
- (4) The improper school placement for some of the children, although more suitable schools were available.

The above factors will be discussed further under the general headings of school and home.

SCHOOLS

The schools attended by these children were the public school for crippled children, and a private school for mentally retarded boys. One requirement for the former placement was that the child have an I.Q. of fifty or above. Children who were severely handicapped physically were not eligible for placement in the latter school. The larger number of the children was both mentally retarded and physically handicapped in varying degrees. The results of the psychological tests made of the children showed that some of them were developing mentally at a slower rate than normal, but they could definitely profit by a learning situation. The mental age of some of the children could not be determined

because of their severe physical disability and their unintelligible speech. There was some doubt as to the educability of other children although a specific measure of intelligence was not obtained in all instances. Therefore, conclusions may be drawn that the schools were not equipped to meet all of the needs of this group, since some of the children rated lower intellectually than the admission standards of the school. Working through and around these physical and mental impairments, which were often more than mild, should have required special methods and techniques. Added to this was a need for a high degree of individualization, which necessitated a larger teaching staff than was reasonable in the schools at this time. Yet some of the children could profit from a learning situation if it were geared to their needs.

Another factor in the failure of some of the children to adapt to the school was the improper placement; that is, a child mentally retarded beyond the limits of the school requirements could not be expected to progress in that setting. This situation, however, cannot always be avoided, for several reasons. One reason is that to secure specific measurements of intelligence through psychological testing is often difficult, because of the physical limitations and sensory defects in some cases. Therefore the record of the child's progress in the school setting with the psychological findings give a more realistic evaluation than the testing results alone. A second reason is that the added values of social contacts and physio-therapies offered by the

school are beneficial to the child, who may be stimulated to the extent that he will profit by academic training. Another reason is that in the absence of more adequate schools for this particular group, those schools which are available will continue to be utilized, if only on a trial basis.

HOME

An analysis of the study group showed that the preponderance of dismissals for behavior difficulties were given to children whose mothers had a questionable or unaccepting attitude toward the children, and who appeared to be more deeply affected by the children's handicap. The mothers who were more accepting had the larger percentage of children that presented physical or mental difficulties. The quality of the inter-personal relationships of mother and child apparently had significance in its relation to the child's adjustment problems in school.

It was shown through case presentations that parents are sometimes prevented by their own emotional conflicts from accepting the child's limitations and thereby planning realistically for the future. Although recommendations for school placement may be predicated upon expert evaluations, the child cannot be helped if the parents fail to act upon the advice.

Cases were presented to show how families were helped through casework services to more realistic action and goals in behalf of their children. Such cases required long term casework services with the parents as an indirect way of helping the child.

Other mothers were able to plan for their children with short term contacts in social service and assistance from other members of the team. However, more emphasis could be upon early casework services to parents who display faulty attitudes. Because of the importance of having parents with healthy attitudes toward the child in the treatment process, faulty attitudes should be corrected or modified early, if possible.

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APPENDIX

SCHEDULE

Name _____ Clinic # _____

Birthdate _____ Sex _____ Race _____ Religion _____

Referred by _____ Schools Attended _____

_____ Number of Dismissals _____

Diagnosis _____ Other abnormalities _____

Motor Coordination: Stand _____ Walk _____ Run _____

Speech _____ Illnesses _____, _____, _____

Family Composition: Mother _____ Father _____

Siblings	Age
_____	_____
_____	_____
_____	_____

Number of rooms _____ Family Income _____

Persons Employed _____, _____

Parental attitude: _____

Family-Child Relationship:

Father _____

Mother _____

Siblings _____

PHYSICAL EVALUATION

Activity	Yes	No	Partial
Wash hands	_____	_____	_____
Wash face	_____	_____	_____
Brush teeth	_____	_____	_____
Comb hair	_____	_____	_____
Undress self	_____	_____	_____
Toilet trained	_____	_____	_____
Get bread to mouth	_____	_____	_____
Raise spoon and eat	_____	_____	_____
Use fork	_____	_____	_____
Raise cup to mouth	_____	_____	_____
Use knife	_____	_____	_____
Sit alone	_____	_____	_____
Stand alone	_____	_____	_____
Walk alone	_____	_____	_____
Run	_____	_____	_____

Clinical psychological findings:

Clinic Recommendations:

School Report:

Problem

Mental

Social

Recommendations

Reasons for dismissal

Action or plans of parents for future care of child: