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A Study of the Social Histories of Cerebral Palsied Patients at the Mercy Hospital Children's Rehabilitation Center

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A STUDY OF THE SOCIAL HISTORIES OF CEREBRAL PALSIED
PATIENTS AT THE MERCY HOSPITAL CHILDREN'S
REHABILITATION CENTER

by

Jo Ann Splon

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

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CHAPTER I

INTRODUCTION

HISTORY AND DEFINITION

In 1862, an English surgeon, William John Little, recognized and described the condition now termed cerebral palsy. Dr. Little considered the cerebral palsied patient feeble-minded and untreatable because of physical appearance, mannerisms, and the multiplicity of defects involved. Physicians no longer employ the term Little's Disease since it is now known that impaired intelligence does not always accompany the physical disability which characterizes the illness. Also, though there is no cure for this condition there has been considerable success in the treatment and habilitation of persons afflicted.

Cerebral palsy is now fairly well defined and classified, and knowledge is continually increasing in diagnosis and treatment of this affliction. There is also increased public awareness of the existence of this condition. This has resulted in the expansion of previously existing diagnostic and therapeutic facilities and the development of new facilities. However it is evident that these advances alone are not adequately meeting the problem because of

the psycho-social implications of this condition. The afflicted person and those responsible for his care may also need help with the psycho-social problems arising from this illness.

Cerebral palsy is recognized as a condition characterized by paralysis, weakness, incoordination, or any other aberration of motor function due to malformation of motor centers of the brain.¹ It is one component of a broader "brain-damage syndrome", as the patient frequently has not only neuromotor dysfunction, but other handicaps such as mental retardation, convulsions and behavior disorders of organic origin.² The term includes five major types of palsies with different sites of brain malfunction producing the different conditions: spastic paralysis, athetosis, ataxia, rigidity and tremor. There is further classification of this condition according to topographical involvement of the extremities: paraplegia, involves the legs only; diplegia, involves the legs primarily and the arms to a slight extent; quadriplegia, involves all four extremities; hemiplegia, lateralization of one half of the body with greater involvement of the arm; and double hemiplegia, spastic quadriplegia with greater involvement of the arms than the legs.²

¹Meyer A. Perlstein, "Medical Aspects of Cerebral Palsy", Nervous Child, Vlll,(1949), 127.

²Eric Denhoff, "Diagnostic Techniques For Children With Cerebral Palsy", Rhode Island Medical Journal, XXXll, (September, 1949), 483.

INC IDENCE

According to Metropolitan Life Insurance Company statistics, 1948, Cerebral Palsy accounts for the second largest group of crippled children next to poliomyelitis. As Cerebral Palsy need not be reported to a health agency in most states, reliable statistics on its extent have been very meager until recent years. The method most commonly used for estimating its incidence is the "Phelps' formula". This is based on the studies of Dr. Winthrop M. Phelps done in several Eastern states. According to the "Phelps' formula", it is estimated that seven cases of Cerebral Palsy are born yearly in every 100,000 population. Because these children are very susceptible to infection, about 15 per cent die within the first five years of life. In round numbers, an estimated half a million persons in the United States are afflicted with Cerebral Palsy.³

ETIOLOGY

Cerebral Palsy is a term used to describe conditions resulting from brain injury or malformation which occur before, during, or after birth. Prenatal factors include genetic defects of the central nervous system, infective conditions in the mother and child, erythroblastosis foetalis (RH factor incompatibility), and cerebral hemorrhage or anoxia. Paranatal factors are injuries to

³C.P. Foundation of Southern Arizona, Inc., A Brochure, Give The Forgotten Child A Future.

the brain resulting from anoxia or trauma. Prematurity is a most prominent factor in fetal anoxia. Not only are prematures more susceptible than full term infants to birth trauma and anoxia, but prematurity may also indicate maternal infectious diseases and nutritional or metabolic deficiencies which in themselves may be factors in the etiology of Cerebral Palsy. Obstetrical conditions such as oversedation, prolonged labor, breech presentation, and forceps delivery have also been considered as causative factors. However, it is generally concluded that prematurity or obstetrical complications are due to pre-existing conditions which are also the causes of the cerebral palsy condition. After birth, cerebral palsy may result from infections such as measles, influenza, pre-tussis, encephalitis, from trauma to the brain, or from neoplastic lesions.⁴

BACKGROUND AND DESCRIPTION OF CLINIC

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

⁴Eric Denhoff, "Cerebral Palsy", New England Journal of Medicine, (November, 1951), 728-736.

Mercy Hospital.

In 1870 the Chicago Medical School was erected on Mercy Hospital property at Twenty-sixth Street and Prairie Avenue. Arrangements were made for the Sisters to conduct a Free Dispensary for the college students' benefit and for the poor of the district. Since its establishment, Mercy Hospital has made a constant effort to keep abreast of progress in the medical and scientific world. It has always been a teaching hospital, having been associated with the Rush Medical College, Northwestern School of Medicine, and most recently with the Stritch School of Medicine of Loyola University.

The Mercy Free Dispensary is now in its forty-first year of service to charity patients. The Dispensary was closed from 1914 to 1919, but was reopened through the support of the Catholic Council to care for the discharged military personnel and their dependents. When it was found that there was a need on the part of the general public for out-patient medical care, the Sisters agreed to resume this service. The medical staff of the hospital from that date gave of their time and effort to the dispensary.⁵ Although M.F.D. is a separate unit, it is administratively an integral part of Mercy Hospital. Financially, it operates on an

⁵Information taken from material compiled for publicity purposes for M.F.D., CP Clinic, (1951), 19-20.

independent budget which is met through a three fold arrangement: the hospital, dispensary fees, and the Community Fund.

The Mercy Free Dispensary Cerebral Palsy Clinic, which is a member of the United Cerebral Palsy Association, was established February 14, 1949, through the efforts of the Sisters, the Medical Staff, and interested community organizations. As it was limited largely to diagnostic services because of lack of space for a treatment center, the Cerebral Palsy Clinic affiliated with the Martha Washington Home for Crippled Children on July 1, 1953. The facilities of the Home were used for in-patient care, and children were admitted for a three month period. This affiliation was dissolved September 30, 1954, because of insufficient funds.

It was decided that diagnostic and rehabilitation services at Mercy Hospital would be continued on an out-patient basis only. Space was made available and the Mercy Hospital Children's Rehabilitation Center was opened in October, 1954.* The specialities of medicine: pediatrics, physical medicine, neurology and orthopedics, and the ancillary services: physical, occupational and speech therapies, and the psychology and social service departments, with the exception of the group therapy, were continued. A complete diagnostic study is made on all patients and a rehabilitation plan is devised for each child. These services are available to any child through fifteen years of age without regard to race, creed or residence. Exceptions are occasionally made to accept

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

persons over sixteen years who are especially in need of the services offered. Fees for services are determined on basis of the ability of parents to pay, and no child is denied services because of insufficient funds. There are no facilities at present for in-patient care during treatment.⁶

In the out-patient clinic there is a close working relationship between the physicians representing the specialties of pediatrics, physical medicine, neurology, and orthopedics, the ancillary services of the physical, occupational, and speech therapies, and the psychology and social service departments. The following procedure is used in the clinic. First, an interview with the medical social worker at the time of application. At this time some interpretation of the clinic program is given to the parent, social history information is obtained, and a clinic appointment is made. The information obtained by the social worker is made available to the clinic staff before the child is seen in the clinic. Second, the patient is brought to the clinic where he is examined by the physician in charge, who also interviews the parents. Third, clinic appointments are then arranged for further examinations and laboratory tests. Finally, a diagnostic evaluation is made upon the findings of the various

⁶Information taken from material compiled for publicity purposes for M.F.D., CP Clinic, (1955), 1.

specialties in the clinic, and after treatment plans are outlined, recommendations are given to the parents.⁷

As there is no cure for cerebral palsy, one objective of treatment is the training of alternate areas of the brain to substitute in some measure for those areas which have been affected. This training is facilitated by physical, occupational, and speech therapy. After a complete diagnostic evaluation, surgery, braces and drugs are prescribed where indicated. Because of the complexity of the condition, treatment requires the coordinated application of the knowledge and skills of many areas of specialization.

PURPOSE AND SCOPE

The purpose of this study is to consider the social history information secured by the social worker in the initial interview. This information was studied to determine if there were any significant similarities in the histories of the pre-natal, natal, and post-natal periods. Most studies of this nature have been inconclusive. However, repetition seemed valid because there are some similarities in the aforementioned life periods of cerebral palsied patients and greater awareness of certain symptoms can lead to earlier diagnosis and treatment.

This study also focused on the environment into which the

⁷Winifred Hill Jones, A Study of Cerebral Palsied Children Who Have Been Dismissed From School. A Thesis Submitted to the Faculty of the Graduate School in Partial Fulfillment of the Requirements for the Degree of Master of Social Work, (June 1952), 9.

patient is born and develops and factors influencing his parents which may affect treatment. It was felt that consideration of this data could lead to a greater understanding and appreciation of the feelings and attitudes of the parents related to their cerebral palsied child which must be considered during the treatment process. Even prior to diagnosis, the parents have been subject to strains, fears and pressures which from our knowledge of human behavior can be assumed to develop in many instances into ambivalence, insecurity and hostility. It seems important that in the treatment of the cerebral palsied patient it be remembered that the parents are about the most important factor in the carrying out of the treatment recommendations and the eventual habilitation of the patient. Therefore, the facility aiming at helping the patient must consider the parent, too, in his totality.

SOURCE AND METHOD

The material for this thesis was obtained through a study of the case histories of two hundred and twenty eight patients known to Mercy Hospital Children's Rehabilitation Center from the time of its establishment, February 14, 1949, through August, 1954. Of the total number of cases studied there were one hundred and thirty eight active and ninety closed cases. Initially, more cases than this known to the clinic, were to be considered in the study. However, a number had to be eliminated for the following reasons: they were unavailable at the time the study was undertaken, were

not conclusively diagnosed cerebral palsy, or had incomplete diagnostic evaluations. This project was undertaken by a group of five students of Loyola University School of Social Work. The selection of material and the general focus were made possible following discussions with the professional clinic personnel in group sessions and individually, as well as through a study of some of the literature in the field. A review of several cases was made and a tentative schedule was drafted. This was presented to the professional members of the clinic staff, who met in group sessions to discuss with the students the strengths and weakness of the schedule. The clinic personnel indicated areas in the schedule which needed development and offered suggestions for a more comprehensive study. The schedule was then revised and a preliminary testing of it was made on a sampling of thirty cases to determine if it were adequately constructed for the purposes of the study. This schedule included four broad categories: Identifying Information, Medical History, Psychological Evaluation, Diagnosis and Treatment. After this additional minor adjustments in the schedule were made. The revised schedule was then used for the collection of pertinent, uniform data on the cases included in the study. The cases were then listed alphabetically and placed in numerical sequence. The total numbers of cases was divided equally among the students for the completion of a schedule for each of the cases. The information obtained was transferred to a

master schedule and tabulated to facilitate the analysis of the data.

CHAPTER II

PRESENTATION OF THE STUDY GROUP

IDENTIFYING INFORMATION

Consideration has been given to sex and race as predisposing factors in the occurrence of cerebral palsy. Dr. Perlstein¹ has stated that there is a higher incidence of cerebral palsy in males as they usually have heavier birth weights than females. He also believes that less Negro than Caucasian infants are afflicted because of their average lower birthweight and lower incidence of Rh negativity in this race.

In the two hundred and twenty eight cases in this study group there were one hundred and twenty six male and one hundred and two female patients. The sexual difference in this study group does not appear notable. Of the total number of cases, two hundred and two were Caucasian and twenty five were Negro. These findings would seem to substantiate Dr. Perlstein's aforementioned theory as the general clinic population at Mercy Free Dispensary is composed of approximately three times as many Negroes as Caucasians.

¹Perlstein, Nervous Child, 130

TABLE I
DISTRIBUTION OF PATIENTS ACCORDING
TO RACE AND SEX

Race	Cases		
	Male	Female	Total
White	113	88	201
Negro	12	14	26
Total	125*	102	227

*The race of one male patient was unrecorded

The patients ranged in age at the time of admission from six months to twenty one years. Forty-five percent of the open cases came to the clinic before the age of four years, and thirty three percent of the closed cases were admitted by this age. In both instances approximately seventy percent were admitted by eight years of age. The mean age at the time of admission was four years and ninemonths. In the open cases, which in most instances would be the most current cases, there was a tendency toward earlier application for clinic services which is important in terms of diagnosis so that treatment can be initiated promptly where indicated. The clinic staff is encouraging this by interpreting the cerebral palsy condition and describing the symptoms associated with the illness to local hospitals and physicians.

TABLE II
DISTRIBUTION OF PATIENTS ACCORDING
TO AGE AT ADMISSION

AGE OF PATIENTS	NUMBER OF CASES			AGE OF PATIENTS	NUMBER OF CASES		
	Open	Closed	Total		Open	Closed	Total
0 - 1	7	0	7	10 - 11	7	6	13
1 - 2	10	10	20	11 - 12	4	3	7
2 - 3	29	13	42	12 - 13	6	5	11
3 - 4	17	8	25	13 - 14	2	1	3
4 - 5	8	7	15	14 - 15	3	1	4
5 - 6	11	5	16	15 - 16	1	0	1
6 - 7	8	11	19	16 - over	1	1	2
7 - 8	8	9	17	Information			
8 - 9	6	5	11	Unrecorded	5	0	5
9 - 10	5	5	10	total	138	90	228

Represented in the study were one hundred and twenty eight Catholic, seventy four Protestant and nine Jewish patients. The religious affiliation of ten patients was not recorded.

FAMILY COMPOSITION

Eighty-four percent of the parents of the patients were married and living together, which could be assumed to provide the basis for a stable environment for the average patient. Of the remaining 16 percent of the patients in the study group, one patient was being cared for by his widowed mother and twelve other patients did not have both parents in the home due to such circumstances in the lives of the parents as unwed parenthood, separation and divorce. Unquestionably the absence of the father from the home adds to the physical and emotional burden of the mothers caring for these patients.

TABLE III

MARITAL STATUS OF PARENTS

Status	Numbers
Total	228
Married	193
Divorced	5
Separated	5
Unmarried	2
Remarried	12
Deceased	1
Information unrecorded	10

One hundred and seven of the cerebral palsied patients were the eldest child in the family. This presents a problem in the family because younger siblings often attempt to imitate the mannerisms and speech habits of the afflicted older brother and sister. Also, under ordinary circumstances, the older child, when normal gradually requires less care, enabling the parents to devote more time to the younger children. However, in the family in which the cerebral palsied patient is the eldest child, in some instances, certain situations may occur: the parents may give the complete care necessary to the cerebral palsied child plus adequate care to the siblings resulting in an overwhelming burden for the parents; or they may give the CP child the care needed and the patient's siblings may be neglected; or the parents may reject the patient and then only the needs of the patient's siblings are met. Forty-five of the patients were the only child in the family. The parents of these children are able to give exclusive care to the patient; however, they often may be disappointed because of the child's abnormality and may feel cheated of a normal parent-child relationship. They, also, tend to fear the birth of a second child. However, since the number of cases in which the cerebral palsied patient was the only child in the family constituted only twenty percent of the study group, (about whom this information was available) it would not appear that the fear of having a second child afflicted with cerebral

palsy was a significant deterrent to further child bearing in these parents. Particularly, since it is recognized that other factors than such a fear could also conceivably have been operating in these cases to limit the families to the cerebral palsied child. Seventy-three patients had only one sibling which might occasion a more direct comparison of the cerebral palsied child with his normal sibling, causing either preferential treatment for or rejection of the patient. In forty-eight percent of the cases in the study group the cerebral palsied child was the only or first child in the family.

TABLE IV

ORDINAL POSITION OF PATIENT AND NUMBER OF SIBLINGS

Position	Cases	Siblings	Cases
Total	228	Total	228
Only Child	107	0	45
2	57	1	73
3	40	2	52
4	13	3	25
5	3	4	17
6	1	5	1
7	2	6	5
8	1	7	0
9	1	8	3
Information		Information	
Unrecorded	3	Unrecorded	7

LIVING ARRANGEMENTS AND ECONOMIC STATUS

Although eighty-seven percent of the patients lived in the Chicago area there were twenty patients from other parts of the

state and eight from out of state. In these latter instances they were diagnosed at Mercy and recommendations for their treatment were forwarded to their local treatment facilities (hospital or private therapist). In many cases the parents try one medical facility after the other, perhaps indicating their inability to accept the diagnosis of cerebral palsy in their child, or their dissatisfaction with the slow results of treatment.

OCCUPATIONAL AND FINANCIAL STATUS OF PARENTS

One hundred and fifty-six of the fathers of the cerebral palsied patients were employed as clerical or sales personnel, craftsmen or operatives. The average income was approximately three hundred dollars per month. The Clinic's intake policy is flexible and consideration is given to applicants from higher income groups when other facilities are not available to them or when their actual income is reduced by payments on debts.

Five mothers in the study group were receiving Aid to Dependent Children funds and one was supported by Old Age and Survivors Insurance. In only three families were both parents employed. This is considerably less than is common in this income group, probably due to the full time care required by these patients.

The majority of the parents of the cerebral palsied patients were renting or in the process of buying their own home. Only one family owned the home completely and eleven families were living with relatives.

TABLE V

JOB CLASSIFICATION* OF WAGE
EARNER IN FAMILY OF PATIENT

Employment	Number
Professional	4
Semi- Professional	6
Farm Manager	2
Proprietor	13
Clerical, Sales	30
Craftsmen	69
Operatives and Kindred Workers	57
Domestic Service	22
Farm Laborer	2
Laborer	2
Information Unrecorded	21
Total	228

*Classification according to
U.S. Bureau of Census

TABLE VI

LIVING ARRANGEMENT OF PATIENT'S FAMILY

<u>Type</u>	<u>Number</u>
Total	228
Renting	134
Purchasing home	64
Living with relative . . .	11
Information unrecorded ..	19

The average economic status of these families necessitates clinic care almost exclusively for the cerebral palsied patients, and, also, demands that assistance be given these families in the purchasing or constructing of special equipment for these patients. The contention is substantiated by the many referrals made of the families to the Illinois State Division of Services for Crippled Children, which aids families in securing special equipment for the child.

CASE PRESENTATION

A fairly average patient seen at Mercy is MaryL., a white Catholic girl who was six and one-half years old at the time of admission. The diagnosis was spastic quadraplegia. She is the only child of John and Ann L. The patients' father is a safety instructor at a large steel company and he earns sixty dollars a week. The family rents a three and one-half room, second floor apartment, in Chicago, for sixty-five dollars per month.

CHAPTER III

THE CEREBRAL PALSY CONDITION

BIRTH HISTORY

"The diagnosis of C.P. can almost be made from the history alone if one stresses the family history, the maternal pregnancy and obstetrical course, and the neonatal and the developmental progress of the infant."¹

Although little information about the family history was recorded in the cases, the other data seemed to indicate that there were symptoms foretelling abnormality in these cases. Ninety-four of the mothers of the patients stated there were complications during the pregnancy; seventy-five reported one, and nineteen several complications. Some of these conditions occur often enough during normal pregnancies not to be particularly significant; however, many are considered predisposing factors to abnormal development. In fifty-five cases there was no information about complications, however, neither did the record indicate that there were none. The pregnancies of

¹Denhoff, "A Primer of Cerebral Palsy for the General Practitioner", Medical Times, (April, 1953), 244.

seventy-nine mothers did not have complications.

The records indicated that forty-seven of the mothers had histories of previous incomplete pregnancies. Dr. Denhoff states that the incidence of this is twenty-eight percent for mothers of C.P. children and fifteen and four-tenths percent for mothers of normal children.²

The incidence of complications in the maternal pregnancy history may add to the negative feeling of the parents at the birth of the cerebral palsied patient. It is conceivable that those who have been disappointed by previous incomplete pregnancies have been first apprehensive and then hopeful as the pregnancy with the patient nears termination. Those mothers who have been ill during the pregnancy have not been able to have the normal satisfactions derived from this period and are often rundown at the time of the birth. In both instances, there may be feelings of resentment and disappointment at the birth of the cerebral palsied infant.

²Ibid, 246.

TABLE VII
COMPLICATIONS DURING PREGNANCY

<u>Complications</u>	<u>Incidence</u>
Psychic	12
Nervousness	11
Depressions	1
Hemotologic	27
Rh incompatibility	20
Anemia	7
Threatened Abortion	23
Spotting	13
Hemorrhage	10
Placenta	2
Placenta previa	2
Placenta abruptio	0
Toxemia	8
Pre-eclampsia	6
Eclampsia	2
Infections	7
German measles	2
Kidney	3
Other	2
Chronic Disease	15
Kidney	2
Diabetes	2
Cardiac	1
Hypertension	8
Other	2
Traumatic	11
Accident	8
Surgery	3
Miscellaneous	12
Hyperemesis	11
Cord around neck	1

TABLE VIII

HISTORIES OF INCOMPLETE PREGNANCIES

<u>Incomplete Pregnancies</u>	<u>Number</u>
Total	228
0	167
1	29
2	13
3	3
4	2
Information Unrecorded	14

In the following table para refers to live births, and gravida to pregnancies.

TABLE IX

 HISTORY OF PATIENTS' BIRTH ACCORDING TO
 MOTHERS' LIVE BIRTHS, PREGNANCIES
 AND SEQUENCE OF CP PREGNANCY

Number	Classification			Number	Classification		
	Para	Gravida	CP Pregnancy		Para	Gravida	CP Pregnancy
1	39	40	77	8	1	1	1
2	73	66	60	9	2	5	1
3	54	43	43	10	2	5	1
4	25	34	18	11	0	1	0
5	15	13	7	Information Unrecorded	10	12	13
6	3	5	2				
7	4	3	5	Total	228	228	228

The parents' ages at the time of the birth of the cerebral palsied child ranged from sixteen to forty-nine for the mothers and from eighteen to fifty-seven for the fathers. One half of the mothers gave birth to these children between the ages of nineteen and thirty-four. From the birth histories of this study group there is no indication that the cerebral palsied child is born more frequently to older women.

TABLE X
AGE OF PARENTS AT THE BIRTH
OF THE C.P. CHILD

A G E	Number	
	Mother	Father
Total	228	228
14 - 19	8	1
19 - 24	52	23
24 - 29	60	56
29 - 34	49	42
34 - 39	26	40
39 - 44	6	20
44 - 49	3	4
49 - 54	2	5
54 - 59	0	3
Information Unrecorded	22	34

The average comparative youth of the parents prompts certain problems for these families. Some of these parents were still in the early stage of adjustment in marriage and the birth of the cerebral palsied child may have placed a strain on their relationship. Immaturity and insecurity in some of these parents could lead to mutual blame at the birth of an abnormal child and make the care of the child more difficult.

In the two hundred and twenty-eight cases, there were fifty premature births. As stated in Chapter I, premature birth are the most prominent factor in fetal anoxia, which in turn causes injury to the brain. Thirty percent of all CP children in another study of this type were premature.³ Obstetrical complications such as Caesarian deliveries, breech births and usage of mid or high forceps are also given consideration in determining the etiology of the cerebral palsy condition. There were twelve caesarian and nineteen breech births in the present study group. Instruments were used in forty-four deliveries but this information requires further qualification as in most instances it was not indicated if mid or high forceps were used. Symptoms at birth were: forty-three infants required oxygen, thirty-seven were cyanotic, twenty-eight were jaundiced, and twenty-six suffered convulsions.

³Ibid, 251.

TABLE XI
NATAL HISTORY

<u>Description of Birth</u>	<u>Number</u>
Normal	135
Term	124
Premature	50
Caesarian	12
Breech	19
Anoxia	24
Cyanosis	37
Instrument Delivery	44
Resuscitation Required	43
Convulsions	26
Jaundice	28
Information Unrecorded	10

The birthweights of these patients do not seem to indicate that heavy weight was a prominent predisposing factor to the cerebral palsy condition in the child.

TABLE XII

CLASSIFICATION OF BIRTHWEIGHT

<u>Weight</u>	<u>Number</u>
Under 3 lbs.	8
3 - 5 lbs.	82
5 - 8 lbs.	66
8 lbs. and over	32
Information unrecorded	40

HISTORY OF PHYSICAL DEVELOPMENT

Sixty-seven percent of the patients' abnormality was manifested, according to their mothers, by the age of one year. One hundred and twenty-one of the conditions were noticed by the age of six months.

TABLE XIII

AGE AT WHICH ABNORMALITY WAS MANIFESTED

<u>Age</u>	<u>Number</u>
0 - 12 mos.	155
12 - 24 mos.	20
24 - 36 mos.	3
36 mos. and over	4
Information unrecorded	46

In most cases the patients' mothers were the first to notice the child's condition. The first symptom usually noted in C.P., and one commonly cited by the mothers, is difficulty in feeding the infant. The patient often has a poor sucking reflex and demonstrates a general lethargy and passivity. Convulsions and strabismus were two other prominent early symptoms. Information of the physical development of these patients was not found to be routinely recorded. However, from the information available the development of the children in the study group coincides with that of the average cerebral palsied child. The parents begin to realize the complexity of the infant's condition when he does not attempt to sit up at six months or stand and walk at about one year of age. The development of the cerebral palsied child is usually considerable retarded. The impression gained from this study was that the average patient takes from one to two years longer than the average child in developing the ability to sit, stand or walk. A number of patients were never able to accomplish these phases of physical development. Speech, too, often is retarded in the child suffering from cerebral palsy.

TABLE XIV

MOTHER'S ACCOUNT OF PATIENT'S EARLY SYMPTOMS

<u>Symptoms</u>	<u>Number</u>
Difficult Feeding	49
Abnormal physical development	82
Passivity	27
Hyperactivity	20
Convulsions	44
Strabismus	37
Other	21
Information unrecorded	53

When the parents are told at the time of the birth to expect some disability in the child their feelings of apprehension convert into those of hope of averting the handicap by giving the child infinite care and protection. However, when the condition becomes, gradually, noticeable the parents at first may deny the existence of the symptoms and later may tend to invent explanations and excuses for the child's delayed development. Finally, perhaps, after admitting the abnormality of the child to themselves they attempt to obtain a diagnosis. Some couples in the study group complained of having been put off by physicians with explanations such as "you are imagining things". Usually, by the time the patient is two or three years old, the diagnosis is confirmed and the family is faced with accepting the diagnosis and

its implications.

One hundred and twelve patients were diagnoses by private physicians as having cerebral palsy and eighty-one were diagnosed at Mercy. The records did not contain information regarding the authority responsible for the diagnosis of thirty-five patients in the study group.

TABLE XV

AGE DIAGNOSED AS CEREBRAL PALSID

<u>AGE</u>	<u>Number</u>
Total	228
Birth to 6 mos.	26
6 to 12 mos.	42
12 to 18 mos.	23
18 to 24 mos.	26
24 to 30 mos.	12
30 to 36 mos.	11
36 mos. and over	57
Information unrecorded	31

There were two main sources of the referrals to Mercy of the patients in the study group. Professional persons, including private physicians and therapists, referred eighty-three patients to Mercy and fifty-seven patients were referred by other hospitals public and private social agencies, and organizations such as the Illinois State Division of Services for Crippled Children and the United Cerebral Palsy Association.

TABLE XVI

SOURCES OF REFERRAL TO MERCY

<u>Sources</u>	<u>Number</u>
Professional	83
Agency	57
Self Referral	
Publicity	38
Friend	20
Independent	19
Information	
Unrecorded	11

ATTITUDES OF PARENTS AND SIBLINGS

The members of the clinic staff recorded that eighty-five of the mothers of the patients exhibited what were considered by the writer as negative attitudes. Because the mothers of the patients most often bring the child to the Clinic, a greater percentage of the mothers were seen than any other member of the family. An attitude was considered in this study as positive or negative according to its effect on treatment. However, the Clinic personnel generally only noted the more overt demonstration of negative attitudes. Forty-five of the fathers and nineteen of the siblings of the cerebral palsied patients were reported as having negative feelings toward the patient or his "condition". The attitudes of the fathers and the siblings were usually reported by the mother. Because of the source of the information

and because of the nature of the problem of a handicapped child in a family it can be assumed that these attitudes merit more attention than indicated by the frequency in this study.

The major difficulty for parents of cerebral palsied children is the great amount of care required by the C.P. child. At first, the parents tend to devote themselves exclusively to the patient and their own personal needs are neglected. It is normal for them to become both physically exhausted and resentful because of the demands made of them. Often, they begin to feel guilty because of the resentment they feel and then they may either reject or over-protect the child. As this conflict is more common for the mother because of her constant contact with the child, the parents often disagree in the care and management of the patient. But whether they are unified or not in their feelings about the care of the child, the birth of a handicapped child intensifies any weakness or dissatisfaction in the marital relationship.⁴

Another problem for the parent is that he has to develop a healthy and accepting relationship with the child despite society's unacceptance. As the child begins to have more social contact the parent repeatedly meets the problem of his child not

⁴Cerebral Palsy, A Social Problem, Proceedings of a symposium conducted by U.C.P. of New York City, Inc. in cooperation with The Study Group of Social Workers in C.P., (November, 1953), 6,7.

being accepted and in turn the parent often shuns society.⁵

The parent is also faced with the problem of securing treatment for the child. Resentment may grow when contradictory diagnoses are made and the parent realizes the inadequacy of treatment facilities and the expense of adequate care.

Often, too, no matter how much effort the parent exerts in endeavoring to help the patient, the results are limited. In some instances, the parent must eventually be faced with the realization that there is little hope that the child will develop sufficiently to be able to take a normal place in society but instead will be dependent upon the parent for life.⁶

The parents have the additional problem of orienting the normal siblings of the cerebral palsied child to his handicap. The sibling, who is often somewhat resentful of the care given the patient, does not understand the situation except that attention is denied him. He is influenced by the attitudes of the parents and senses their unhappiness and insecurity. He is also embarrassed by his brother's or sister's handicap and somewhat hampered in his own social development because of the patient's presence in the home.⁷

⁵Ibid, 10.

⁶Ibid, 16.

⁷Howard A. Kelman, "Parent Guidance In a Clinic for Mentally Retarded Children", Social Casework, (December, 1953), 441.

CASE PRESENTATION

A fairly typical case in the study group is that of William R, a male, white, Catholic, who was admitted to Mercy at the age of ten months and diagnosed as having a mild athetoid condition. He had been diagnosed by a private physician as having cerebral palsy at eight months of age. William was Mrs. R.'s first pregnancy and she reported that there was vaginal bleeding and then hemorrhaging in the eighth month of pregnancy. Twenty-three percent of the mothers reported similar complications. The infant was delivered by Caesarian section and weighed eight pounds and two ounces. This type of delivery is not typical for the study group. Ten hours after birth the child suffered convulsions which continued for three days. The first abnormalities that the mother noted in the child were that he had a strabismus and also experienced difficulty in holding up his head and in sitting.

During the Clinic evaluation process it was reported that William's parents were cooperative, interested and offering good stimulation to the child. However, during treatment Mrs. R. stated that she had come to the Clinic because of family pressure and she impressed as being highly defensive and unable to accept the child's limitations. After about a year in treatment the patient showed some improvement, however, the mother then discontinued all treatment and contact with the Clinic with no explanation. Consideration is given to those instances where treatment was terminated with no explanation by one of the other

members of the group project.

CHAPTER IV

SUMMARY

THE PATIENT

In this study the average patient at Mercy Hospital Children's Rehabilitation Center was found to be a Caucasian, Catholic male who was four years and nine months of age at the time of admission.

He was referred to Mercy by a professional person after being diagnosed by a private physician before he was two years of age. The patient's abnormality was manifested by the age of one year and was noticed by his mother because of abnormal physical development, convulsions and strabismus.

He weighed from three to five pounds at birth and the average patient had a normal, term birth. However, in a significant number of cases complications such as prematurity, instrument delivery, the need for resuscitation, cyanosis, jaundice and convulsions were common.

The birth of this patient terminated the mother's first pregnancy which was commonly complicated by Rh incompatibility and threatened abortion. Twenty percent of the mothers had histories of incomplete pregnancies prior to the birth of the cerebral palsied child.

It seems that there are many similarities in the patients' development which will aid in early diagnosis and, therefore, more effective treatment.

THE HOME

The patient's parents were married and living together and ranged in age from between nineteen to twenty-nine years for the mothers and twenty-four to thirty-four years for the fathers at the time of the patient's birth. They have had one normal child since the birth of the cerebral palsied child.

The family is renting a home in Chicago and the father is earning, approximately, three hundred dollars per month as a skilled laborer.

There is indication that the family is having difficulty in adjusting to the child's handicap. The problems range from difficulty in managing his care to actual rejection of the patient. As it is believed that the family is a vital part of treatment it seems that more recognition should be given to these problems in the home. It has been suggested¹ that a social diagnosis be formulated indicating the strengths and strains in the family. Labeling a family member "rejecting" or "over-anxious" in their attitude toward the cerebral palsied child is useless but counseling should be provided where indicated for family members

¹Cerebral Palsy, A Social Problem, Proceedings of a symposium conducted by U.C.P. of New York City, Inc. in cooperation with The Study Group of Social Workers in C.P. November, 1953.

to give a better conception of the patient. It must be remembered that in most instances the parent of the cerebral palsied child cannot carry the responsibility alone.

BIBLIOGRAPHY

Secondary Sources

A. Books

- Cordwell, Viola E. The Cerebral Palsied Child and his Care in the Homes. New York July, 1947
- C.P. Foundation of Southern Arizona, Inc. A Brochure, "Give the Forgotten Child a Future."

B. Periodicals

- Denhoff, Eric, "Cerebral Palsy". New England Journal of Medicine, November, 1951
-"Diagnostic Techniques For Children With Cerebral Palsy" Rhode Island Medical Journal, September, 1949
-"A Primer of Cerebral Palsy for the General Practitioner", Medical Times, April, 1953
-"The Significance of Delayed Development in the Diagnosis of Cerebral Palsy" Journal of Pediatrics, April, 1951
- Perlstein, Meyer A., "Medical Aspects of Cerebral Palsy", Nervous Child, 1949
- Powers, Ann M., "Mother-Child Relationships in Rehabilitation of the Physically Disabled". Social Casework June, 1951
- Kelman, Howard R., "Parent Guidance in a Clinic for Mentally Retarded Children"., Social Casework, December, 1953

C. Miscellaneous

Proceedings of a symposium conducted by United Cerebral Palsy of New York City, Inc. in cooperation with The Study Group of Social Workers in Cerebral Palsy, Cerebral Palsy, A Social Problem, November, 1953

Material Compiled for publicity purposes for M.F.D.C.P. Clinic, 1951

Jones, Winifred H. A Study of Cerebral Palsied Children Who Have Been Dismissed From School, 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, June, 1952

APPENDIX

Schedule

I. Identifying Information

A. Research	Clinic
B. Address	Birthdate
C. Age at admission	Religion
D. Source of referral	Sex
E. Different diagnosis prior to admission	Race

Treatment: OT _____ PT _____ ST _____
Surgery _____ Medication _____

F. Age of child when abnormality was first observed:
Noted by 1) M D 2) Mother 3) Other
Diagnosed as CP: Age _____ Authority _____

II. Social History at Time of Admission:

A. Constellation	Age at birth of CP Child	Marital Status
------------------	--------------------------	----------------

1. Father

2. Mother

3. Children (a) At home (b)

(1)

(2)

(3)

(4)

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 member 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

1. Employed	Unemployed occupation
-------------	-----------------------

- a. Father
- b. Mother
- c. Siblings
- d. Other

Income

Financial Assistance

2. Insurance: Group Health: Yes No

D. Attitudes: As observed by:

- 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, disability or illness
- 3. Labor: normal prolonged other
- 4. Delivery
 - Breech Footling Head Transverse Versional and
 - Extraction Instrument Anesthesia Analgesia
- 5. Birth:
 - Caesarian Normal Premature Precipitat Delayed Other
- 6. Para Gravida Which pregnancy CP Miscarriage(s)

B. Child

- 1. Birth
 - Normal Anoxia Cyanosis Jaundice Resuscitation Convulsions
 - a. birthweight 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. Patients disposition as reported by:
- 5. Illness or accident after birth:

IV. Training and Education:

- A. Level of Achievement
- B. Number of schools attended
- C. Number of dismissals / withdrawals
 - Reasons
- D. Reason no 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 "

In contact

M.A. _____

I.Q. _____

Practically measurable

Largely out of contact

Test used:

Amonons

Ravens

Revised Stanf - Binet L

Modification of

1. Proceedure

2. Material

Outlook for educability:

Good Fair Poor

VIII. Diagnostic Advisory Study:

A. Recommendations:

1. Re-evaluation

2. Treatment

out-patient

home care

referral

AT

PT

OT

Casework Services

B. Present Disposition of Case:

1. In treatment

institution

deceased

2. Result of treatment:

No improvement

some

marked

PT

OT

ST

C. Prognosis

Master Schedule

Residence

City
Suburb
State
Out of State

Identifying Info

Male - Female
Religion
Parental Marital Status
Foster parents
Adoptive parents
Age of Father at birth of patient
Age of Mother at birth of patient
Number of Siblings
Patient position in family
Other Cp in family
Other illness in family

Source of referral

Professional
Agency
Publicity
Friend

Living Arrangements

Rent
Own
Living with relatives

Economic Status

Employed
Unemployed
Financial Assistance
Occupation
Insurance

Attitudes

Father
Mother
Siblings
Others

Observed by

MFD
Board of Education
Agency
Professional

Marital Status**Birth History**

Complications during pregnancy

Para

Gravida

Which Pregnancy CP

Miscarriages

Normal

Precipitate

Prolonged

Term

Pre-mature

Head

Transverse

Vers. and Ext.

Breech

Footling

Instrumental

Caesarian

Drugs

Birth

Normal

Anoxia

Cyanosis

Jaundice

Resuscitation

Convulsions

Birth Weight

Feeding Method

Physical Development

Head erect

Sat alone

Stood alone

Walked alone

First words

Toilet trained

Pathological Div.

Age manifested

Observed by

Mothers account of symptoms

Onset of convulsions

Illness / accident

Age diagnosed CP**Diagnosis by MFD MD**

Age Admission

Type

- Athetoid
- Spastic
- Rigid
- Atoxic
- Tremor

Involvement

- Hemiplegia
- Diplegia
- Paraplegia
- Quadriplegia

Training Education

- In school
- Withdrawals
- Dismissals
- Special
- Ungraded
- Nursery

Social Activity

- Spectator
- Solitary
- Participant

Child's behavior

Psychological Evaluation

Tests used:

- Ammons
- Ravens
- Revised S.B.
- Vineland
- Other

Modifications

Measurable

Partially "

Partially "

Non "

IQ

Educability (GFP)

Prognosis (GFP)

Treatment

- Institution
- Clinic

Disposition

Closed

Custodial

No return

Out of State

Deceased

Other

Results of treatment

OT

PT

ST

Psychotherapy

Mother

Father

Child

MWH Residence

Different diagnosis