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UNIVERSITY OF LOUISVILLE

HOME INSTRUCTION FOR PHYSICALLY HANDICAPPED WHITE CHILDREN IN LOUISVILLE, KENTUCKY 1939-1940 to 1943-1944, INCLUSIVE

A Dissertation

Submitted to the Faculty

Of the Graduate School of the University of Louisville

In Partial Fulfillment of the

Requirements for the Degree

Of Master of Arts

Department of Education

(Visiting Teacher Curriculum)

By

Caroline Finzer Gray

Year

1944

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July 2015

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TITLE OF THESIS: HOME INSTRUCTION FOR PHYSICALLY HANDICAPPED WHITE CHILDREN IN LOUISVILLE, KENTUCKY 1939-1940 to 1943-1944, INCLUSIVE

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HOME INSTRUCTION FOR PHYSICALLY HANDICAPPED WHITE CHILDREN IN LOUISVILLE, KENTUCKY, 1939-1940 to 1943-1944, INCLUSIVE

HOME INSTRUCTION FOR PHYSICALLY HANDICAPPED

WHITE CHILDREN IN LOUISVILLE, KENTUCKY,

1939 - 1940 to 1943 - 1944, inclusive

INTRODUCTION

Eighty-four children have been enrolled in Home Instruction given by the Louisville Public Schools, during the past five years, 1939-1940 to 1943-1944, inclusive.[1] Home Instruction is given only to those children who cannot attend school, due to various physical handicaps.

The writer[2] feels that it will be profitable to examine the data collected concerning the eighty-four pupils, not only for the guidance of those intimately concerned with the Louisville program, but also for the information of similar workers in other cities and of the large numbers of lay people whose chief interest is due to their feeling that "the physically handicapped child is as much entitled to a

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1 Although the Home Instruction program was inagurated in September, 1938, the first year was not typical of the present set-up, as the enrollees included some children who, except for the lack of transportation facilities, could have attended a special class.

2 The writer has taught cardiac and orthopedic cripples and children home-bound due to other causes for almost six years.

public school education as is the normal child".[1]

The data will be examined for information as to the composition of this group of eighty-four atypical children: where they live; what their families are like, what kind of homes they have, what the physical handicaps are, how old the children are when they enter Home Instruction and how much schooling they have had prior to their entrance, how much their illness has retarded them, whether Home Instruction is an effective means of helping them to keep up with their education, how long they are enrolled, and where they go when they are no longer confined to their homes.

The material used in this study has been gathered from the files of the Louisville Board of Education's Department of Health and Safety. Records used were the file cards and achievement tests. Routinely, achievement tests are administered by the Home Teacher upon enrollment and upon discharge, with three exceptions (1) those who, because they have had no previous schooling, obviously cannot take an achievement test, (2) those who, having completed 9A in Home Instruction, go to the Bureau of Research for high school entrance examinations[2] and (3) those who enrollment terminates abruptly

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[1] Russell M. Bythewood, "The Home-Bound Pupil in Lincoln Public School System: As Seen by a Parent". <u>The Oklahoma Parent-Teacher Bulletin</u>, February, 1939, Vol. II, No.6, p.10.

[2] This is more fully explained in Chapter VI.

will illness or removal from the city. In the beginning, this testing program included only pupils above the fourth grade, so that only thirty-five complete sets of test scores covering the entire period of enrollment could be used in analyzing the data on scholastic progress. However, some of the incomplete material is used in the case studies.

At a given time, about sixty-five white physically handicapped children are enrolled in one of three special classes or in Home Instruction. The latter usually comprises about 20 per cent of the total, or thirteen pupils. At the close of the semester in June, 1944, twelve children remained on the Home Instruction roll. However, eight of these pupils were expected to enter a special class in September. Placement will be made upon recommendation of the child's physician, as the policy of the Louisville Board of Education requires a physician's statement[1] at the first enrollment in Home Instruction and at the beginning of each ensuing school year, unless the child has returned to regular school. Similarly, a physician's statement is presented for each pupil of a special class, except those orthopedic cripples whose physi-

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[1] A copy of the Physician's Statement will be found in the Appendix.

cal condition obviates the possibility of attendance at a regular school.

As to length of enrollment, there are three types of cases:

1. Short-time cases (one semester or less).
2. Children facing long periods of convalescence.
3. Virtually permanent cases.

More than half of the eighty-four Home Instruction pupils were enrolled for one semester or less, while one-fourth were enrolled for six months to one year.

The handicaps which caused the children to become Home Instruction pupils may be classified into four broad groups:

1. Chronic illness.
2. Disabilities caused by illness.
3. Congenital defects.
4. Injuries.

The largest group is the first; 69 per cent of the children suffered from chronic illness, of which rheumatic heart disease was the most frequent handicap. Of the total number of Home Instruction pupils, 34.5 per cent had rheumatic heart disease.

The homes of the children were widely scattered. With the exception of a small area adjacent to the Children's Free Hospital, which was served by the teacher at that Institution,

almost every school district was represented by at least one Home Instruction pupil. In trips between her home and that of her pupils, the writer averaged eight hundred miles of automobile travel per month.

The writer will endeavor to show whether the Home Instruction pupils were able to profit academically from the program. Also, she will discuss in which ways the children's homes and families are like those of any other child, and in which ways they differ.

CHAPTER I

SPECIAL EDUCATION FOR PHYSICALLY HANDICAPPED CHILDREN IN THE UNITED STATES

SPECIAL EDUCATION FOR PHYSICALLY HANDICAPPED CHILDREN IN THE UNITED STATES

DEFINITION OF THE TERM "SPECIAL EDUCATION"

Special education is the education of children who, due to various types of handicaps, cannot attend regular classes.

THE AIM OF THE PROGRAM

The special education program aims to enable the child to adjust to his handicap in order to lead a life as nearly normal as possible. As McLeod puts it,

> "The aim of the special education program for crippled children is to fit the individual to take his place in the social and economic world, and to train him to apply his ability and knowledge to the highest degree of efficiency of which he is capable. One of the most serious handicaps of the cripple comes from the limitation of normal social and cooperative relations resulting from his physical condition. This inability to become a part of the social group is often due to a feeling of isolation which comes from a consciousness of the handicap. Hence, insofar as possible the child should be placed in an environment of group fellowship and of active participation in group experiences. He should not be permitted by means of segregation, or by shielding, which delay adjustment into the normal life of the community to develop a "cripple psychology" and a feeling of being different from other children. He should be given an opportunity and should be encouraged to develop initiative and independence. In order to teach him to cooperate as well as to compete, it is essential to develop within

> him the self confidence which will later enable him to mingle and cooperate with his normal associates in a normal community." [1]

THE VALUE OF THE PROGRAM TO THE COMMUNITY

There is abundant evidence that those interested in the educational programs for handicapped children feel that it is most worthwhile. The general attitude seems to be that the child should receive his education during the years that are school years for all children, handicapped or normal, but that the handicapped child may need more help in vocational guidance, training and placement. Many children who have handicaps in early years go on into adulthood and compete on a common basis with those who had no handicaps to overcome. If, during childhood, handicaps can be alleviated and education can be provided, the erstwhile dependent can be made self-supporting, thus relieving the state of the necessity to support him.

> "In many cases, the child can be restored to normal or nearly normal condition through operative procedures. It is not uncommon to see a badly crippled child spend his elementary school years in a special school and

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[1] Beatrice McLeod, Teachers' Problems With Exceptional Children, Research Bulletin of the United States Department of the Interior, Washington, D.C., 1934, p.16.

> then by virtue of his special school program, plus medical treatment, go on to high school and fit in naturally with normal children." [1]

This quotation, of course, applies only to the crippled child. Miss Mary May Wyman was asked whether the deaf child was able to compete with physically normal children. Her reply was that, after the deaf child has successfully completed the ninth grade in the special classes, he is able to attend high school on an equal basis. However, the child who has attended special classes for the deaf since four years old and has had little success before he reaches high school age is not likely to make a good adjustment to normal competition.[2]

The blind child, perhaps more than any other physically handicapped child, needs special vocational help.

The delicate child, having less obvious handicaps, has an emotional problem to solve. To the lay eye physically normal, he receives less consideration than other handicapped

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[1] Merrill T. Hollinshead, "Types of Provisions for Children With Physical Handicaps", The National Elementary Principal, Vol. XIX, No.6, July, 1940, p.486.

[2] Mary May Wyman, Supervisor of Special Classes for physically handicapped children in Louisville, Unpublished lecture to Seniors in The University of Louisville Medical School, June, 1944.

children. Those who work closely with such children are thoroughly familiar with the would-be helpful neighbor or cousin who says that there is nothing wrong with that child except his mother's spoiling, and that he ought to get out and play as all the other children do. This is the child who even more than other handicapped children must learn to be realistic about his problems and to live in such a way that he does not overstep his limitations. Once he has learned what he can do with impunity, he can lead a very comfortable life and earn his own way. Powell says of such children,

> "Many, many extremely handicapped children develop into self-supporting, independent successful men and women. Money spent in rehabilitating the health and well-being of a child earns society large dividends when that child becomes an adult.
>
> . . . .
>
> The handicapped child must receive a basic education and must learn to apply it if he is to avoid adult dependency." [1]

That special education can mean the difference between dependency and independence is brought out by Wyman:

> "Are these children worth the effort? A thousand times, yes. Economically the state cannot continue in her neglect. Neglected physically handicapped children bid fair to become state wards who must be supported through a dependent adulthood and old age. The self-sustaining

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[1] Frank V. Powell, "Wisconsin's Program for Its Handicapped Children", Journal of Exceptional Children, February 1942, p.144.

> handicapped adult is the happy, useful citizen - living a normal life." 1

The importance of vocational guidance and placement is stressed by Patterson.

> "Every crippled child is a liability which should be turned into an asset to the community. We contend that every crippled child has a right to vocational placement. Unless the child, after having been given proper physical care and treatment and having been educated and trained, is actually placed in a proper position in life, all that has gone before is of no avail." 2

In time, it is to be hoped that every physically handicapped child will be able to look forward to a program of education which will enable him to be economically independent. That the program is growing will be shown in another section of this chapter.

THE VALUE OF THE PROGRAM TO THE CHILD

Aside from providing for future needs as to adult economic standing, education for physically handicapped children has an immediate beneficial effect, particularly for the

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1 Mary May Wyman, "Handicapped Children in Kentucky", Kentucky School Journal, Vol.19, No.3, November, 1940, p.23.

2 William J. Patterson, "They Do Grow Up", Hospitals, Vol.13, No.11, November, 1939, p.75.

crippled child who has just undergone an operation and for the delicate child who is going through a long period of convalescence. It is felt for these two classes of physically handicapped children, education has a definite therapeutic value. In these cases, education obviously takes the form of bedside instruction in hospital or home.

> "It should be remembered that not all crippled children are sick children, and except for a few days following surgery, the child will make a speedier recovery, if he is happily occupied with constructive work. If he can be helped to keep up with his regular school work, one of the most serious handicaps to successful treatment will have been eliminated. Individuals who work with the crippled child during the treatment and the convalescent periods know that his greatest worry is getting behind in school". [1]

The contribution of special education in regard to the continuity of the handicapped child's educational program is brought out by Darlington:

> "The value of home study to the physically handicapped child who has been starving for an educational opportunity so long are innumerable. In place of

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[1] Meredith W. Darlington and Ruth E. Wendell, "Crippled and Isolated Children", The Phi Delta Kappan, Vol.XXII, No.4, December, 1939, p.168.

> a life of idleness and shiftlessness, there is now purposeful activity. In place of frequent, and sometimes prolonged hiatuses in education, there is a continuous program of learning. In place of special abilities or capacities withering away, there is now encouragement and development. In place of unsolicited suggestions and advice, there is wise educational and vocational guidance. In place of becoming a desolate, gloomy, crippled adult, there is now the opportunity to become a self-supporting, contributing member of society." [1]

In the writer's own experience, it is quite usual to hear the mother exclaim that, since the child had started having lessons, he had been so much happier and so much more willing to follow the doctor's orders about remaining quiet. Strange as it may seem to those acquainted only with physically normal children, vacations and holidays are often very unwelcome to the home-bound child.

THE CLASSIFICATION OF PHYSICALLY HANDICAPPED CHILDREN

Physically handicapped children are divided into five classifications. The committees of the White House Conference in 1931 adopted the following:

1. Crippled.

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[1] Meredith W. Darlington, The Physically Handicapped Child Rings His Own School Bell, Bulletin released by the National Society for Crippled Children of the United States of America, Inc., Elyria, Ohio, January, 1939.

2. Deaf and Hard of Hearing.

3. Blind and Partially Seeing.

4. Speech Defective.

5. Children of Lowered Vitality - anemic, pre-tuberculous and cardiopathic.[1]

Martens and Foster group their statistics on physically handicapped children in this way:

1. Blind and partially seeing.

2. Deaf and hard of hearing.

3. Speech defective.

4. Crippled.

5. Delicate.

The writer feels that group served under the fifth classification might be more clearly indicated as "Delicate and convalescent".

SPECIAL EDUCATIONAL PROVISIONS FOR PHYSICALLY HANDICAPPED CHILDREN

1. Crippled children.

Crippled children are cared for in several different ways, according to the extent of crippling. For the least affected, special care in his regular school may be sufficient.

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[1] J.E.W.Wallin, The Education of Handicapped Children. pp.37-38.

One-floor schedules, permission to absent himself from physical activities, or early dismissal at recess or other periods, so that he can move about the building while the halls are uncrowded, are sufficient to enable him to attend school with a minimum of danger to himself. If his crippled condition is more severe, he must be provided for in a special class with other crippled children. The White House Conference defines these children:

> "A crippled child eligible to attend a special school or class for crippled children is one who, by reason of disease, accident, or congenital deformity, cannot attend the regular school with safety and profit during the period of his physical rehabilitation, simultaneous mental training and social adjustment.
> "A child for whom physicians and surgeons have recommended the daily care of nurses and physiotherapists.
> "A child who must have transportation service to reach school, specially adjusted furniture or other facilities.
> "A child who needs special attention in vocational guidance, training and placement.
> "A child handicapped by cardiac complications or other medical conditions for whom no other provision has been made.
> "A child who requires plastic surgery which must be followed by muscle training or speech training." [1]

For a few crippled children, home instruction is the only solution. These are the children whose presence is un-

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[1] The White House Conference, <u>Special Education: The Handicapped and the Gifted</u>", p.23.

pleasant to others, such as those who have not acquired bladder and bowel control, and the athetoid cerebral palsy cases whose movements would be distracting in a classroom. McLeod sums up the other cases for whom home instruction is necessary thus:

> "It is generally accepted that Home Instruction should be provided only for those pupils who are confined to the home because of physical disability. In communities where Home Instruction has not been authorized, other arrangements should be made to bring instruction to the home-bound child. Even in isolated places, the regular teacher can often so schedule her time as to furnish a few hours' instruction during the week or on Saturday. The expense incurred with the few cases likely to occur in isolated communities should be provided for by the local school board." 1

2. Delicate children.

Delicate children may have shortened school-days, with special schedules or may have rest periods during the school day, if they remain in regular schools. Some school systems maintain open-air classrooms or open-window classrooms for pre-tuberculous children. During hospitalization and convalescence, these children may have bedside teaching by one of three methods, and upon improvement, may be sent to special classes. The three methods of home teaching are: 1, instruction by a teacher who visits the child's home to teach him,

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1 Beatrice McLeod, op.cit., p.14.

assign "homework" and check the preparation of previous assignments, 2, correspondence courses with supervision, as practiced in Benton Harbor, Michigan and Nebraska,[1] and 3, two-way telephone connection between the child's classroom and bed-room, as practiced in Iowa.[2] The latter was started in 1939 and by 1941, more than seventy sets were in use. This was in addition to 196 home teaching cases. . . . The cost of the unit, in June, 1942, was $65.00[3] and the monthly service charge was $1.25 per month for the first quarter mile and .75 per month for each additional quarter mile. The distance used in computing the monthly bills was the measured mileage from the school to the home, without regard for the length of the telephone wires.[4] The average cost per pupil

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[1] Meredith W. Darlington, "A Special Education Service for Home-Bound Physically Handicapped Elementary Youth", Address read before Special Education Group, N.E.A., San Francisco, 1939.

[2] S.R. Winters, "School Goes to the Handicapped Child", Hygeia, July, 1943, p.508.

[3] E.S. Schmidt, Radio Laboratories, Omaha, Nebraska, letter to National Society for Crippled Children.

[4] Jessie M. Parker, "School via a Box", The Crippled Child, August, 1941, p.43.

served was $40.00.[1]

3. Deaf and Hard of Hearing Children and Blind and Partially Seeing Children.

While it is possible that a few deaf and hard of hearing children and blind and partially seeing children are being taught at home, the writer found no statistics on such cases, and concluded that the vast majority of these children who were provided for attended school, either day classes, or in the case of blind and deaf children, residential schools. Martens and Foster do not separate the data on special schools and classes in city schools systems for deaf and hard of hearing or for blind and partially seeing; however, the statistics on residential schools are for blind or deaf only. The inference is that children with partial visual or auditory handicaps do not attend residential schools.

4. Speech defectives.

Children with speech defects are not usually placed in special classes but are generally cared for by special instruction during the school day; that is, they are given a period of speech correction work during the day, but spend the rest of the day in regular classrooms. Martens and Foster show that 68.3 per cent of the physically handicapped children receiving

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[1] S.R.Winters, op.cit., p.508.

special education are children with speech defects.

STATISTICS ON NUMBER OF PHYSICALLY
HANDICAPPED CHILDREN RECEIVING SPECIAL
EDUCATION IN THE UNITED STATES

In 1940, Martens and Foster gave the following enrollment for physically handicapped children receiving special education in special schools and classes in city school systems:

1. Blind and partially seeing	8,812
2. Deaf and hard-of-hearing	13,471
3. Speech defective	126,127
4. Crippled	14,565
5. Delicate	21,575

statistics for residential schools follow:

1. Blind	5,870
2. Deaf	14,673

Enrollment for home and hospital instruction was 16,909 of which 11,209 were crippled, 5,217 were delicate, 63 blind and partially seeing, 17 deaf and hard of hearing, 307 epileptic and 77 mentally deficient. Note that separate figures for home instruction were not given.

THE NEED FOR FURTHER DEVELOPMENT

Only about one-tenth (11.9 per cent) of the estimated number of physically handicapped children for whom special educational services were needed were being provided for in 1940. Table I shows that, as conservatively estimated, 1,865,000 physically handicapped children were in need of special educational services while only 221,618 were being provided for.

TABLE I

NUMBER OF CHILDREN FOR WHOM SPECIAL EDUCATIONAL SERVICES ARE NEEDED AND NUMBER OF CHILDREN ENROLLED IN SPECIAL CLASSES, CLASSIFIED ACCORDING TO TYPE OF HANDICAP (IN CONTINENTAL UNITED STATES, 1939-40)[1]

Type of Handicap	No. of children for whom provision is needed	No. of children for whom provision is made	Per cent Col. 2 is of Col. 1
1. Blind and partially seeing	65,000	14,745	22.7
2. Deaf and hard of hearing	400,000	28,151	7.
3. Speech defective	1,000,000	126,146	12.6
4. Crippled	100,000	25,784	25.7
5. Delicate	300,000	26,792	8.9
Total	1,865,000	221,618	11.9

[1] Elise H. Martens and Emery M. Foster, Statistics of Special Schools and Classes for Exceptional Children, Vol. II, Chapter V. Table 5, p. 12.

In 43 states and the District of Columbia 729 different cities contributed to these figures. Only three states were making no provision for special classes. These states were Mississippi, Nevada and New Mexico; however, three states operating under county unit systems were not included. These states were West Virginia, Florida and one other not mentioned by name.

EVIDENCES THAT THE TREND IS TOWARD EXPANSION OF THE PROGRAM

Judging from comparison of statistics given in studies on the education of physically handicapped the trend is toward greater enrollment for most of the children. The enrollment is increased in two ways; not only are more children being given the opportunity to have an education, but also the physically handicapped adolescents are being accepted as a responsibility of the secondary schools. There is an unexplained slight decrease in services for speech defectives.

Heck gives the credit for the establishment of the first institution for the care and education of crippled children to Bavaria; this was in 1832. In the United States, the first class for crippled children was started in 1899, in Chicago.[1]

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[1] J.E.W.Wallin, Education of the Handicapped Children, p.37.

TABLE II

HISTORICAL SUMMARY SHOWING DEVELOPMENT OF SPECIAL EDUCATION PROGRAM IN CITY SCHOOL SYSTEMS 1932 to 1940, INCLUSIVE

	No. of states and cities reporting special schools and classes		Number of pupils enrolled
Year	States	Cities	
	Blind and partially seeing		
1932	20	95	5,308
1936	27	161	7,251
1940	28	181	8,875
	Deaf and hard-of-hearing		
1932	24	116	4,434
1936	31	168	9,318
1940	30	168	13,478
	Crippled		
1932	24	145	16,166
1936	30	301	24,865
1940	31	356	25,784
	Delicate		
1932	28	135	24,020
1936	30	150	23,517
1940	27	166	26,792
	Speech defective		
1932	(1)	(1)	22,735
1936	22	123	116,770
1940	29	144	126,146

(1) Data not available.

(All data taken from Table I. Historical summary of statistics reported for special schools and classes in city school systems. Elise W. Martens and Emery M. Foster, "Statistics of Special Schools and Classes For Exceptional Children," 1939-40, p.7.)

Table II indicates that, in the four-year periods covered in this summary, each classification of physically handicapped children has had an increase in enrollment, although there has not been much growth in the number of states providing special schools and classes in city schools systems, except for speech defectives. The table from which these statistics were taken gave information beginning in 1922 for the blind and partially seeing and for the deaf and hard-of-hearing, whereas data were not available before 1930 for the crippled and for the delicate and not before 1932 for the speech-defective children.

It is interesting to note the present number of teachers of physically handicapped children, in view of the estimated number of children needing special education. Table V, showing the number of teachers of physically handicapped children in 1940, with the number of children enrolled and the estimated number needing special education, seems to indicate a great field for special teachers. Data on the training of these teachers were not given.

TABLE III

NUMBER OF TEACHERS OF PHYSICALLY HANDICAPPED CHILDREN, PRESENT ENROLLMENT AND NUMBER OF CHILDREN ESTIMATED TO NEED SPECIAL EDUCATION, CLASSIFIED AS TO TYPE OF HANDICAP[3]

	Number of teachers, 1940 in residential schools and city school systems[1]	Enrollment 1940	Estimated number needing special education
1. Blind and partially seeing	1,535[2]	14,745	65,000
2. Deaf and hard-of-hearing	2,843[2]	28,151	400,000
3. Crippled	815	25,784	100,000
4. Delicate	865½	26,792	300,000
5. Speech defective	438	126,146	1,000,000

[1] Excluding 1,381½ home and hospital teachers.

[2] Twelve of these teach both the deaf and the blind, appear only onwe in totals.

[3] Elise W. Martens and Emery M. Foster, op. cit.,

Teachers Table 10, p.25.
Enrollment Table 5, p.12.

INFORMATION ON HOME INSTRUCTION IN THE UNITED STATES

The writer found little detailed information on home instruction, with the exception of the material on the Iowa plan of two way communication and the Nebraska and Benton Harbor, Michigan plans of supervised correspondence courses, both of which methods were mentioned earlier in this chapter. The most detailed information as to the administration program was given in a bulletin of the Malden, Massachusetts, Public Schools.[1] However, the inference from the information contained therein was that there were no special classes for physically handicapped children, but that all these cases were cared for by home instruction, as with a school population of 11,122, Malden had an average of 50 "home students". With a white school population of 48,013[2] Louisville has an average of 22 white home instruction pupils as the majority of the white physically handicapped children are able to attend one of the three special classes.

In Malden, each teacher visits four pupils per day, for one hour periods, the high school teachers seeing ten pupils

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[1] "Synopsis of Detail of Procedure with Home Instructed Students", Bulletin of Malden Public Schools, 1941.

[2] Statistics furnished by Bureau of Census, Louisville Public Schools.

per week and the junior high school and elementary teachers seeing seven pupils per week. The high school pupils are given one hour of instruction per subject per week, total four to five hours per week, with four to five hours daily homework expected. The junior high school pupils have three one-hour lessons per week with two to three hours daily of home work expected, while the elementary pupils, with three one-hour lessons per week are expected to do home work for from half hour to two hours daily. All the home work requirements however, are subject to the limitations set by the child's physician.

One full-time high school teacher teaches history and English, which are required subjects, while other high school subjects desired are taught by regular high school teachers who are sent to the homes of the home students from 2:30 to 3:30 P.M., after the regular classes are over. A full-time director and one full-time elementary teacher complete the staff. Either teacher may be required to teach junior high school subjects. Substitute teachers are added as required.

The general procedure seems to be to give the home instruction pupils the same course of study that is followed in the schools. Those who commented on the topic said that progress in academic subjects was often even better than that made in attendance at regular school and that achievement after

the pupil returned to school was uniformly gratifying.

The usual opinion of those who were not intimately concerned in the program of home instruction was that the children probably could not make as fast progress at home; these people had to be convinced.[1] The story of Berenice as told to illustrate this point is typical of several such stories.

After attending public school for seven years, Berenice had home instruction while lying in a specially prepared bed with thirty pounds of weights pulling her spine into shape. Berenice had looked forward to graduation from the eighth grade, and she wanted her report card and diploma to come from her former school. However, she was having only five hours of school per week, so the principal refused her the report card. Berenice worked so hard that she completed the wighth grade in one semester. When the vice-principal came to her home and gave her the 8A examinations, she not only passed, but made the highest grade in her class. The happy ending came; the principal, himself, came to her home and presented her diploma from her old school, just as she had desired.

While the writer cannot give any such exciting finishes to her case studies, the information in Chapter VI will show that Berenice's achievement was not unusual.

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1. Mary W. Lyons, "Special Adjustments in Branch Brook School", The Binet Review, November, 1935. p.24.

CHAPTER II

SPECIAL EDUCATION FOR PHYSICALLY HANDICAPPED CHILDREN IN LOUISVILLE

SPECIAL EDUCATION FOR PHYSICALLY HANDICAPPED CHILDREN IN LOUISVILLE

The program of special education for physically handicapped children in Louisville has been developing fairly regularly since 1912, at which time the Audubon Open Air Class for "below-par" children was opened. This class at first included only grades two and three.

STEPS IN THE DEVELOPMENT OF THE PROGRAM

Search through the old directories of the Louisville Board of Education since 1893 reveals the dates of various steps in the development of the department of Special Education for Physically Handicapped Children, as follows:

1912 - The Audubon Open Air class was opened and one teacher was provided. The Board of Tuberculosis Hospital furnished a nurse. Active cases of tuberculosis were not accepted at this school; such cases were sent to Waverly Hills Sanitorium. This was before the wide use of X-ray and the Manteaux test.[1]

1913 - Grade four was added to the Audubon Open Air class. Presumably this was partly due to promotion of the previous year's third grade pupils.

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[1] Information furnished by Miss Mary May Wyman, Supervisor of Health and Safety Education, Louisville Board of Education.

1914 - A second teacher was added and the name was changed to Audubon Open Air School; the first teacher became a teaching principal.

1915 - The Children's Free Hospital Class was added to the program. This class is the oldest one included in the present set-up.

1917 - The Louisville Board of Education assumed financial responsibility for the nurse at the Audubon Open Air School.

1918 - For the first time, the directory had a special section for "special classes". The latter included two classes for the mentally exceptional. Also an open-air class was added at J. Stoddard Johnson School.

1919 - A third open-air class was added, this met at Madison Street School until 1925, at which time expansion of Western Junior High School, housed at the same location, led to discontinuation of Madison Street School.

1924 - An open-air class for Negro children was opened.

1926 - A teacher was assigned to Kosair Crippled Children's Hospital, newly opened, to teach the patients. A class for day attendance by Louisville children was also opened at the same location. The latter were taken to school daily in Police Squad cars until June, 1935.

1927 - A teacher was assigned to the crippled children's ward at the Kentucky Baptist Hospital.

A class for deaf children was opened at George W. Morris School.

1929 - Open Air classes were discontinued. This was in line with new thought on the treatment of tuberculosis.

1932 - The crippled children's ward was moved from the Kentucky Baptist Hospital to St. Joseph's Infirmary for one year. The teacher moved with the class.

1933 - The Kosair City class was moved from the basement of the hospital building to make room for a brace shop. The Louisville Board of Education built a "portable" class room on the grounds of the hospital, located near the driveway for the convenience of pupils using wheelchairs or crutches.

1934 - The first Sight-Saving Class was opened at Gavin H. Cochran School. Grades one through five were included.

1935 - A second Sight-Saving Class was opened. This included grades one through three and was held at Johnson School. The class at Cochran School was for grades four through six.

1936 - Junior high school sight-saving classes were opened at Madison Junior High School (for Negroes) and at Halleck Hall. Three deaf-oral classes were being held; one at Parkland Elementary School and two at Emerson School. A teacher was sent to General Hospital to teach the patients in the poliomyelitis ward, in January.

1937 - The three deaf-oral classes were all held at Emerson School.

The poliomyelitis ward at General Hospital was closed in January, 1937.

1938 - White Home Instruction was begun.

Five elementary sight-saving classes were in operation. All included grades one through six. In addition to Cochran and Johnson Schools, Longfellow, Salisbury and Dunbar were added, the latter being for Negroes.

The Halleck Hall class was moved to Barrett Junior High School, where it remained through June, 1944.

In accordance with the recommendations of the Works Survey, the class is to be located at Halleck Hall again, due to better transportation facilities for the present enrollment.

1939 - Speech correction was begun, with one white teacher traveling from one school to another, all over the city. Two additional classes for white crippled and delicate children were held; one in the southern section of the city, at Charles D. Jacob School, and one in the west-central section at F.D. Salisbury School. Transportation was furnished by various clubs which contributed toward the taxi bill. Seven sight-saving classes were being held.

1940 - The classes for crippled and delicate children were not opened until the semester was half over; the clubs

which had contributed the taxi transportation felt that the Board of Education ought to assume financial responsibility. Since discontinuation of the practice of furnishing transportation by the Louisville Police Department, various interested persons and clubs had furnished three taxis for the Kosair city classes.
Another speech correction teacher for white children was added.

1941 - The Board of Education assumed financial responsibility for the taxi-cabs.
A Negro home teacher was added.

1942 - Another deaf-oral class was added at Emerson School.
The Negro home teacher was assigned to bedside teaching at Red Cross Hospital for part of the time, varying with the number of children being treated there.

Table IV shows the first establishment of atypical classes for physically handicapped children in Louisville and in public schools of 52 cities.

TABLE IV

DATE OF FIRST ESTABLISHMENT OF ATYPICAL CLASSES IN PUBLIC SCHOOLS OF[1] 52 CITIES OF OVER 100,000 POPULATION AND IN LOUISVILLE

	Date of establishment	
	Louisville	Other cities
Anemic	1912	1902 - Chicago
Blind	--	1878 - Chicago
Sight-saving	1934	1910 - Newark
Cardiac	1939	1913 - Philadelphia
Crippled	1926	1901 - Chicago
Deaf	1927	1869 - Boston
Hard of hearing	--	1869 - Boston
Homebound	1938	1915 - Milwaukee and New York
Hospital	1915	1912 - Seattle
Open-air	1912	1904 - New York
Speech	1939	1910 - Detroit
Tubercular	--	1904 - New York

[1] From Robert W. Kunzig "Public School Education of Atypical Children" Bulletin, 1931, No.10, United States Department of the Interior, Washington, Government Printing Office, 1931. pp.70-71.

THE PRESENT SET UP FOR SPECIAL EDUCATION IN LOUISVILLE

The program for special education is supervised by Miss Mary May Wyman, supervisor of Health and Safety Education. However, beginning with the school year 1944-45, health education will be transferred to the department of physical education, and supervision of special education for mentally exceptional children will be added, thus including under one department all special education for exceptional children, as recommended by the Works Survey.

Services for crippled and delicate children include a white home teacher, a colored home teacher who devotes part of her time to bedside teaching at the Red Cross Hospital, a white bedside teacher who divides her time between children's Free Hospital and the Jewish Children's Home, where convalescent care is given and three classes to which crippled and delicate children who cannot attend their regular neighborhood schools are given taxi transportation paid for by the Louisville Board of Education. In some cases, children within reach of public transportation are so slightly handicapped that special schedules can be arranged at regular schools. These are junior or senior high school students who are given one-floor plan schedules or part-time schedules inthe school most accessible, which is not necessarily the school nearest the child's home. These special arrangements are requested through the health

counselors in the school most convenient to the child's home, upon receipt of the Doctor's statement requesting special class; that is, if one of these older pupils needs special consideration, and public transportation is convenient, the writer calls the health counselor to inquire whether a one-floor schedule can be arranged for the child. If this is possible, the supervisor then writes to the doctor attending the child, and informs him that, subject to his approval, his patient can be given such a schedule in a regular school, but that transfer to a special class will be made if the doctor feels that this is preferable from a health standpoint. The choice is invariably the doctor's. During the past school year, eight white children and five Negro children were given such arrangements.

For the deaf, there are four classes for white children at Emerson School. These classes are grouped in one school to provide better grading facilities and to make equipment available to all the pupils. Colored deaf children are sent to the Kentucky School for the Deaf, a residential school located in Danville, Kentucky, and established in 1822.

For the hard-of-hearing, no special class provisions are made, unless the handicap borders upon deafness, in which cases, white children may be sent to Emerson School. Children suspected of loss of hearing by their parents or by their teachers are given individual audiometer tests at the Admin-

istration Building of the Louisville Board of Education by the speech correctionists or the supervisor, and are interviewed, with their parents, by the latter, to determine whether the child has been given every possible medical care in order to alleviate the condition. Parents are urged to bend every effort to see that the child gets as much medical attention as he needs.

No provision need be made for blind children by the Louisville Board of Education, as the Kentucky School for the Blind, located in the city, takes care of these cases.

Partially-seeing children are provided with seven classes. White elementary pupils may choose between four classes, according to convenience in transportation. White junior high school pupils attend a sight-saving class at Halleck Hall. Negro elementary pupils attend a sight-saving class at Paul Dunbar Colored School, while the Negro junior high school sight-saving class is held at Madison Street Colored Junior High School.

White children with defective speech are given class instruction by one of two teachers, and in a few cases, are given individual instruction at the administration building of the Louisville Board of Education. One such case is a spastic home instruction pupil who is taken to the Administration Building once each week for a special lesson. The two teachers do not visit every school. Scattered schools are

chosen for the weekly lessons, and children from neighboring schools are brought in by Parent-Teacher Association cooperation, so that the membership of any speech correction class may be composed of pupils from several schools. The classes are held in different schools from year to year, so that the burden of arranging for transportation is not borne by any one association for too many years in succession. There are no speech correction provisions for Negro children.

HOW THE CRIPPLED AND DELICATE CHILDREN ARE LOCATED

In 1938, at the beginning of the home instruction program, a check of the files of the Bureau of School Census, located at the administration building of the Louisville Board of Education, yielded names, ages, and addresses of all children non-enrolled due to physical disability. Each of these was visited in order to determine whether the child was educable, and a file card was made out showing whether the child had been located, and whether the visitor judged that he could be taught academic subjects. It was upon the results of this survey that the first year's home instruction class was established. For the next two years, the writer checked the files of the census against those of the supervisor of Health and Safety Education in order to determine that every physically handicapped child was being reached. Since that time, the Census Bureau has reported to us those children non-enrolled

or discharged due to physical disability. Upon receipt of such notice, given upon a census enrollment form (see appendix) the writer visits the home of the child the next time she has a spare moment and is in the neighborhood. Since most of the physically handicapped children are first reported by other agencies, visits of this sort can be handled in this way without adding materially to the home teaching schedule.

RECOMMENDATIONS MADE BY THE WORKS SURVEY

During the school year 1942-43, the City of Louisville employed Dr. Works to make a survey of the Louisville Public Schools. No survey testing was done. The recommendations made in the report of the survey follow:

"If the crippled children of Louisville are to have educational opportunities equal to those of normal children, many additional services must be provided and material changes must be made in the present class organization for these children.

"No provision is now made for any special physical care for crippled children.

"The three isolated classes for crippled children should be combined into a single unit in a building where the entire group can be accomodated on the first floor.

"A physio-therapist should be added to the school staff. For many crippled children, physicians recommend therapeutic

treatment to be included as a part of their daily school routine.

"If physical services can be increased for these children at school, it is possible that children who are now receiving Home Instruction can be included in the school group, thus creating for them a more normal situation educationally and giving them the group contacts that they so much need. Additional equipment will be needed for carrying on a program of physical therapy.

"An increased amount of time should be made available for the instruction of each homebound child. The present limit of two hours weekly is insufficient for very effective work. New York, for instance, allows 4.5 hours per week for each child and fixes the teacher load at eight children."[1]

The writer must point out that the statement above concerning the effectiveness of the program was not based upon the records of the Louisville Board of Education. No attempt was made by the Works Survey to evaluate the accomplishment of the pupils, either during their enrollment in Home Instruction or after their return to school. The Survey was concerned only with the administration of the program and not with educational progress. It is true, however, that the tool subjects, English, including grammar, spelling and literature and arithmetic, had to be stressed, not only because of the

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[1] Works Survey, pp.283-284.

time limit, but also because so many of the children's achievement tests showed retardation in these subjects. Inspection of the children's previous school records shows frequent scattered absence, in many cases, before illness forced them to withdraw from school. Information concerning school placements and ages in Chapter VI, as well as other educational data shown, will give evidence of the special help needed by these children.

If the recommendations of the Survey were carried out, all four of the home instruction pupils now considered as permanent could be given the advantages, both social and educational, of attending special class. Home instruction is not an ideal medium for education, it is merely the only solution, and the least desirable solution, to the problem of carrying on the education of these children whose physical condition prohibits their attending regular school. Special class is always preferable to home instruction, for the sake of social integration, if the former can be arranged so that the teacher's time is not consumed in physical care rather than in teaching.

ADMINISTRATION OF THE PROGRAM

The program is under the charge of the assistant superintendent in charge of elementary schools and of the supervisor of Health and Safety Education. With the exception of one substitute teacher, all the teachers are regularly certi-

ficated and are paid according to the regular salary schedule, with differentials pf $50.00 to $100.00 yearly for different types of special education. Although many gifts of books and equipment have been made from time to time by interested lay persons and clubs, notably the sight-saving equipment presented to the Cochran Sight-Saving class by the Lion's Club, most of the equipment and supplies are furnished by the Board of Education, which also furnishes supplementary books, while the State of Kentucky furnishes the regular text-books, just as is the case with any other classes in the Louisville Public Schools system.

In addition to special records necessitated by the nature of the program, such as taxi lists and doctor's statements, all the records usually kept by any other department are used. Promotions made by the special teachers are valid in any part of the school system to which the child may transfer.

Taxi transportation, paid for by the Board of Education, is arranged by the assistant superintendent, upon notice by the supervisor, and transfer notices are sent by the former to the Director of Attendance Department, who has charge of the Bureau of School Census.

CHAPTER III

THE WORK OF THE HOME TEACHER -
ADMINISTRATIVE ASPECTS AND INSTRUCTIONAL ASPECTS

THE WORK OF THE HOME TEACHER

ADMINISTRATIVE ASPECTS AND INSTRUCTIONAL ASPECTS

ELIGIBILITY REQUIREMENTS

Any child who is eligible to attend the Louisville Public Schools may have home instruction if his doctor certifies that, while the child's health does not permit daily attendance at school, home instruction is recommended. In addition, the doctor is asked to give the diagnosis and prognosis as well as special directions, if any are advisable,[1] for limitations of school services to be rendered.

To be eligible to attend the public schools, the child must be an educable resident of the city. It does not matter where his brothers and sisters attend school, nor where he, himself, has attended previously. Of the eighty-four children who have received home instruction during the past five years, sixteen had previously attended parochial schools and four would have entered parochial schools had their health permitted. Thus, twenty children, or 23.8 per cent of the home instruction pupils, would not have attended public school except for reasons of health. This is less than the proportion of parochial school enrollment to totalwhite school en-

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[1] A copy of this form will be found in the Appendix.

rollment in Louisville. White parochial school enrollment is given by the Bureau of School Census as 15,754, or 28 per cent of the total white school enrollment of 55,913.

In cases of doubtful educability, the child must be taken to the Bureau of Research of the Board of Education for a psychometric test, after which recommendations as to possibilities for educational achievement are made by the psychologist administering the test.

REFERRAL PROCEDURE

Children may be referred for home instruction by sending to the office of the supervisor, one of the physician's statements above mentioned, or by telephone call, personal call, or letter to the Supervisor of Health and Safety. For purposes of convenience, a supply of the forms is furnished the General Hospital and the Kentucky Crippled Children Commission at the beginning of each school year.

SOURCES OF REFERRAL

Anyone who is interested in a physically handicapped child may refer him to the Board of Education Department of Health and Safety Education. It is not unusual for a child to be referred more than once. This is particularly true of the uneducable child, who may be referred at various times by his family, his neighbors, a visiting nurse, the visiting

teacher in the school district and by the pastor of his church. A file card is made out for each child visited, so that subsequent referrals may be replied to without delay. Not realizing that home instruction is given only to children who can assimilate academic subjects, interested persons sometimes request home instruction as a means of entertainment for the child or relief for the mother. With the present set-up, it is impossible to supply any sort of occupational therapy or recreation to these cases, but it is the personal opinion of the writer that this is a needed field.

The eighty-four cases accepted for home instruction during the past four years were referred by social service agencies, parents, school personnel, or interested persons, such as clergymen, friends, neighbors, or relatives other than parents. Social service agencies referred thirty-three children, or 39.3 per cent of the eighty-four cases and parents referred twenty-six children or 31 per cent.

TABLE V

NUMBER OF HOME INSTRUCTION PUPILS REFERRED
1939-40 TO 1943-44, INCLUSIVE, CLASSIFIED AS
TO SOURCE OF REFERRAL

Source of referral		Total No. of cases	Per Cent
Social Service Agencies		33	39.3
General Hospital	18		
Children's Free Hospital	4		
Ky. Crippled Children Commission	10		
Public Health Nurses	1		
Parents of the pupils		26	31.01
School Personnel		20	23.8
Principal	7		
Visiting Teacher	12		
Bureau of School Census	1		
Interested Persons		5	5.9
Total		84	100.

With referrals coming from so many sources, it becomes necessary to note on the file card the source of referral, so that a letter giving information on the disposition of the case can be sent to the person or agency making the referral, unless the application has been made by a person in the child's own home.

INVESTIGATION OF REFERRALS

The home teacher investigates every request for home instruction, unless there is in the files a card showing that the child has been referred and rejected previously. If the rejection was on the basis of low mentality, a check is made to see when the psychologist's recommendation was made, and whether, according to the psychologist's report to the Department of Health and Safety, it is time for a recheck. If a new test is due, the home teacher makes an appointment, subject to the parent's convenience, and writes a letter so informing the parents. If the date is inconvenient, the parents are requested to call the Bureau of Research so that a convenient time may be set. If the child has been rejected so recently that there is no necessity for a new test, the person who made the referral is notified that we can do nothing for the child at present, as he is not ready for regular school work. This notification is usually made at the time of referral; if the material is not at hand a letter is sent as

soon as the investigation is completed. Information as to the new referral is noted on the file card.

If the child is new to the department, the home teacher makes out a file card, calling the Bureau of Census for any information not given by the person who referred the child.[1]

The home teacher next clears through the Social Service Exchange for information as to whether the family is active with any agency and whether the child is, or has been, active with the Mental Hygiene Clinic. If the child has had a recent psychometric test at the clinic, it is not necessary to have him brought to the Bureau of Research, as the psychologist can make recommendations based upon the findings of the Mental Hygiene Clinic. If information obtained from the Bureau of School Census shows that the child has attended public school in Louisville, the home teacher calls the last school attended for information as to the child's scholarship rating. If the scholarship mark is unfavorable, she inquires whether this was due to low mentality, absence caused by illness, or other causes. If low mentality is the cause, she checks through the Bureau of Research to see whether the child has been given an individual psychometric test either there or at his own school. If the psychologist has rated the child lower than "slow learning" the outlook for success in home instruction is unfavorable.

[1]A copy of the file card will be found in the Appendix.

the child is usually not accepted and the person referring the child is so informed.

If the investigation, thus far, indicates that the child probably can make a successful adjustment to home instruction, the home teacher visits the child's home. If the child has attended school with a reasonable degree of success in the past, the chances are that he can make normal progress in home teaching.

If the child is unknown to the Bureau of Census, or if there is no information available that would indicate that the child probably could not derive benefit from home instruction, the home teacher makes a visit to the child's home, not only to become acquainted with the child and his problems and to inform the parents as to what we can offer the child, but also to get information for the census and to make an estimate as to the child's educability. In a few cases, children not living with their parents, must go or send a representative to the office of the attorney of the Board of Education for a ruling as to eligibility.

Since the Bureau of Research has only one psychologist to do the individual testing for the entire city, it is not possible to refer any but the doubtful cases for individual psychometric tests. The writer has evolved a simple informal test to indicate whether the child is probably ready for aca-

demic training. The writer makes no claims as to the validity of the test; she has merely found it helpful in selecting doubtful cases. If the child responds readily to questions as to his age, the colors of various objects in the room and the number of buttons on his suit or the number of flowers in a vase, etc., the writer makes a quick and simple test of reading readiness, which can be used even with children with little speech. Drawing a few sketches on a piece of paper, the writer labels them in script, "boy", "girl", "house", "dog", etc. The child watches the drawing and is asked to tell what the pictures represent before the label is made. Thus, if he says "chickie" for chick or "Mother Hen" for hen, the label is lettered at his dictation. At the bottom of the page, the labels are repeated, in different order. The child is asked to match the words by looking at the bottom line and finding the work like it under the picture. When he has pointed to the matching word, the writer says "What does that say?" "Now, what does this word down here say?" To his joy, and the mother's amazement, he finds that he can "read" the words at the bottom of the page. Sometimes he can even remember how to read the words with the pictures covered. The writer always carries a box of those "wonderful things" - gummed stars - in her bag and when the child has successfully read the words at the bottom of the page, a star of the child's favorite color is

chosen, and affixed to the paper, which the child may keep as an evidence of his success. Thus, in a few minutes, the child has had a pleasant feeling of success, the mother has been reassured as to the good intentions toward the child, and the visitor has an indication as to whether the child has a chance to succeed in academic subjects. Establishing rapport with the family as well as the child is important, as many of these children are so protected that outside contacts are sometimes very much feared.

In the event the the child cannot respond to questions, the writer tries to get from the mother an admission that the child is not ready for instruction in reading. The writer tells the mother that home instruction starts with first grade reading and that children usually are not ready for reading until they can distinguish between colors, count to twenty by ones, tell their names and ages and draw pictures or use a coloring book, unless the hands and arms are crippled. If the mother feels that perhaps the child should have schooling even though he cannot do these things, or if his speech is so bad that one cannot tell whether he knows these things, the mother is told that she may take the child to the Bureau of Research so that the psychologist can tell her whether the child is ready for school work, or how long it will be before he can have schooling. The visitor explains that there are many kinds of tests

so the psychologist can choose the test best suited to the child's physical condition. The mother usually is glad to take the child to the Bureau of Research and requests thst the visitor make the appointment and "explain all about Johnny" to the psychologist. She is told that, after the test, she will be given an interpretation by the psychologist.

The writer always tells the mother that it is not at all unusual to find that children who have been handicapped from birth or infancy are not ready for schooling at the customary age of six. They have not had the experiences of other, normal, children and have often gone through operations or long periods of illness that would daunt even the hardiest adult. This is perfectly accurate, but the writer contributes this fact, not in the interest of truth, but to enable the mother to save face in the event the child is not recommended for instruction. Many of the mothers are sensitive and understandably protective of the children, but they are quick to respond when they meet some one who has known many handicapped children and can understand a few of the problems connected with their care. It is interesting to note how often, when the visitor mentions some problem which another mother has to solve but which the child being visited does not present, although he may present other, and apparently more difficult problems, the mother being interviewed will say, "My, my,

we never realize how thankful we ought to be, until we hear about the difficulties of others".

PLACEMENT IN THE PROGRAM FOR CRIPPLED AND DELICATE CHILDREN

Children referred for home instruction sometimes can be sent to special class. With the exception of social service agencies, there seems to be a tendency on the part of those making referrals to ask for home instruction rather than placement in special class. We have never known the reason for this. When the home visit is made, information on the child's physical condition is requested; the visitor then suggests, if conditions seem to warrant it, placement in special class rather than home instruction. In the case of the child referred by transmission of a doctor's form from General Hospital, Children's Free Hospital, or the Kentucky Crippled Children Commission, this step is unnecessary. She explains that home instruction is not considered an ideal way to acquire education, but is an attempt to solve a problem for those children who could not possibly attend school. She explains why children who cannot attend their regular school can often go to special class, as taxi transportation is furnished by the Board of Education and the children are not required to move about. They can even be carried into the school room and placed in wheel chairs, if necessary. In these cases, the

parents are required to place the child in the taxi at the home and to take him out of the taxi at the end of the school day. These conditions were laid down by the taxi company after so many of the able bodied drivers were drafted into the Armed Forces. The child who needs it may have a rest period at school. The class, although it includes the first grade through the ninth grade, is run on an elementary school schedule, since two of the three classes are held in regular elementary buildings.

The visitor gives a physician's statement form to the mother and asks that the latter discuss special class placement with the doctor before he fills out the form and mails it to the Supervisor of Health and Safety. The doctor is asked to mail the form so that, if he wishes to give any confidential information which he is withholding from the patient, he may do so. Upon receipt of the form, properly completed, the child is enrolled.

WHAT HOME INSTRUCTION CAN DO FOR THE CHILD

The mother usually asks what can be accomplished by the child during the period of enrollment in home instruction; the child who has attended school always asks whether the teacher thinks he can make up for lost time and be promoted when the rest of his class at school is promoted. The answer to children who have had a reasonable amount of success at school and

have not been out of school more than a semester, is that if they are well enough to feel like studying and if they really want to catch up, they can. The visitor explains that she starts by administering an achievement test in order to find out quickly whether the child has any special difficulties as so many of her pupils have had a great deal of scattered absence even before illness caused withdrawal from school. When the doctor recommends transfer from home instruction to special class or to regular school, another achievement test will determine grade placement. While achievement tests cannot be given children beginning their formal education in home instruction, these children are given the tests at the end of each school year, if still enrolled, or at the end of enrollment in home instruction. Information on tests of such children will be found in Chapter VI.

ADMINISTRATIVE DETAILS

Once the child has been accepted for home instruction, certain routine procedure is followed. If the child has not been enrolled in any school during the current school year, an enrollment card is sent to the census. Otherwise, a transfer slip is made out by the supervisor and sent to the assistant supervisor in charge of elementary schools, showing that, although the child lives in a given public school district,

he will be enrolled in home instruction, transferring from the school previously attended. The home teacher writes a postcard to the school last attended, to the effect that the child is to be enrolled in home instruction and requesting that the child's school records be sent to the office of the Supervisor, where they are kept in a folder with the child's special education records. This follows the usual procedure of transmission of records from school to school as the child transfers. Free state text books are furnished the child on the same basis as regular school pupils, except that the home teacher takes the books to the child's home after requisitioning the supply department, subject to approval by the assistant superintendent in charge of instructional supplies and the business director. Parents are requested by the teacher to furnish an 8½" by 11" loose leaf binder with rings, preferably an old one, if stores in the neighborhood have only the "victory" ones which are difficult to manipulate and so often tear the paper, a set of index sheets, paper, and pencils. The older children need rulers and , in some grades, protractors; the younger children need crayons and scrapbooks instead of binders. In the few cases where parents cannot buy these supplies, the teacher does so. She also furnishes reading workbooks, for which an occasional parent reimburses her; she does not inform the parents that these are not furnished in the same

way as the text books, but a few, realizing that the child uses the book differently and that it cannot be passed on, insist upon paying the negligible cost.

LESSON PROCEDURE

Each child is given two hours of instruction a week. Ten children are given two one-hour periods and three children are given one two-hour period. This time was set arbitrarily in the beginning of the program by dividing the number of candidates into the number of hours per week available for home instruction. One group of five children have their lessons on Mondays and Thursdays, a second group of five children have lessons on Tuesdays and Fridays, while three children with good habits of work have their lessons on Wednesdays. The latter are usually junior high school pupils; fortunately, the textbooks now in use lend themselves admirably to the purposes of weekly home instruction. Especially good is the organization of the Modern Junior Mathematics series, which gives the explanation of the new step, with samples, followed by practice exercises based upon the new step, then followed by problems based upon the new step. Each chapter ends with mixed problem practice and a general review. Particularly helpful, also, in the case of home instruction, are the diagnostic tests.

Before setting a time for the lessons, it is necessary

to get information of the routine of the home and the child. If it is possible, the teacher takes into consideration the father's working hours, the schedule of meals observed by the family, and the nap times of young children in the home. This latter point is very important, as small children running in and out can be quite a problem if the mother persistently calls out to them. Left to their own devices, these children usually stand and watch the lesson for a few minutes, then become bored and go elsewhere to find more interesting pastimes. In addition it is necessary to consider the pupil's schedule of naps, meals, treatments, hot-packs and trips to doctor or clinic. Making out a schedule to fit thirteen homes is no sinecure, but, without exception, the mothers have been understanding and have taken any inconveniences with the best of grace. Fortunately, things seem to have a way of working out favorably and there have not been any insurmountable difficulties.

When the teacher arrives for the lesson, the child is usually ready in his customary place, with his materials before him. The teacher has learned that it is a very bad omen if the mother has to be asked to fetch books and other supplies after the teacher arrives. This usually indicates a lack of interest on the part of the child or the mother, or both. However, the interested child can usually prod the mother even though the latter is not particularly interested. The writer might add that she never arrives before the hour scheduled, as the

children are very much disconcerted if they are not fresh and clean for their lessons. Instead, when a pupil is too ill for his lesson, the teacher uses that period for visits to children newly referred.

While removing her coat and getting out her pencils and gummed stars, the teacher gives the child and mother an opportunity to exhibit new pajamas, house-coats, or hairdos or to tell their news about visits to the doctor or clinic and any new privileges which may have been granted. These are milestones on the road to recovery, and permission to go to the table for one meal a day, or to go outside for thirty minutes calls for a real celebration.

If the exciting news is imparted before the lesson begins, concentration is benefited. If time permits, after the lesson is over, the teacher tells the news of the other pupils. Children who never see each other take a great deal of interest in the doings of other households, such as trips to the movies or to the circus, privileges granted by the doctors of the other pupils, and particularly do they love to see snapshots of the other pupils. They rejoice sincerely when another pupil is able to be discharged from home teaching.

Except for very little children, who use scrapbooks, all work is kept in the binder, with a separate index sheet for each subject. The children become very proud of their binders, and keep them in a conspicuous place to exhibit to

visitors. The teacher uses gummed stars or seals to affix to good work. The stars are used for most of the year, but flags for Armistice Day and other patriotic holidays, turkeys for Thanksgiving Day and Santa Claus seals for Christmas, are used for the lessons immediately preceding the holiday, except in reading work books where as many as six stars per page can be earned. There is a section for penmanship; the child writes each spelling word three times, under the copy which the teacher has made. The next section is for language. Here, the pupil writes a sentence using each spelling word so as to show that he knows the meaning. For older pupils, former language assignments are included in this section. The third section is for spelling. Here, the papers are the ones used in the spelling test which the teacher administers when the lesson starts. If a child misses a word, it is written in red pencil on his next penmanship paper, for re-assignment. If not, he goes on to the next assignment with no review of words since review lessons are given at the end of the semester. The next section is for that branch of mathematics which the child is studying. The teacher quickly checks the work by means of an answer book, if one is available, and makes a red cross on any incorrect items. Then she goes over the incorrect items with the child to find what sort of mistakes are occurring, and labels the mistakes. Thus, if there is a multiplication mistake, she crosses out the incorrect number and writes the proper item at

the side, thus: 8X4- 32. She makes all corrections in red, so the child can refer back, if necessary. After the mistakes have been corrected, she either assigns more practice in the same work, or goes on to the next step, as indicated by the child's work. Thus the child has a great incentive for accurate work; he never has to wait while others catch up. Any new steps are explained, and the teacher works a sample, then gives samples to the child until his work shows he understands the new step. The paper upon which these samples are worked are kept in the binder for reference, if needed. If illness or any other reason prevents the child from completing his assignment while he remembers what the teacher has told him, he thus has a reference which will refresh his memory. The last section in the binder is for reading. For primary pupils, there is a list of vocabulary words to be learned, before preparation of each reading lesson. The mothers can usually help the child to learn this, after the teacher has taught the mother how to proceed. The child reads the list to the teacher and either gets a star or has the words he missed underscored in red in which case, these words are repeated for the next lesson. For the older pupils, there are questions to be answered, concerning what they read. While the child is writing his spelling words, the teacher marks the reading workbook. Then, she shows the child the result and goes over the directions for the new assignment to see that the child understands

them. For very little children, the parents are asked to give help with the directions if the children request it. They are also asked to hear tables or drill with combination flashcards and to dictate spelling words for a pre-test if they are emotionally able. However, quite often the parents cannot be helpful in these ways, and the child's progress is somewhat slowed. The teacher tells the parents that assistance is helpful, but not imperative.

Keeping the last for the best, the reading or literature lesson is now brought out. Very little children read aloud, the older ones answer questions or make reports giving the main ideas.

As each lesson has been taken up, the teacher has written the new assignment upon a sheet of paper which is kept at the front of the book, and has made a note of the grade beside each item of the old assignment. The children seem to enjoy being very definite about their grades; probably this is partly due to the fact that they receive report cards only at the end of the home instruction enrollment or at the end of the school year, whichever comes first.

Now, if time permits, the mother, the teacher, and the pupil can have a little visit. This is the time used for starting the children on weaving pot-holders, knitting or other handicraft. Then it is time to go on to the next pupil's house.

This is the routine followed until the child's condition

permits him to go on to special class or back to regular school. Home instruction is considered a class and a part of the regular procedure of the school system. Promotions made by the home teacher have the same standing as those made by any other teacher.

DISCHARGE FROM HOME INSTRUCTION

Children leave home instruction for various reasons, the most frequent being improvement in health, so that the child may progress to special class, to his own school with special schedule, or even to his own regular school with no restrictions. Table VI shows that fifty-three children fall into this classification, and, with one pupil who graduated from high school at the same time that he was dismissed by his doctor, and two who became overage, comprise 66.6 per cent of the eighty-four pupils. At the end of the past school year, in June, 1944, twelve children, or 14.3 per cent were still active; that is, their doctors had not yet recommended that they could make a change when school opened in September. Seven children or 8.3 per cent left the city while still enrolled in home instruction. Three children, or 3.6 per cent were discontinued because they could not adjust. Three children or 3.6 per cent died, two children went to the hospital and one became too ill to continue.

TABLE VI

NUMBER OF HOME INSTRUCTION PUPILS CLASSIFIED

ACCORDING TO REASONS FOR TERMINATION OF ENROLLMENT

Reason for Termination		Terminated Cases Total No.	Terminated Cases Per Cent
Returned to school or finished		56	66.6
Special class	31		
Regular school			
With special schedule	7		
No special schedule	15		
Graduated from high school	1		
Became overage	2		
Still enrolled, June, 1944		12	14.3
Left the city		7	8.3
Could not adjust		3	3.6
Died		3	3.6
Entered hospital		2	2.4
Too ill to continue		1	1.2
Total		84	100.

Of the children still enrolled in June, 1944, only four are permanent cases; the remaining eight will probably be able to go to special class, in September. It is a routine requirement for each special class and home teaching pupil except the obvious cripples who could not possibly get along in a regular class to have a physical checkup during the latter part of August and to present a new statement from his physician at the beginning of each school year, in order to ascertain whether the school placement should be changed in any way.

CHAPTER IV

SOCIAL - ECONOMIC INFORMATION CONCERNING THE FAMILIES OF THE HOME INSTRUCTION PUPILS

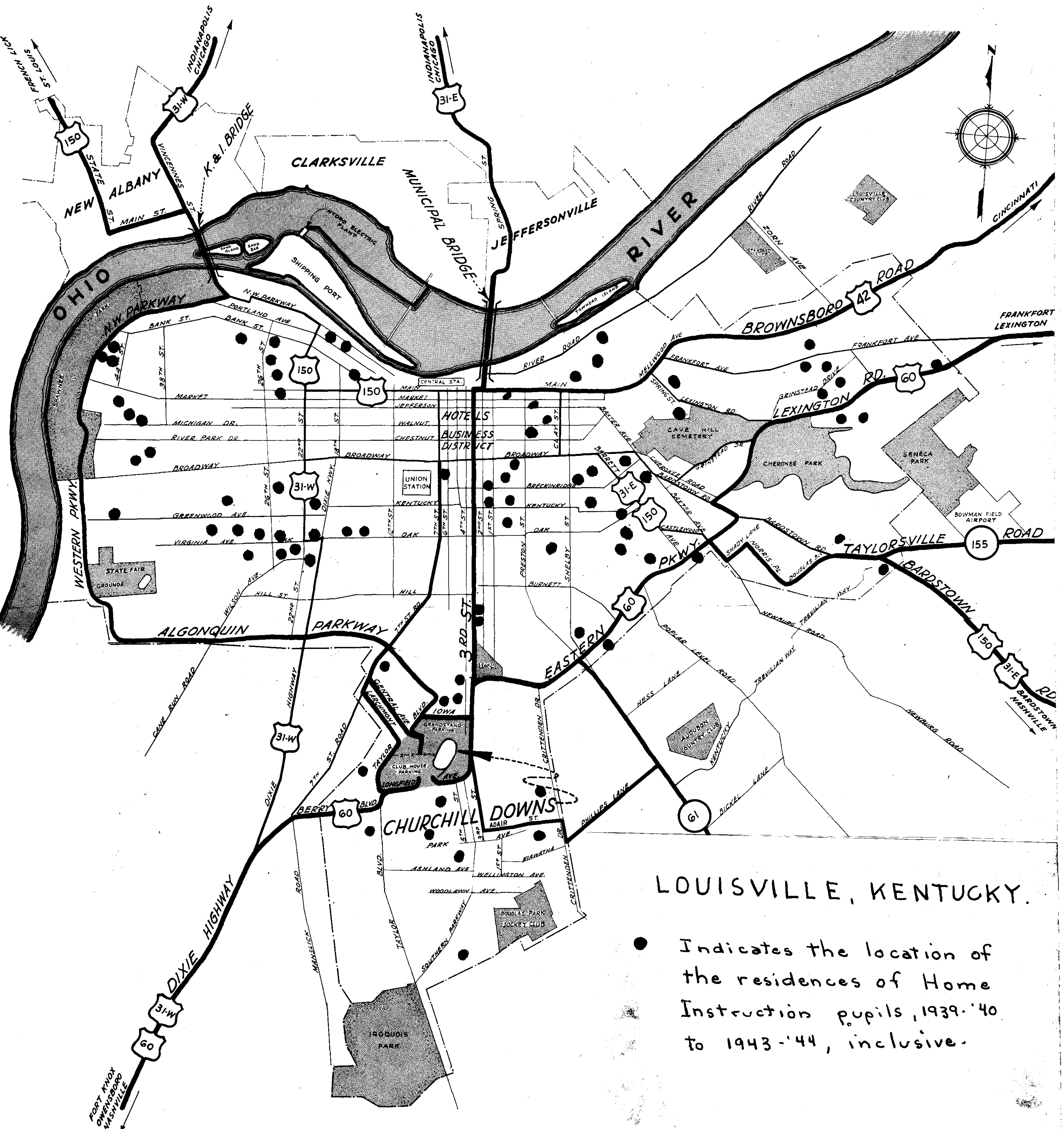
SOCIAL - ECONOMIC INFORMATION CONCERNING THE FAMILIES OF THE HOME INSTRUCTION PUPILS

GEOGRAPHICAL LOCATION OF THE HOMES

The families of home instruction pupils seem likely to live almost anywhere within the city limits of Louisville. Travel between the home of the teacher and the homes of the pupils averaged two hundred miles per week.

A few cases living near the Children's Free Hospital and two children living within walking distance of the Jewish Children's Home were taught by the teacher who divided her time between these two institutions, so that the writer could use her car to reach outlying homes. These were short-time cases expected to enter special class within a few months and achievement tests were not used. These children are not included in the eighty-four cases reported upon in this study, as records for them are not complete.

The map shows the location of the homes of the eighty-one families. As one family had two daughters receiving home instruction at various times, and two children lived in an orphanage, only eighty-one families are included; however, eighty-five homes are shown, as four families moved during the period of enrollment. As will be noticed, there were few pupils living in the thickly-populated section north of


LOUISVILLE, KENTUCKY.
● Indicates the location of the residences of Home Instruction pupils, 1939-'40 to 1943-'44, inclusive.
OHIO RIVER
CLARKSVILLE
NEW ALBANY
JEFFERSONVILLE
MUNICIPAL BRIDGE
K.& I. BRIDGE
SHIPPING PORT
FRENCH LICK ST. LOUIS
INDIANAPOLIS CHICAGO
CINCINNATI
FRANKFORT LEXINGTON
BROWNSBORO ROAD
LEXINGTON RD.
TAYLORSVILLE ROAD
BARDSTOWN RD
BARDSTOWN NASHVILLE
FORT KNOX OWENSBORO NASHVILLE
DIXIE HIGHWAY
ALGONQUIN PARKWAY
EASTERN PKWY.
WESTERN PKWY.
N.W. PARKWAY
CHURCHILL DOWNS
HOTELS
BUSINESS DISTRICT
UNION STATION
CENTRAL STA.
CAVE HILL CEMETERY
CHEROKEE PARK
SENECA PARK
BOWMAN FIELD AIRPORT
STATE FAIR GROUNDS
IROQUOIS PARK
DOUGLAS PARK JOCKEY CLUB
AUDUBON COUNTRY CLUB
LOUISVILLE COUNTRY CLUB
3 RD ST.
MAIN
MARKET
JEFFERSON
WALNUT
CHESTNUT
BROADWAY
KENTUCKY
OAK
HILL
BURNETT
BRECKINRIDGE
GREENWOOD AVE.
VIRGINIA AVE.
MICHIGAN DR.
RIVER PARK DR.
PORTLAND AVE
BANK ST.
RIVER ROAD
FRANKFORT AVE
MELLWOOD AVE
PRESTON
SHELBY
CLAY ST
SPRING ST.
BAXTER AVE
BARRETT
POPLAR LEVEL ROAD
NEWBURG ROAD
TREVILIAN WAY
HESS LANE
PHILLIPS LANE
BICKEL LANE
CRITTENDEN DR.
TAYLOR BLVD.
CENTRAL AVE.
IOWA
ADAIR ST
PARK
ASHLAND AVE
WELLINGTON AVE.
WOODLAWN AVE.
HIAWATHA
SOUTHERN PARKWAY
MANSLICK ROAD
CANE RUN ROAD
7TH ST. ROAD
WILSON AVE.
BERRY BLVD.
DIXIE HIGHWAY
ZORN AVE
GRINSTEAD DRIVE
SHADY LANE
NORRIS PL.
DOUGLAS BLVD.
CASTLEWOOD AVE
150
31-W
31-E
60
42
155
61

Broadway, west of Shelby and east of First Street. Few children living in this section are referred for home instruction although there are many hospital and special class pupils from the more crowded districts. As a rule, these children convalesce at the Jewish Children's Home after leaving the hospital, and go to special class upon dismissal from the former. A few children living in Clarksdale are able to convalesce at home, and it is usually these children who are taught by the hospital teacher if the home teacher has a waiting list.

POPULATION OF THE HOMES

The homes of the pupils varied from one room in a dismal rooming house to a beautifully appointed nine room Georgian Colonial home in one of the most spacious subdivisions. Each of the two latter homes housed a family of four, two children and their parents.

The number of persons in the household varied from two to eleven. The smallest household consisted of a widowed mother and her son; the largest consisted of eight children, the parents, and the aged deaf, grandfather.

The homes of the Louisville Home Instruction group were slightly less crowded than those of all Louisville families. Only 14.8 per cent of the former group had less than one-half room per person, compared with 24 per cent for the city as a

whole. Table VII shows that 63.3 per cent of the Home Instruction had one-half to one room per person, whereas 52 per cent of the Louisville families were in this classification.

The distribution as to number of persons in the family and number of rooms is shown in Table VII. Twenty-one of the homes had only three rooms, sheltering from three to nine persons. The three room home sheltering nine persons was the one with two children suffering from rheumatic heart. Amazingly, this home presented excellent working conditions for both the pupil and the child. It was a remodeled residence on Southern Parkway, the first floor apartment of which consisted of the former living-room, dining room, kitchen, pantry, and back hall. The rooms were large, and the mother was ingenious. While the child studied or was having her lesson in the front room all the rest of the family remained in the kitchen, with all doors closed. This made a "buffer" of the middle room, and afforded quiet and peace. The room was warm and clean, no small accomplishment, when one remembers that, as well as the living-room, it was also the bedroom of four persons! Interestingly, the family used matching double beds, arranged as twin beds, to accomodate four people; a clever solution of a big problem, as it not only made for a presentable bedroom, but eliminated the necessity for having a bed in the kitchen, as the ninth person, a teen-age boy, had a cot in the back hall.

Twenty-five families had four rooms, divided among from four to seven people. With four rooms, the usual arrangement seems to be to have folding beds of the davenport or studio couch type in the living-room, or, if a dining-room is included, in the latter. The mothers work very hard getting all of these beds into their day-time disguises before the teacher arrives. It is always best to schedule these homes later in the day, if possible, not only to avoid rushing the mother but also because the home instruction pupil is usually kept in bed, out of the way, until the others get off for school or work. With so crowded a home situation, sometimes the sick child needs a morning nap, after the others have left, before he feels able to begin the day. Many sick children, although they may need very badly to build up, have poor appetities, and some seize the teacher's imminent arrival as an excuse to curtail breakfast or lunch.

Such children are benefitted by a little device which takes little of the lesson time, but is very effective. This is a page in the binder, ruled so as to provide seven spaces for each day, to represent the "Basic Seven" food groups which the children hear about on the radio. Pasted to the back inside cover of the binder is a brightly covered picture, in seven strips, showing members of the various groups. The child checks each group he has actually eaten. A list is provided

TABLE VII

NUMBER OF LOUISVILLE FAMILIES AND

NUMBER OF WHITE HOME INSTRUCTION FAMILIES

CLASSIFIED AS TO NUMBER OF ROOMS PER PERSON

	Louisville Families	Home Instruction Families	No.
Number of rooms per person			
½ or less	24.	14.8	12
½ to 3/4	23.1	30.	21
3/4 to 1	28.9	33.3	27
1 to 1½	13.2	7.4	6
1½ to 2	7.8	16.	13
2 or more	3.	2.5	2
Total		100.	81[1]

[1] One home had two children receiving home instruction and two children lived in an orphanage, making a total of eighty-one private homes.

the mother so that she can be sure to serve something from each group. For each day showing seven check marks, the teacher affixes a star. The mothers are usually pleased with this simple device and many children have shown definite improvement.

Another problem, in the more crowded homes, is that of keeping the pupil's books and materials neat, clean, and available. Putting the child's "school things" on top of a high cabinet might keep them out of reach of little brothers and sisters, but too often, keeps them out of reach of the pupils, also. It is best to keep them in school bags which can be hung on a bed-post or wheel-chair while the child is awake. Small size satchels or brief cases are sometimes used, but the school bags are best because they do connote school, and these home-bound children love to feel that they really are school children.

Only eighty-one homes are shown in this table, as only the latest homes of the families which moved were used. In one case, the new home had the same number of rooms as the old, in another case, while the new home was larger, the family was augmented by the grandmother and the great-uncle, so that the number of rooms per person remained the same. In the other two cases, a family of four moved from six rooms to four and another family of four moved from four rooms to six, so that the total picture was not changed by any of the moves.

TABLE VIII

NUMBER OF PERSONS IN FAMILY CLASSIFIED
AS TO NUMBER OF ROOMS IN HOME

	Number of families										
	Number of persons in family										
Number of rooms	2	3	4	5	6	7	8	9	10	11	Total
1	1		1								2
2		2	1								3
3		5	3	4	5	2	1	1			21
4		4	7	6	5	3					25
5		4	2	4	4	1					15
6		1	2	3	1		1	1		1	10
7			1								1
8				2							2
9			1		1						2
Total	1	16	18	19	16	6	2	2		1	81

TABLE IX

NUMBER AND PER CENT OF FAMILIES IN HOME INSTRUCTION GROUP AND PERCENT OF FAMILIES IN SAMPLE D, UNITED STATES CENSUS 1940, CLASSIFIED AS TO NUMBER OF CHILDREN UNDER EIGHTEEN

	Louisville Home Instruction No. of families	Per Cent	Census U.S. 1940 Per Cent
Number of children under eighteen			
1	21	26.25	42.35
2	24	30.	29.02
3 or more	35	43.75	28.63
Total	80[1]	100.	100.

[1] One family had two children who received home instruction. Three children were orphans for whom no information was available.

TABLE X

NUMBER OF CHILDREN UNDER EIGHTEEN IN FAMILIES OF HOME INSTRUCTION GROUP WITH REFERENCE TO CAUSE OF REFERRAL

	Number of children under eighteen			
	1	2	3 or more	Total
Delicate				
Rheumatic heart	8	8	11	27[1]
Tuberculosis	3	2	2	7
Nephritis	1	1	2	4
Osteomyelitis			3	3[2]
Chorea	1	2	1	4
Post-meningitis	1	1	1	3
Lung abscess	2	1		3
Leukemia	1		1	2
Bronchiectasis			1	1
Anemia	1			1
Crippled				
Poliomyelitis		5	5	10
Arthritis	1		1	2
Perthe's disease			3	3
Hemophilia			1	1
Cerebral Palsy		2	1	3
Spinabifida		1	1	2
Hydrocephalus	1			1
Injuries	1	1	2	4
Total	21	24	36[3]	81

[1] Two of the orphans had rheumatic heart

[2] One of the orphans had osteomyelitis

[3] The family which had two rheumatic heart patients had four children under eighteen.

SIZE OF FAMILIES OF HOME INSTRUCTION PUPILS

The number of children under eighteen, per family, is shown in Table IX. We find quite a difference between Louisville white home instruction families and white families of Sample D, as shown in the United States census of 1940, as to the number of families having one, two, or three or more children under eighteen. While Sample D was 42.35 per cent in the first classification, Louisville home instruction families show only 26.5 per cent in that class. However, Sample D shows only 28.63 per cent of the families as having three or more children, while in Louisville, 43.75 per cent of the home instruction families had as large families. Thus, it appears that Louisville home instruction pupils have families definitely larger than those of comparable general population groups.

In order to try to determine whether larger families seem to have children with any particular handicap, Table X was devised. All of the osteomyelitis and Perthe's disease cases came from the larger families and the poliomyelitis cases were divided between the two-child families and the larger families. However, the other cases were divided fairly evenly among the groups. With such a small universe, it is difficult to draw any valid conclusions.

TABLE XV

NUMBER AND PERCENT OF HOMES CLASSIFIED ACCORDING TO MARITAL STATUS AND EMPLOYMENT STATUS

Marital status and employment status		Number of cases	%
Two parents in home		64	79.0
Child's own parents, father working			
Mother not employed	50		
Mother employed part-time	2		
Mother employed full-time	5		
Mother and stepfather, latter employed			
Mother not employed	2		
Mother employed	1		
Stepmother and father, latter employed			
Step-mother not employed	1		
Step-mother employed full-time	1		
Foster parents (legal adoption)			
F-father retird, f-mother not working	1		
F-father working, f-mother employed caring for babies in home	1		
Mother, only, in home		15	18.6
Father dead, mother working	4		
Father dead, mother not working	7		
Father divorced, mother working fulltime	2		
Father divorced, mother working parttime	1		
Father divorced, mother not working	1		
Child placed in foster home by agency	1	1	1.2
Child staying with aunt (mother dead)	1	1	1.2
Total		81[1]	100.

[1] Two children lived in an orphanage

MARITAL STATUS AND EMPLOYMENT STATUS OF FAMILIES

In the main, the homes of the home instruction group follow the normal pattern of the bread-winning father and the house-keeping mother. Table XI shows that fifty homes, or 63.6 per cent, follow this pattern, while in only fifteen homes, or 18.6 per cent was there only one parent. In five of the latter, the mother was enabled to stay in the home by grants from Aid to Dependent Children, while in two, older brothers were the bread-winners. In the case of th divorced mother who did not work, support was given by the mother's uncle.

In all but five families, the situation is a happy one. In one case, the child rejects the stepmother and uses his permanent and very real disability to gain attention and to frustrate her plans. In two homes, the mothers are suffering from psychoneuroses; in one of these homes, the father is also alcoholic. In one home, the mother has not been well for years, as she had a brain tumor which caused disturbing symptoms such as loss of speech, and it has taken her years to regain her health since the operation to remove the tumor. In the fifth home, the stepfather, although he earns sufficient money at a defense plant, does not provide adequately for the family, so that the mother is forced to leave her invalid child to the care of indifferent neighbors and go out to work.

TABLE XII

NUMBER AND PERCENT OF FAMILIES IN WHITE HOME INSTRUCTION GROUP AND PERCENT OF WHITE FAMILIES IN LOUISVILLE ACCORDING TO UNITED STATES CENSUS, 1940, CLASSIFIED AS TO OCCUPATIONAL GROUP OF THE BREADWINNER

	Home instruction group No. of families	%	Census Louisville %
Professional	5	6.7	6.7
Semi-professional	1	1.4	1.3
Proprietors, managers and officials	10	13.5	9.6
Clerical, sales and kindred	15	20.3	26.1
Craftsmen, foremen and kindred	5	6.7	15.8
Operatives and kindred	33	44.6	23.8
Domestic service	1	1.4	2.0
Service, except domestic	2	2.7	7.6
Laborers	2	2.7	6.4
Total	74[1]	100.	99.3[2]

[1] One family had two children receiving home instruction
One family of child and mother was supported by allowance from a relative
Three children were orphans, two in an orphanage and one in a foster home.
Five children were wards of Aid to Dependent Children.

[2] Those groups not applicable to home teaching groups (farm managers and farmers) not included.

TABLE XIII

NUMBER OF FAMILIES OF HOME INSTRUCTION PUPILS CLASSIFIED AS TO NUMBER OF AGENCIES IN WHICH CASES WERE ACTIVE DURING ENROLLMENT PERIOD

Number of agencies active	Number of families	Per cent
No agency active	38	46.9
One agency active	31	38.3
Two agencies active	9	11.1
Three agencies active	3	3.7
Total	81	100.0

TABLE XIV

NUMBER OF FAMILIES OF HOME INSTRUCTION PUPILS CLASSIFIED AS TO THE AGENCIES ACTIVE

Name of agency	Number of families
General Hospital	21
Kentucky Crippled Children Commission	12
Children's Free Hospital	6
Aid to Dependent Children	5
Mental Hygiene Clinic	4
Board of Tuberculosis Hospital	3
Jewish Children's Home	2
Public Health Nursing Association	1
Children's Agency	1
Juvenile Court	1
Ormsby Village	1
Maternal Health Clinic	1

OCCUPATION OF THE BREADWINNER

The classification of the breadwinner is shown in Table XII. The home instruction group in Louisville has more breadwinners in the class composed of proprietors, managers and officials and in the class composed of operatives and kindred than in the white Louisville families as shown by the census reports. Fewer of the breadwinners are in the class composed of clerical, sales and kindred and particularly in the classes of craftsmen, foremen and kindred, service except domestic, and laborers.

SOCIAL SERVICE AGENCIES ACTIVE IN THE HOMES

Thirty-eight of the families, or 46.9 per cent. were active with no health or Social Service agency, as shown in Table XIII. Thirty-one families, or 38.3 per cent were active with one agency. The agencies interested in the families are shown in Table XIV. General Hospital, the Kentucky Crippled Children Commission and Children's Free Hospital had thirty-nine of the fifty-eight registrations. Few case-work agencies were active; however casework services are badly needed in two families. Unfortunately, neither desires such services. These are the neurotic mothers; although the children in both families were discharged from home instruction one and two years ago, respectively, the mothers still telephone the teacher to verbalize their conflicts. Needless to say, both

are hindering the adjustment of their erstwhile sick children by wanting to withdraw them, as they, themselves, have withdrawn from the world. Telephone conversations during the teacher's few hours at her own home are not a satisfactory medium of casework, even if these mothers felt the need of solving their own problems. Neither does; each feels that the world should adjust to her. If more casework services were available during home instruction, perhaps such unhappy mothers could be helped to solve their own problems and to help their children to adjust upon going back to the normal routine of the recovered child.

Working conditions can affect the success of Home Instruction. Good working conditions include a place for the child to work comfortably, with a good light, accessibility of materials, freedom from interruption and approval for work well done. For the teacher, unpleasant odors of the child or the home can be quite a discomfort.

The twenty-five homes presenting problems of minor physical discomforts or interruptions included twenty-eight items, as three homes were found to present more than one problem.

Among the unfavorable conditions, indifference was shown in six homes. This indifference led to a number of deleterious aspects, such as, failure to provide materials (books are furnished by the state) failure to provide a comfortable place

for the child to work, lack of encouragement of the child, allowing small children to destroy the child's work, not having the child ready for his lesson, losing the books, and failure to follow the teacher's suggestions as to speech drill (in the case of a spastic who needed daily exercise with tongue and lips). The five others presented varying problems.

B.R. was the child who lived in the beautiful home with nine rooms. Although his scores in achievement tests were slightly below the national norms, his mother felt that he was unusually well advanced, and could not see the necessity for spending any time with the tool subjects. As the child had not missed any school, due to the fact that his injury ocurred immediately after the close of school in June, and his school report card showed good grades, the writer did not tell the mother just how much retarded the child was, feeling that it would be more politic to establish rapport first. The child's attitude was affected to the extent that he did not feel that it was very important to follow directions about the "baby" work he was asked to do, and his grades suffered, slowing down the tempo of the work, as he had to repeat some lessons. When the mother compared what her child was doing with what "Group One" was doing in his class at school, she feared that he would not be able to be promoted with his class. However, the mother had, fortunately, misrepresented the extent of the child's injuries in order to assure his being given home instruction, and

the child was able to return to school after less than six weeks of home instruction instead of the semester which she had asked the doctor to certify. Notwithstanding the mother's unfortunate inability to trust the teacher to carry on to the child's advantage, B's final achievement test was entirely satisfactory, as he showed a gain of three months in educational age between September 23, when he began the first test, and November 1, when he finished the final test, and his score was slightly above the national norms. Having known this family so short a time, the writer does not feel able to say whether the mother could have learned to have confidence in the teacher, or whether a longer period would have been unsuccessful.

J.L. was another short-time case. She had had poliomyelitis during the summer and had returned to her home about the middle of October. During the Christmas holidays, the mother telephoned the supervisor, saying that the child was very restless at home, and that she needed home instruction very badly. She asked that home instruction be started immediately; she felt that J. could rejoin her class at school and soon catch up with them, as she was a very brilliant child, but she was unhappy at having to remain idle at home. She would have the doctor's statement filled out at once. The first lesson was given on January 4, and the mother was present. The child's achievement test scores were very scattered, she was fifteen months above her chronological age in paragraph mean-

TABLE XV

NUMBER AND PERCENTAGE OF FAMILIES OF HOME INSTRUCTION PUPILS CLASSIFIED AS TO WORKING CONDITIONS WITHIN THE HOME

		Number of families	Per cent
Conditions entirely favorable		45	55.6
Conditions less favorable		25[1]	30.8
Minor physical discomforts			
Temperature too hot	8		
Temperature too cold	2		
Unpleasant odors of child	6		
Unpleasant odors of home	3		
Interruptions			
By smaller children	4		
By mother	4		
By others (home crowded)	1		
Conditions unfavorable		11	13.6
Indifference	6		
Others[2]	5		
Total		81[3]	100.0

[1] As will be noted, some of the homes in this group presented more than one unfavorable aspect.

[2] Explained in text.

[3] Although the orphanage is not included in this total, conditions there were entirely favorable.

ing, eleven months above in vocabulary, and eight months below in arithmetic fundamentals and arithmetic problems. The teacher saw the mother only once during the next month, as the latter spent much time doing club work, addressing mother's meetings, etc. No two consecutive lessons were held in the same place, and the child's books and materials had to be hunted after the teacher arrived. The child's work was indifferently prepared, and it was difficult to find a place to affix a star, although the teacher felt that it was imperative to give the child approval. When, at last, it was possible to award some stars, the child showed them to the mother who said that that work was so easy that the child certainly should have expected stars. Shortly after this, the mother left town for three weeks and the teacher suggested that the father be shown the stars. It was during the season of Lent, and the child had been sent a box in which to save her Easter offering. The teacher told of another child who was earning his offering by means of the pennies his father gave him for stars on his work, and J. approached her father for a like award. He assented, and the child started out very happily. However, the father left town also, and the child was left with an old negro maid who was expected to do the cooking and house-cleaning also. Various business associates of the father were asked to spend the night, but J. insisted upon remaining up until after

the visitors went to bed. The result was that she overslept the mornings following, and either refused to take her hot packs or behaved so badly during them that her lunch was delayed and she had not time to prepare her lessons. On other occasions, she insisted upon preparing all her lessons the evening after the teacher's visit, and thus was able to postpone her bedtime. A most insecure and superactive child, J. became more and more of a problem to the maid, who quarreled with her as another child would, and was unable to secure her cooperation. By the time the parents returned to town, the teacher felt it was not possible for the child to adjust to such a situation in her weakened condition and in view of the emotional disturbance following her extremely slight crippling. As no doctor's statement has been presented, in spite of the mother's promise, the teacher suggested that the supervisor insist upon an immediate checkup. The teacher hoped very devoutly that the doctor would institute a regime which would give the child some feeling of security, as well as benefiting her, physically. The doctor suggested that the child enter school, being dismissed at noon to go home for lunch before going to the Kosair Crippled Children's Hospital for her treatments on alternate days. This worked out very well; the child became less disturbed and adjusted fairly well at school and by the end of the semester was remaining at school all day, having been able to arrange her treatments so they would not

conflict with school. The teacher met th child and mother at the grocery and was delighted to see how much happier the child seemed, and how much her hyperactivity had leveled off. At the end of exactly two months of home instruction, J. had improved her paragraph meaning score eight months, her vocabulary score seventeen months, her arithmetic fundamentals score four months and her arithmetic problem score three months, in spite of her indifferent cooperation.

F.C. had poliomyelitis during August and began home instruction on December 10. His mother said that, while he had been in 5A the previous semester, he really knew more than most seventh grade children, however, just for the sake of "red tape" she knew that it would be necessary for him to have a little home instruction in order to enter junior high school the following September. F. was a most attractive boy, but his mother's optimistic opinion of his mentality made him a little indifferent to instructions, with the result that the first few lessons were extremely painful to his ego. Accustomed to grades of "1", he was shocked to be graded 40 per cent, 60 per cent, etc. in red pencil; he said the teacher had not explained the work intelligibly. He was showing dangerous symptoms of alibying; in view of what is known concerning the advisability of allowing children to form the habit of shifting blame to others, the teacher realized that she must bend every effort to help the child overcome this tendency. Although he

was eleven years and six months old, F.'s score in arithmetic fundamentals was 4A. However, his score in arithmetic problems was 7B, so it seemed entirely possible to help him catch up. Starting at the point where F. began to make errors in the test, the teacher explained each successive step and had F. do several examples right on the page the teacher used. This page was put into the binder as a proof that the step had been explained and that F. could do this work. F. was expected to complete the assignment on his own responsibility. When F. was able to return to school in April,his arithmetic fundamental score was 8B! His vocabulary test had risen from 6B to 8A, but as he took the paragraph meaning and arithmetic reasoning tests at school and went from 6B to adult level in the former and from 7B to adult level in the latter, the writer feared that time limits had not been observed and that those two tests were thus invalid; consequently F.'s test scores are not included in the data in Chapter VI. F. took part of his final test at school because the home teacher was unwilling to ask him to remain at home an extra week just to take the tests; the K.E.A. holidays were imminent and F. would have had only one lesson that week, and would have had to wait a whole week before finishing the tests.

S.P. was a much indulged child of foreign-born parents. Shortly after the parents'marriage, the father had come to America, and it was not until eight years later that he was

able to send passage money for the mother and brother. S. was born in America and the family lived in the slums until their house was purchased for clearance. Having prospered in the meantime, the family bought a new home in one of the more snobbish outlying sections, where the almost unintelligible speech of the parents and the "different" pattern of living of the family prevented their integration. Shortly after the adored son joined the Air Corps, S. was stricken with rheumatic fever, and it was a most unhappy home situation which the teacher entered. The mother was most emotional and was entirely unable to solve her problems; at one time, she would cast her eyes heavenward and say that what God sent must be accepted as a cross while at another time she would take S. to various private physicians or General Hospital to try to get "medshin" to cure S., although as is usual in rheumatic heart cases, rest and a good diet are most important. Part of the time, she would make S. rest flat in bed without anything to entertain her; at other times, she would allow S. to go to the movies or out into the yard. She did not want home instruction for S.; she wanted S. to go to school so she, herself, could return to work, but she said that the Board of Education's books were no good and wanted S. to study the Catholic books she had used at school. She said the Catholic school might not grant credit for home instruction (this was proved to be in-

accurate upon the child's return to school). It was extremely difficult to help this poor unhappy woman, due to the language difficulty and the mother's feeling of distrust concerning the whole community. However, she did begin to ask how other rheumatic heart patients were treated and how they progressed; when she began to realize that S. had had substantially the same treatment, she did put her to bed for six weeks, at the end of which, S. was able to return to her own school on a part-time schedule. To the end, however, she retained her distrust of the "Board of Education books". The end of the story is sad; S. had a recurrence the following autumn but refused to cooperate with her physician's suggestions. She contracted pneumonia and died after a few days' illness. S. was not given an achievement test at the end of her home instruction period, as she returned to school following the Christmas holidays, without notice to the home teacher. However, her first achievement test had been satisfactory as to national norms, with the exception of arithmetic fundamentals, and her progress was average in the other subjects and rapid in the latter.

All the foregoing cases were of short duration, but B.E. had home instruction for four years. This was a trying home situation; the father was alcoholic and the mother a neurotic. Understandably, the marriage was not a happy one for

either partner, and the mother sought emotional satisfaction from the child, who had had a real handicap, but was being over-protected to the extent that needed surgery was delayed more than a year. The mother was not able to follow the teacher's instructions as to helping the child, and although B. had at least average intelligence, the teacher felt that her achievement was below average, as at the end of the four years, she scored only 3-1 in arithmetic fundamentals, 2-7 in arithmetic problems and 2-6 in spelling while her score in reading was 3-9 in both tests. Her progress is more fully reported in Chapter VI. The writer feels that, had the mother been able to cooperate, the child could have made better progress during home instruction, and could have adjusted better when she entered school. Cut off entirely from the social contacts which might have jeopardized her recovery, due to possible contagion, B. had had no opportunity for social integration and could not enter into school life on an even basis. She assumed the role of reporter to her mother, and the latter distorted every little schoolroom procedure into a threat to her child. Thus, the morning health inspection was an insult, drill in using the school stairs was an attempt to exhaust the child and giving B. the usually coveted position of scorekeeper during directed play periods was construed as excluding her from the game. In an effort to give the child an opportunity to adjust in a

smaller, less active group, the Supervisor transferred her to a special class. However, the mother felt that the first teacher, who had "had a pick on B." would influence the special class teacher to treat her badly, and after two weeks, she removed B. to a private school, which she attended intermittantly the remainder of the year, accompanied in a taxi by the mother. The father does not know that the child made this last change. We found our efforts to help this child adjust entirely ineffective, due to the mother's disturbed condition. Unfortunately, the latter does not feel that she needs help, and the father does not seem able to make a move. Having been a psychopathic patient himself, he may feel that it would not be possible for him to refer his wife; on the other hand, he not only is not informed as to the arrangements made by his wife, but also may not be able to face reality himself.

In each of these cases in which the home conditions hampered the full effectiveness of home instruction, it is of some comfort to note that the children did derive some benefit; the progress in academic subjects was evident, although in no case was it as good as the teacher felt would have been possible under more favorable conditions. However, we know that progress in "book-learning", while considered the ultimate goal of schooling by some, can never be considered the whole picture of education by those who consider the child's future happiness dependent upon his ability to solve the problems of "sex, subsistence and society".

TABLE XVI

NUMBER AND PER CENT OF CHILDREN, CLASSIFIED
ACCORDING TO DEGREE OF COOPERATION WITH
DOCTORS' SUGGESTIONS

Degree of cooperation	Number of children	Per cent
Cooperating in every respect	25	29.8
Cooperating in almost every respect	37	44.0
Cooperating in many respects, but failing in a few	13	15.5
Cooperating so little as to jeopardize the child's future	9	10.7
Total	84	100.

COOPERATION OF THE HOME WITH THE PHYSICIAN

In only nine cases, or 10.7 per cent, was the cooperation of the home with the physician so poor as to militate against the child's chances of recovery. Table XVI shows the comparative degrees of cooperation and it is pleasant to note that twenty-five children, or 29.8 per cent were encouraged by their home conditions to cooperate in every respect with their doctors' suggestions, while thirty-seven children, or 44 per cent failed in only a few minor details, such as, perhaps, slight dietary indiscretion, or failure to return promptly to the doctor's office because the child seemed so greatly improved that strict adherence to the doctor's schedule of check-up was deemed by the parents less important than during the first, more serious months of the illness. On the whole, parents really want to help their children make as full recovery as possible.

THE ATTITUDE OF THE FAMILY TOWARD THE CHILD

In considering the reactions of the families to the children's handicaps, it is necessary to divide the group into several classifications. The congenitally crippled children present a different problem from the children crippled later in life, just as the children stricken with illness which has a bad prognosis from the start present different problems from

TABLE XVII

DEGREES OF COOPERATION WITH PHYSICIANS'

SUGGESTIONS, CLASSIFIED ACCORDING TO THE PROGNOSIS

	Degree of cooperation[1] Percent			
	I	II	III	IV
Illness with favorable prognosis	30.4	45.6	13.0	11.0
Illness with unfavorable prognosis	36.3	45.5		18.2
Crippling caused by illness	21.4	42.9	21.4	14.3
Congenital crippling	14.3	28.5	57.2	
Injuries	100			
Post-meningitis		100		

[1] Degrees of cooperation are taken from Table XVI, preceding this table.

I Cooperating in every respect.
II Cooperating in almost every respect.
III Cooperating in many respects, but failing in a few.
IV Cooperating so poorly as to jeopardize the child's future.

illness which, while necessitating much adjustment of family routine, ultimately may be expected to end happily.

Table XVII shows that, of the forty-six cases with favorable prognosis, however, five cooperated so poorly as to affect the child's recovery. One of these children has since died, and another has had her third attack of rheumatic fever during the past six months and was not expected to recover. Another was crippled due to his failure to cooperate, and the other two have failed to make the expected improvement, although one of the latter did reenter school after partial recovery. However, 89 per cent of those children having favorable prognosis cooperated well.

In the cases with unfavorable prognosis, we find 81.8 per cent cooperating to degrees which place them in columns I and II, and in the injury cases we find 100 per cent in column I, while 100 per cent of the post-meningitis cases are found in column II.

The crippled children show slightly less ability to cooperate; however we find no congenitally crippled child in column IV, and only 14.3 per cent of the cripples whose condition was caused by illness are in that column. Nevertheless, excellent cooperation (column I) was given by only 21.4 per cent of the cripples caused by illness and 14.3 per cent of the congenital cripples. Sadly enough, two of the poliomyelitis victims whose cooperation was very bad probably could have been much improved by hot-packs, exercise and wearing braces, but both are helplessly confined to wheelchairs now.

The crippled children definitely cooperate less closely than other handicapped children; certainly their handicaps must be more discouraging because they are so obvious. Many children with rheumatic heart look entirely healthy; thus the outlook for these children is seemingly more hopeful.

It is with the crippled children, also, that we find a more definite tendency to separate the child from reality. A crippled condition seems so irrevocable that it is sometimes difficult for the parents to hold the child to standards set up for the remainder of the family. Educators feel that the handicapped child should be given special consideration only to the extent that his physical condition demands modification of normal routine, but parents and other relatives of these children sometimes find it difficult not to be too indulgent, even though other children in the family might be unfairly treated, as a result. Thus, in one family, an older brother expressed the wish that he had been born crippled, while in another family, a younger brother was referred to Mental Hygiene Clinic by the home teacher because he was reacting to his feelings of being rejected at home by seeking attention elsewhere by means of undesirable agressiveness. The parents were really desirous of helping this boy, and were able to derive so much benefit from their contact with the clinic that the boy has adjusted excellently.

In another home where the crippled child is the oldest,

the teacher fears that a dangerous situation is developing; the crippled child is never punished, although the younger children are whipped and the former is given first choice on all occasions. Understandable as is the parent's desire to "make up to" the child for her unfortunate conditions, this situation is undesirable for all the children, and the crippled child, although she is only nine, seems to be developing a paranoid feeling that she is always right; she is becoming censorious of the brothers, who are five and seven, respectively. Unfortunately, the parents are so over-protective of this child that it may be difficult to help in this situation; however, the boys may precipitate a crisis in which the teacher can suggest the Mental Hygiene Clinic. Until the parents realize they are being unfair, however, the teacher must go slowly in order to avoid disturbing the excellent rapport which prevails.

As the writer has mentioned elsewhere, the parents of the congenitally crippled children frequently show feelings of guilt which they try to release by overprotection of the child or by projection; they tend to say that the doctor who delivered the child was incompetant, or that the nurse must have dropped the baby. Rejection is covered up by projection, also. It is interesting to note that so many of the mothers of hopeless spastics (those so crippled and so low mentally that they cannot have even home teaching) tell of the child's ill-

nesses, saying, "We almost lost him when he was two, and again when he was three, and he was terribly ill last winter, too". The teacher sometimes wonders whether these children really have frequent dangerous illnesses or whether the mothers, realizing what a merciful release death would be, magnify the seriousness of the child's illness. It is known that spastics are poor operative risks, and in view of the difficulty of giving a balanced diet in many of these cases, it is possible that the mother is entirely correct. At any rate, the writer has yet to see one of these pitiful cases in which the child was not carefully tended to the limits of the mother's ability, even though it means neglect of the rest of the family.

The writer always feels that the mother is more to be pitied than the child, in the cases of congenital crippling. The child knows no other way of life except his own, but the mother can always torture herself with visions of "what might have been", if the child had been born normal.

Children who are born normal and are crippled later, however, go through a period of readjustment which is sometimes very difficult. They work at their lessons in the hope of returning to school with their classmates, but gradually they forget about going back to school and build up a routine of their own. It is fortunate that the future means so little to children; the children suddenly stricken by a crippling

accident or disease do not seem to realize the implications for the future.

The evanescence of the future, however, militates against children suffering from such illnesses as rheumatic heart disease, because these children so often cannot realize that a few months of careful cooperation with the physician's suggestions can make all the difference between an almost normal early adulthood and a life of invalidism or untimely death. Immature parents, also, have the same difficulty in looking ahead; they either cannot face reality, or cannot understand the importance of a hygienic regime. Children from such homes have a very poor outlook, since it is not often that children cooperate without encouragement from their parents.

Although the writer has made the negative cases more conspicuous by taking them up in such detail, it must be remembered that these cases are by far in the minority; she has emphasized these cases only in order to analyse the difficulties. Certainly, the physically handicapped children with whom the writer has come into contact are usually given a great deal of loving care, and it is remarkable that they show such pronounced feelings of security, in spite of their handicaps.

CHAPTER V

MEDICAL INFORMATION CONCERNING CAUSES FOR REFERRAL FOR HOME INSTRUCTION

MEDICAL INFORMATION CONCERNING CAUSES FOR REFERRAL FOR HOME INSTRUCTION

DISTRIBUTION OF CAUSES OF REFERRAL

As shown in an earlier chapter, delicate children are more often referred for home teaching than crippled or injured children. Rheumatic heart disease is the most frequent cause of referral in Louisville, with twenty-nine children, totalling thirty-seven enrollments. Tuberculosis, with seven children totalling seven enrollments, and poliomyelitis, with ten children totalling eleven enrollments, come next in order. Table XVIII shows the number of enrollments and number of children referred for the various causes. That is, a child who had three years of home teaching would have been enrolled three times. In items where the number of enrollements is equal to the number of children, it is obvious that no child was enrolled in home teaching more than once. There are one hundred seven enrollments for eighty-four pupils, so that twenty-three of the enrollments were for children who had had home instruction more than one year. Eight of these repetitive enrollments were under rheumatic heart, three under nephritis, one each under osteomyelitis, poliomyeltis and cerebral palsy, three under lung abscess[1] (see case study B.E. in chapter VI), two under anemia, and four under spinabifida. Unless changes are

made, to comply with suggestions of The Works Survey, the spinabifida and cerebral palsy cases and the two poliomyelitis cases not discharged at the end of the semester, June 1944, will be home instruction pupils until they complete the junior high school curriculum. Two of these children will enter fifth grade in September, one, the fourth grade, and one the seventh grade, thus having a total of nineteen years of home instruction before them. All four of these children would attend the same special class, if a matron could be provided, so that it might be worth while to compare the cost of nineteen years of home instruction with the cost of a matron for the next six years. Heck[1] reports that salaries paid to matrons vary from $400. to $1200. Using the midsalary $750. as a basis for calculation, the salary of a matron for the special class which these four children would attend during the next six years would total $4500. A rough estimate of the total cose of home instruction for these children through the ninth grade is $6,000. When one considers the additional benefits the children would derive from school attendance, this saving of $1500 seems most desirable.

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[1] Arch O. Heck, Education of Crippled Children, Research Bulletin of the United States Department of the Interior, 1930, No. 11, p.19.

TABLE XVIII

NUMBER OF PUPILS AND NUMBER OF ENROLLEMNTS

CLASSIFIED AS TO TYPE OF PHYSICAL HANDICAP

Type of handicap	No. of Pupils	Per cent	No. of enrollments	Per cent
Delicate				
Rheumatic heart	29	34.5	37	34.6
Tuberculosis	7	8.3	7	6.5
Nephritis	4	4.7	7	6.5
Osteomyelitis	4	4.7	5	4.8
Chorea	4	4.7	4	3.8
Post-meningitis	3	3.6	3	2.8
Lung Abscess	3	3.6	6	5.6
Leukemia	2	2.4	2	1.8
Bronchiectasis	1	1.2	1	.9
Anemia	1	1.2	3	2.8
Crippled				
By disease				
Poliomyelitis	10	11.9	11	10.3
Arthritis	2	2.4	2	1.8
Perthe's disease	3	3.6	3	2.8
Hemophilia	1	1.2	1	.9
Congenital defects				
Cerebral palsy	3	3.6	4	3.8
Spinabifida	2	2.4	6	5.6
Hydrocaphelus	1	1.2	1	.9
Injuries	4	4.8	4	3.8
Total	84	100.	107	100.

TABLE XIX

LENGTH OF ENROLLMENT IN HOME INSTRUCTION,

CLASSIFIED AS TO CAUSE OF REFERRAL (DISCHARGED CASES)

Cause of referral	Length of enrollment months								years			
	2	3	4	5	6	7	8	9	1	2	3	4
Delicate											1	
Rheumatic heart	4	6	4	2	1				4		3	
Tuberculosis	2	1		4					1			
Nephritis	1						1[2]					1
Osteomyelitis			1			1	1		1			
Chorea				4								
Post-meningitis		1[3]		1	1							
Lung abscess							1					1
Leukemia					1				1			
Bronchiectasis									1			
Anemia											1	
Crippled												
By disease												
Poliomyelitis	1		4		1				2			
Arthritis									2			
Perthe's disease				1					2			
Hemophilia		1										
Congenital defects												
Cerebral palsy	1[3]		1[4]									
Spinabifida		1[4]										
Hydrocephalus									1			
Injuries	1		1	1		1						
Total	8	10	11	13	4	2	3		15		4	2

[1]One child died

[2]Died

[3]Discharged, unable to adjust

[4]Moved away from city

LENGTH OF ENROLLMENT IN HOME INSTRUCTION,
AS TO CAUSE OF REFERRAL

Table XIX shows the length of enrollment of the seventy-two discharged cases, according to the cause of referral. While four children suffering from rheumatic heart had a whole year of home instruction and three had three years, sixteen of the children were discharged after one semester, or less, and one after six months. Of the eight non-permanent home teaching pupils still enrolled at the end of the school year 1943-1944, four were rheumatic heart patients who had had only two months of home instruction and one who had had six months.

Four children suffering from tuberculosis were discharged at the end of one semester, with one child discharged after three months of home instruction and one after a year. One child not discharged in June, 1944, had had one semester of home instruction.

Only one of the three nephritis cases discharged is still living; she went into special class after four years of home instruction, and expects to enter regular school in September, 1944, having been out of regular school since March, 1939. One undischarged case had had two months of home instruction and will probably be able to return to his regular school in September.

With the exception of one child who entered the hospital

after four months of home instruction, the osteomyelitis sufferers all had more than a semester of enrollment in home instruction, one child having seven months, one eight months, and one a full year.

The four chorea patients had one semester of home instruction.[1] While these children all seemed glad to have the teacher visit them, they did not seem to be able to prepare their homework; consequently, the writer has never felt particularly useful to these patients as far as academic education was concerned. All of these patients were referred by General Hospital, except one who was referred by Children's Free Hospital, and the inference is that it is felt that there is some value in having the teacher visit the home, although we have reported little scholastic success.

One of the post-meningitis cases was discharged as unable to adjust; the other two entered home instruction in the winter. One finished out the school year in home instruction and entered special class in September, the other had five

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[1] The writer has been able to find very little literature on the educability of chorea patients, and has consulted Dr. Brewer, psychologist of the Mental Hygiene Clinic and Mr. Hadley of the Louisville Board of Education's Bureau of Research, as well as Miss Nancy Collins, psychologist of the latter Bureau.

months of home instruction, transferred to special class for the last two months of the school year, and spent the next year, also, in special class.

One child with lung abscess was able to return to school for the last two months of the school year. The writer always urges that, if it is possible, not to wait to finish the year in home instruction, but to get back to regular school, or into special class as soon as possible, so as to have the socializing influences as well as the subject matter. The other child with lung abscess had four years of home instruction, but probably could have returned to school sooner if her mother could have made up her mind to have necessary surgery performed.[1]

A third lung abscess patient, not discharged in June, 1944, was in the hospital convalescing from an operation. She left the hospital about July first, and probably will go to special class in the fall. She had had ten weeks of home instruction.

The leukemia patients were sad cases: one returned to the hospital after six months of home teaching and later died, and one, although the doctor wanted her to get out of the home and go to special class, due to unfavorable home conditions impossible to remedy, became worse, and did not even request home instruction.

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[1] See case study B. E. in Chapter VI.

The pupil with anemia returned to regular class after three years of home instruction.

Two of the undischarged poliomyelitis patients are virtually permanent cases, as they need constant physical care, although both can feed themselves and write with difficulty. The eight discharged polio patients include two who had a whole year of home instruction, four who had four months, one who had two months and one who had six months.

Both arthritis patients had a whole year of home instruction.

Two of the patients with Perthe's disease had a full year of home instruction; one then entered special class and the other returned to his regular school.

The hemophilia patient had three months of home instruction and entered special class at the beginning of the next school year. At the t me that home instruction was recommended by the child's doctor, the child was suffering from severe hemorrhages into the knee joints. He could walk only with extreme difficulty and much pain. This condition became better, but further hemorrhages may occur at any time.

The cerebral palsy cases who were discharged were a child who was unable to adjust, due to unfavorable home conditions and another child who moved out of town at the end of four months' home instruction.

The spinabifida case who was discharged moved out of town. She would have been a permanent case, had she remained in town.

The hydrocephalus case was recommended for special class at the end of the year's home instruction.

One of the injured children was a boy who had severe burns from a gasoline explosion on his legs, necessitating skin grafting. At the end of two months of home instruction, he returned to regular school. Another burned child was the deaf spinabifida case mentioned elsewhere, who stood on hot concrete and burned his feet badly. He had five months of home instruction. The injured child who had four months of instruction before entering special class, cracked the upper epiphysis of the femur and had to have an operation to fasten the bone in place. He was in bed for seven months, and up on crutches for two months before he was allowed to go to special class. The injured boy who had seven months of home instruction broke his femur thirteen months before being referred for home instruction. He got back into high school for enough of the following semester to complete his courses, and get his credits, but had to have an operation, as the bone was not healing. Following the operation, he was in bed for eleven months. During his seven months of home instruction, he was able to do the work necessary to earn the three credits he needed for

TABLE XX

CAUSE OF DISCHARGE OF 84 CHILDREN RECEIVING HOME INSTRUCTION WITH REFERENCE TO CAUSE OF REFERRAL

Cause of referral	Cause of discharge from home instruction							
	Returned to school or graduated	Over age	Could not adjust	Too ill	Died	Left city	Not discharged	Total
Delicate								
Rheumatic heart	18		1	1	1	3[1]	5	29
Tuberculosis	5					1	1	7
Nephritis	1				2		1	4
Osteomyelitis	3	1						4
Chorea	4							4
Post-meningitis	2						1	3
Lung abscess	2		1					3
Leukemia				2				2
Bronchiectasis	1							1
Anemia	1							1
Crippled								
By disease								
Poliomyelitis	7					1	2	10
Arthritis	1	1						2
Perthe's disease	3							3
Hemophilia	1							1
Congenital defects								
Cerebral palsy			1			1	1	3
Spinabifida						1	1	2
Hydrocephalus	1							1
Injuries	4							4
Total	54	2	3	3	3	7	12	84

[1] All left for different climates, one to Florida and two to Texas.

graduation, English VIII and two electives, physical geography and South American history. For five of the seven months, he was in a cast which left free only his neck and head, his shoulders and arms. He had to lie on his back, so that it was impossible for him to read. The teacher read to him every word of the course which was in literature and included Henry Esmond and Hamlet. This took up so much time that it was necessary to give him extra time, by scheduling his lessons at the end of the day so the teacher could stay on for an additional period. Another way of providing extra time was scheduling a child who frequently missed lessons just before this boy's lesson, so that he could have both lesson periods. In this way, during the first five months, this boy averaged four hours per week, although technically, the Board of Education was giving him only two hours. However, should any more high school pupils be recommended for home instruction, it would probably be advisable to give them additional time.

CAUSE OF DISCHARGE, WITH REFERENCE TO CAUSE OF REFERRAL FOR HOME INSTRUCTION

Most of the children discharged from home instruction during the past five years had improved in health, graduated, or had become overage. As shown in Table XX seventy-two discharged cases fall into the classification. Nine children were discharged

for unhappy reasons, but this is only 10,7 per cent of the eighty-four children enrolled during the period under consideration. Three of these could not adjust, three were too ill to continue and three died. One in each of these classifications was a rheumatic heart case, two of those becoming too ill to continue were suffering from leukemia, and two of the deaths were from nephritis. Of the children who left the city, three were rheumatic heart patients seeking a more beneficial climate in order to avoid colds which might bring on recurrences. One was a tuberculosis patient who had been living with her aunt since her mother's death; she returned to her father when the latter remarried. One of the poliomyelitis cases left the city to visit in the country; he returned after some time, but did not again enroll for home instruction. He is a hopeless cripple who spends his time reading and listening to the radio and does not feel the need of further schooling. As he is a member of a large family, he does not miss the social life at school. The cerebral palsy case who left town was the child of an itinerant truck driver. The spinabifida case who moved out of the city was the daughter of a railroad worker who was in Louisville for only a few months before being transferred. The osteomyelitis patient who became overage and chose not to continue was very slow mentally, and had not learned to

read fluently although he had had several years in special class before another flare-up of the disease caused him to be referred for home instruction. The other boy who became overage was a bed-fast cripple from arthritis; he felt that he had gotten all the education he would ever need.

CHAPTER VI

EDUCATIONAL DATA ON THE GROUP RECEIVING HOME INSTRUCTION DURING 1939-40 TO 1943-44, INCLUSIVE

EDUCATIONAL DATA ON THE GROUP RECEIVING HOME INSTRUCTION DURING 1939-40 TO 1943-44, INCLUSIVE

SCHOOL EXPERIENCE PREVIOUS TO ENTRANCE INTO HOME INSTRUCTION

Almost half of the children who received home instruction during the years 1939-40 and 1943-44, inclusive, were in the third, fourth or fifth grades when they were forced to withdraw from school. Thirty-nine children, or 46.5 per cent of the eighty-four children fall into these grades. As Table XXI shows, seven children, or 8.3 per cent had had no previous schooling, nine children, or 10.7 per cent had had only the first grade at school, while twelve children, or 14.3 per cent, however, one of these had had home instruction in another city, were in the second grade. Thirteen children or 15.5 per cent, were in each of the next three grades, third, fourth and fifth. One of the fourth grade pupils had received all previous schooling in a special class. Seven children, or 8.3 per cent, were in the sixth grade and nine children had reached junior high school before illness compelled them to withdraw, five children, or 5.9 per cent in the seventh grade, two children, or 2.4 per cent in the eighth grade, and the same number in the ninth. One boy had only three credits to earn for high school graduation.

TABLE XXI

SCHOOL EXPERIENCE PREVIOUS TO ENTRANCE INTO HOME INSTRUCTION, CLASSIFIED ACCORDING TO LAST GRADE COMPLETED

Last grade completed		Number of children	Per cent
No previous school experience		7	8.3
1 B 1 A	 9	9	10.7
2 B 2 A	2 10	12	14.3
3 B 3 A	3 10[1]	13	15.5
4 B 4 A	2 11[2]	13	15.5
5 B 5 A	1 12	13	15.5
6 B 6 A	2 5	7	8.3
7 B 7 A	2 3	5	5.9
8 B 8 A	2 	2	2.4
9 B 9 A	1 1	2	2.4
12 B		1	1.2
Total		84	100.

[1] One child had received all previous schooling in home instruction in Ohio.

[2] One child had received all previous schooling in special class in Louisville. This child returned to special class when her family moved into a home where her wheelchair could be taken to the taxi.

A study of the grade placement of various types of physically handicapped children shows that the children who reached junior high school level before enrollment in home instruction were more likely to fall into the category of "delicate" children; of the twelve children in junior high or senior high school, ten are classed as "delicate". One of these, an osteomyelitis patient, having his first attack, had home instruction only during the drainage period; he attended special class as soon as he was able to be up on crutches. For this reason, he was classed as delicate instead of crippled. One child in the eighth grade, had had poliomyelitis and was later able to attend special class and one ninth grade boy had Perthe's disease and entered regular school at the end of one semester. Of the four children who entered home instruction in the seventh grade, three had had previous attacks. All of these were overage for their grade, one having missed a complete semester; one, two semesters and the other, three semesters. All had had their first attacks prior to the establishment of home instruction.

As would be expected, those children with congenital defects had not entered school. However, one spinabidida case entered Louisville home instruction at third grade level, having had two hours daily of home instruction for two years in Ohio. This child moved out of the city after two months

of Louisville home instruction. The child who had had hydro-cephalus had not been permitted to do anything for himself and was accustomed to being led by the hand when he walked, which was very seldom. After a year of home instruction, his doctor certified that he was able to attend special school. Of the three cerebral palsy cases, one moved away from the city, one could not adjust, and was discharged for trial later, and the third is still enrolled in home instruct-ion, where she will have to remain, unless the recommendations of The Works Survey are carried out, as she needs help in eating and at the toilet. This child, with the remaining spinabifida case and two of the poliomyelitis cases, has been classified as "permanent" pending additional services and accomodations in the special class. See Table XXII.

TABLE XXII

GRADE PLACEMENT AT ENTRANCE INTO HOME INSTRUCTION, CLASSIFIED AS TO CAUSE OF REFERRAL

	Grade placement at entrance into home instruction, as determined by achievement test scores.												
Cause of referral	1	2	3	4	5	6	7	8	9	10	11	12	T
Delicate													
Rheumatic heart		5	3	8	4	5	4						29
Tuberculosis		1	1	1	1	1		2					7
Nephritis			1		2	1							4
Osteomyelitis[1]			1	2				1					4
Chorea				1	1	1				1			4
Post-meningitis	3[2]												3
Lung Abscess	1		1		1								3
Leukemia			1				1						2
Bronchiectasis		1											1
Anemia							1						1
Crippled													
By disease													
Poliomyelitis		1	4	1	1	2		1					10
Arthritis	1				1								2
Perthe's disease		1		1					1				33
Hemophilia[3]					1								1
Congenital defects													
Cerebral palsy	3												3
Spinabifida	1		1[4]										2
Hydrocephalus	1												1
Injuries			1				1	1				1	4
Total	10	9	14	14	12	10	7	5	1	1		1	84

[1]All previous schooling in home instruction in Ohio. Has moved out of the city.

[2]Two had attended school, but illness had caused retrogression.

[3]Included under crippled because hemorrhages into knee-joints were cause of crippling, which led to referral for home instruction.

[4]Enrolled in home instruction while draining.

Any apparent discrepencies between the grades shown, Table XXI and Table XXII are due to the fact that, although many of the children go into home instruction after only two or three months have elapsed since withdrawal from school, which is particularly true of the rheumatic heart cases, which make up 34.5 per cent of the eighty-four home instruction cases treated in this study, others have been out of school some time, whether too ill at home to want to do school work, or in a hospital undergoing operations or strenuous treatment, so that their achievement test scores fall below the norms for the last test completed.

Various causes are found for the fact that many of the children receiving home instruction are overage for their grade placement. The eight year old child in the first grade was a cerebral palsy case unknown to the Department of Health and Safety until the visiting teacher in the district discovered her when a younger sister enrolled at school. The mother took the two children to school the first day, the crippled child in a baby buggy, and the visiting teacher reported the case for investigation. This was the child that was given a trial period, but was unable to adjust as her mother took employment in a tobacco factory, leaving the child with various neighbors and relatives. The child's father was remarried, and the stepfather was an indifferent provider, but the mother refused to take any legal steps to force either to contribute, although

the crippled child really needed to have her mother at home.

The three ten-year old children in the first grade ~~were~~ were an arthritis patient who moved into the city from a rural district where no special education was offered, and two post-meningitis cases who had retrogressed as a result of illness. One was able to make progress in home instruction and went on to special class for a year, then back to regular school. The other could not adjust to home instruction, and was discontinued, but later entered an ungraded class for mentally retarded children. Both of the latter placements were made on recommendation by the Bureau of Research.

Both of the nine-year-olds in the second grade were children having their second attack of rheumatic fever. Both were from other cities with no special education facilities.

One of the ten-year-old children and the eleven year old child in the third grade were having second and third attacks of rheumatic heart. The ten-year-old had been in the convalescent home for three years, often too ill to have her lessons and hampered by rather low mentality. The eleven-year-old child had attended parochial school when her health permitted, but had failed so often due to intermittent attendance that the mother requested home instruction. The child had home instruction from February 1942 to January 1943 and was able to transfer to 5A in special class, where she has made good progress. The other ten-year-old child in the ~~third~~

third grade had been a frail child, missing a great deal of school, previous to being diagnosed as tuberculer. He was able to return to regular school after a spring semester in home instruction.

In the fourth grade, the eleven-year-old was a rheumatic heart patient who had, earlier in life, been kept out of school during an attack of osteomyelitis. This had occurred before the Louisville program of special education had been extended to include orthepedic and cardiac cripples and other delicate children. One of the twelve year old children had had poliomyelitis at an early age, and had remained in General Hospital until eight years old; when she returned to her home, she was able to attend special school until she became so heavy that she could not be carried down the steep stome steps in front of her home to the taxi. After a year in home instruction, however, she was able to return to special class as he family purchased a home with an alley entrance suited to her needs. The other twelve year old had her first attack of rheumatic heart when she was four years old, and had been in and out of the hospital and special class at Salisbury for eight years, having started in the latter when it was opened in 1939. Her slow learning ability and her frequent absences and transfers had impeded her progress. The thirteen-year-old and the fifteen-year-old were

both boys who had had several attacks of osteomyelitis; these, coupled with slow learning ability, kept them from making normal progress.

In the fifth grade, the thirteen-year-old had been out of school earlier in life, due to tuberculosis and was having a flare-up. The eighteen-year-old had been out of school a number of years before coming to Louisville and had been in the hospital for several years before having home instruction. His reading ability was adult, but in the other subjects, he was much retarded. However, at the end of one year of home instruction, he scored grade 9^0 or better, in his subjects, except arithmetic reasoning, and was content with his education. He was an excellent student, as well as of good learning ability, and did all the work in the fifth, sixth and seventh grade arithmetic and mathematics books so faithfully that he scored 8^4 in reasoning and 9^2 in computation.

In the sixth grade, two fourteen-year-old and one fifteen-year-old had been out of school some time before enrollment in home instruction. One of the former was a severely handicapped rheumatic heart patient who died after three years of home instruction. Before home instruction was inaugurated, he was out of school three years, so that his achievement test was lower than the grade he had last attended. The other fourteen-year-old was a tuberculosis patient who had had the same sort of experience. The fifteen-year-old had com-

pleted the fifth grade four years before enrollment, but had been so ill with nephritis that he had not been interested in having school. For a while, however, he seemed better, and he had home instruction for just two months, during which he made excellent grades, before he became worse and died.

The seventh grade overage children were a rheumatic heart patient having her third attack and a deaf boy, who, due to spinabifida, had no sensation in his feet so that he burned them severely on hot concrete walks at a swimming pool. The pedal extremities of spinabifida patients have so little circulation that they heal very slowly; therefore, this boy was out of school a year as a result of these burns. Totally deaf, he was able to profit by home instruction because he had been taught lip-reading in the special classes for the deaf.

The sixteen-year-old in the eighth grade was a boy who had been crippled by tuberculosis in early years, and had been sent to the King's Daughter's Home for Incurables from his home in the Kentucky mountains. He had been adopted, and his foster parents had had his hip operated upon to lessen the extent of the crippling. It was during convalescence from this operation that he was enrolled in home instruction.

ACHIEVEMENT OF HOME INSTRUCTION PUPILS DURING ENROLLMENT

As shown elsewhere in this study, the length of enrollment in home instruction varied from two months to five years. Twelve of the children had not been discharged up to the close of the semester in June, 1944. Of the seventy-two children who had been discharged from home teaching, forty-five, or 62.5 per cent had left at the end of five months, or less. Twenty-one, or 29.2 per cent of the discharged cases had been enrolled for from six to ten months inclusive.

Achievement tests are administered on entrance into home instruction to all children except those who have had no previous schooling. At the end of each semester, or at the end of enrollment, whichever occurs first, achievement tests are again administered if the child is able to take the tests. Except for those children expecting to enter high school, the home teacher administers the tests. The high school candidates go to the Bureau of Research, where the psychologist administers the tests and makes recommendations. This procedure as to high school entrance is followed for the special classes for orthopedic and cardiac cripples and delicate children.

TABLE XXIII

ACHIEVEMENT TESTS OF HOME INSTRUCTION PUPILS,

SHOWING NUMBER OF SETS, CLASSIFIED

AS TO REASON FOR LACK OF COMPLETION

~~Complete sets~~		Number of pupils	Per cent
Complete sets		35	41.7
Children below 5th grade, tests not administered		17	20.3
Incomplete sets		32	38.0
No previous schooling	7		
Final tests at Bureau of Research	2		
Parallel tests not available	5		
Progressed beyond available tests	1		
Enrollment too short	5		
Test not valid (time limits apparently not used)	1		
Too ill to take final test	5		
Died	3		
Left city	3		
Total		84	100.

In the past five years, only thirty-five children took both tests. Reasons for lack of complete sets are given in Table XXIII. Seventeen children below fifth grade level were enrolled before achievement tests were made compulsory for these children. Of the remaining thirty-two incomplete sets, seven children could not take achievement tests because they had had no previous schooling, and two were high school candidates. Reports on some of the final tests are given in the case studies.

In five cases, parallel tests were not available; the Bureau of Research supplies these tests, and could not furnish two different forms of the same test. One child progressed beyond the available tests and one child, who was given his final reading test after he returned to school scored so high that the writer discarded the result, fearing that the time limit was not correctly used. In five cases, the enrollment period was too short for the tests to have much validity; the write felt that there was too much chance that lucky guesses would affect the scores. Five children were too ill to take their final examinations, and three died. Three children left the city, two unexpectedly and the third after such a short period of enrollment that she was not given a test, the time being used for lessons up to the last, as she was going to a place with no special education program.

Comparison of the achievement test scores with length of enrollment of the thirty-five children shows wide variation in the number of months gained in educational age during a given period of enrollment.

TABLE XXIV

NUMBER OF MONTHS ENROLLED AND NUMBER OF MONTHS GAINED IN EDUCATIONAL AGE AS SHOWN BY ACHEIVEMENT TEST SCORES OF THIRTY-FIVE CHILDREN HAVING HOME INSTRUCTION IN LOUISVILLE, 1939-40 TO 1943-44, INCLUSIVE

Case number	Col. I Number of months enrolled	Col. II Number of months gained or lost in educational age	Per cent Column II is of Column I
1*	2	+4	200
2*	2	+8	400
3	2	+11	550
4	2	+13	650
5*	3	+3	100
6	3	+12	400
7	4	+6	150
8	4	+7	175
9*	4	+8	200
10	4	+9	225
11	4	+10	250
12*	4	+19	475
13	4	+20	500
14	4	+23	575
15	5	- 5	-100
16	5	+ 5	100
17*	5	+ 9	180
18	5	+ 9	180
19	5	+10	200
20	5	+18	360
21	5	+19	380
22	5	+23	560
23	6	+12	200
24	7	+21	300
25	9	+13	144
26	10	+13	130
27	10	+13	130
28	10	+15	150
29	10	+22	220
30*	10	+25	250
31	10	+30	300
32	10	+31	310
33	10	+35	350
34	10	+36	360
35	20	+37	185

* Indicates pupils who were given Metropolitan Achievement Tests. Cases not marked were given the New Stanford 4-9 Tests.

Table XXIV shows that, during two months of enrollment, four children gained from four to thirteen months in educational age. The latter child, who showed the fastest gain of the group, was a ten-year old 4A boy of superior ability who had failed in the second grade. He had never liked school and had just slipped through on a minimum amount of effort. When he became ill with rheumatic heart disease in November he started Home Instruction with very little enthusiasm. However, he soon became interested in bringing up his arithmetic score to the level of his other studies, as the father obtained a transfer to Dallas, Texas, for the sake of the boy's health. As the schools in that city have no mid-year promotions, the teacher tried to encourage the pupil, who was a good reader, to work hard on the arithmetic so as to be able to go into the fifth grade in Dallas, instead of having to mark time in the fourth. The mother had fallen into an unfortunate habit of expecting more of the boy than he did; that is, she never seemed able to give the child approval, but always took the attitude that he could accomplish even more, if he tried. This was undoubtedly true, in view of the child's apathy toward school, but the teacher helped the mother to understand that approval might be a better spur than condemnation. Fortunately, the boy's work began to improve, so that the mother really had to give ap-

proval, and this, in turn, led to greater effort. The boy was able to enter fifth grade when the family arrived in Dallas, in February, and was promoted to the sixth grade in June. As indicated by results of an individual psychometric test at the Bureau of Research, this child was of definitely superior abilty, and was not being challenged by the work of the grade in which he was spending boring weeks. After the boy entered the sixth grade, his mother wrote to tell the teacher of his success, and commented that, for the first time in his life, he now liked school.

The variation in the amount of achievement of the pupils is due to a number of causes. The child's interest in school, the frequency of sick spells which cause him to miss lessons, the interest his parents show in having his materials at hand, and their willingness to dictate spelling words or work with flash cards, and their ability to encourage the child, all contribute to the results, as well as the most obrious cause of variation in speed of learning, mental ability.

Beginning reading progresses very slowly, unless the mother is able to learn to help the pupil between lessons, but above first grade level, the experience in Louisville has shown that, other factors being favorable, the child who could make normal progress in regular school, if he were not physically handicapped, can make better than normal progress

in home teaching. That is, given normal mentality and emotional stability, as well as reasonably regular lessons and preparation, the crippled or delicate child can progress faster in academic subjects at home than the physically normal child does at school. In many cases, school work is the physically handicapped child's main interest; it is a link with the outside world in the sense that the child feels that he is doing what any other child can do.

That normal progress is possible, although the pupil is homebound, is the general feeling of those who work closely with physically handicapped children. It is felt that these children should have every opportunity to follow the same curriculum offered to physically normal children, within the limits of their physical ability. As Riker says, "Maintaining academic standards that approximate those of the regular schools helps to create a feeling in our children of the importance of school achievement as preparation for a rich experience in later years."[1]

It is felt keeping up in his school work helps the patients morale. A physcian's point of view is: "An attempt

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[1] Jeannette Riker, "A School for Crippled Children" The National Elementary Principal, Bulletin of Elementary School Principals, National Education Association, Nineteenth Yearbook, July, 1940, p. 526.

must be made to keep the patient up to his scholastic level".[1]

The experience in Los Angeles bears out that in Louisville. "The amount of work which a child at home can do depends on his degree of illness. Some are allowed a small quota of study, while a majority do quite satisfactorily all the minimum essentials of the elementary course of study. In the main it has been found that elementary pupils keep up to grade with this type of teaching if they have a crippling condition which does not cause pain or temperature."[2]

New York City home instruction pupils follow the regular curriculum, as Lee says, "The homebound children pursue the same courses of study as the children in our regular classes in public schools."[3]

Promotions and tests in New York City are the same as those given physically normal children. Spillman says," The same school program and instruction in the same subjects are

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[1] T. Duckett Jones, "Chronically Ill Cardiac Children in Institutions and Foster Homes," Transactions of the American Hospital Association, 1939, p.759.

[2] Mabel Fonda Wells, "Home Instruction for Physically Handicapped Children", Los Angeles School Journal, January, 1939, p.12.

[3] Grace E. Lee, "News and Comments New York City Home Instruction Class Graduated in January," Journal of Exceptional Children, April, 1942, p.230.

provided for them that other children are receiving in classes in school. Promotions are made as the children finish the work of each grade, and their monthly progress is compared with that of the children in a nearby school of affiliation.

"Regardless of physical handicaps and other difficulties, with ready smiles and determination to succeed, these exceptional children have passed, many with honors, the same examinations, Regents' tests, and qualifications of the principals and superintendents, as the children in regular classes."[1]

Follow up work in Portland, Oregon, is reported by Lundberg, "Fifteen per cent made the same average in grades after return to school as before leaving for home instruction, 50.8 per cent made a higher average."[2]

CASE STUDIES OF CHILDREN NOT HAVING COMPLETE SETS OF ACHIEVEMENT TESTS

Many of the thirty-two children not having complete sets of achievement tests did outstanding work in Home In-

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[1] Esther Spillman, et al "Home Instruction in New York City", Journal of Exceptional Children, March, 1941, p.246

[2] Ruth W. Lundberg, "A Survey of the Physically Handicapped Children Taught in the Disabled Department of the Portland (Oregon) Public Schools," p.69.

struction. The fact that individual difficulties are brought out at the time Home Instruction begins, and are dealt with in the privacy of his own home where the child is not embarassed by having to ask for repetition of explanations helps the Home Instruction pupil to work at his own problems until he has mastered them. He soon begins to have a feeling of success that he may never have experienced before. Reports on children who did not have complete sets of achievement tests follow.

1. P.H. A lung abscess patient, took her first achievement test on March 1, 1944, scoring as follows:

Paragraph meaning 8^2 Word meaning 6^0

Arithmetic reasoning 4^6
Arithmetic fundamentals 4^7

She had entered 5 B the previous September, and had withdrawn from school in November. She entered the hospital for an operation May 15, 1944, after ten weeks of home instruction. At this time she had completed the arithmetic course for the fifth grade, with the exception of denominate numbers. After her operation, she had one lesson at the hospital, in which she mastered the principles of denominate numbers. She had also learned multiplication and division of fractions, which are usually taught in 6B. She had almost completed the reading workbook and had covered half the course in geography. In spelling, she was ready to start the last unit in the book, which means that, with the exception of the reviews, she had covered five-sixths of the year's work. An excellent worker, with splendid habits of work, she prepared her work carefully and her binder with all its

stars, was her bedside companion at the hospital. Her mother reported that her attitude was much more cheerful and her appetite improved after she started Home Instruction. If she is able to go back to school in September, she will be able to hold her own in 6B. The teacher always tries to keep her pupils several weeks in advance of the pupils in regular school, to make provision for just such emergencies as this child's sudden admission to the hospital. P. is one of the children who could not take the final achievement test, but there is no doubt that she earned promotion.

2. R.L.C. attended a parochial school until he became ill with nephritis in February, 1944 and entered Children's Free Hospital, where he was given bedside instruction as soon as he was able to profit by having lessons. When he returned to his home, the hospital teacher reported that the child was very much distressed about school; he feared that, instead of entering the sixth grade in September, 1944, he would have to start the fifth grade all over again, and thus lose contact with his classmates. The mother had visited the principal of his school, after having been informed concerning home instruction by the hospital teacher, and had been told by the principal that if the child could have home instruction for the remaining six weeks of the semester, he would be permitted to enter the sixth grade in September, if the home teacher felt that he could do the work. The principal was familiar with the results of home teaching, having had in her school for almost two years a child who had his first grade experience in home instruction.

R. was an excellent pupil, as his past records showed, but he had missed the lessons on fractions and was not very sure of long division. As there was such a short time remaining, the teacher

did not use the first two lessons for achievement tests, but went right into the arithmetic. In the six weeks, R. learned addition of fractions with carrying and subtracting of fractions with borrowing, addition and subtraction denominate numbers and perfected himself in long division. He finished the course in spelling, in which he had not been behind, and completed the whole reading workbook. The week before school was over, the doctor removed all restrictions and told him he could gradually resume all his past activities. When he took the final achievement tests in reading and arithmetic, his grade scores were as follows:

Paragraph meaning 5^{6} Word meaning 5^{3}
Arith. reasoning 7^{4} Arith. computation 6^{7}

Although his reading scores were not up to sixth grade level, they were near his chronological age, which was 11^{3} at the time of the test; his paragraph meaning score was age 11^{5} and his word meaning age score was 11^{2}. The teacher feels that, as he is such a good worker, and as he has a feeling of success in his fifth grade work, he will be able to succeed in the sixth grade next year.

3. J.P. has had no schooling except home instruction. Born in 1932, he is the oldest of five children; his brother and three sisters attend parochial school. Beginning home instruction in September, 1939, at age 7^{5} he was not given a test because he had had no previous instruction. Born with spinabifida, a congenital cataract and club feet, he was just beginning to walk on crutches when the teacher first visited him. Lacking bladder and bowel control, he will not be able to attend special class unless the provisions of the Works Survey as to a nurse or matron are carried out.

He is of slow learning ability, well within the range of normal; he was given a psychometric at the Board of Education on September 5, 1941, as the nurses at the Kentucky Crippled Children Commission felt that he was not normal, mentally. They based this conclusion upon the fact that the child did not talk to them when he was taken in for examination as a young child. However, the mother reports that when she took him to a follow-up clinic in the spring of 1944, the nurses were amazed at his friendliness; the mother feels that he has been developed socially as well as educationally by his home instruction experience. J. is a most attractive child; he is friendly, interested in others and in current events, and able to accept the limitations imposed by his handicaps with good grace. An instance of his cleverness in compensating for his physical short-comings was his purchase of an army canteen to take to the movies, which he attends weekly. He said, "the other kids"always went to the back of the theatre for a drink, so he decided to take his drink along.He even added a touch by taking R.C." instead of water! Although he has missed many lessons, and has been unable to prepare many more, due to recurrent ulcers of the buttocks which send his temperature soaring, he has made splendid progress during the five school years he has been enrolled in home instruction. In April, 1944, he missed most of his lessons, due to another ulcer, and lost some of the arithmetic skills he had gained, especially the more recently acquired ones. Test scores for the past three years follow:

Metropolitan Tests Achievement:

Primary III Battery: Form C, June,1942

Reading 2^3 Vocabulary 2^5
Arith.fundamentals 3^4 Arith.Problems 3^0

Primary III Battery: Form A, June 1943

Reading 3^4 Vocabulary 2^9
Arith. Fundamentals 3^5 Arith.Problems 3^3

New Standard Achievement Test:

Primary Examination: Form V, June,1944

Paragraph meaning 4^6 Word meaning 5^0
Arith, Computation 3^9 Arith. reasoning 5^1

In the latest test, his educational age is placed at 10^6, or grade 4^6, at the end of five years of interrupted home instruction. As will be seen by examination of the test scores, the beginning reading was very slow. This was due partly to the fact that the mother was reluctant to take him to a doctor for refraction; she now regrets that she did not take him sooner, and voluntarily suggested that he be taken for re-examination before the beginning of the next school year. The teacher has found that children who have had no previous schooling are rather slow in learning to read at home. However, once they have started reading, they progress rapidly, as seen by J.'s increase of a year and a half in reading average in a year of instruction. During the past year, he has become interested in reading the little papers, similar to _My Weekly Reader_ which the brother and sisters bring home from school and in reading the text of comic books. The teacher furnished a library list, from the Louisville _Course of Study in Reading_ so he could

have books brought to him from the library, His first choice was The Little Lame Prince.

This is a most cooperative home; the child has his own desk at a large window in the dining room, and keeps his materials there except while he studies in bed. The mother drills him in spelling and the father sees to it that he reads the arithmetic problems correctly. However, neither was able to help with reading in the early days; the teacher feels that they are more sure of the child's success now, and can be unemotional about his errors. Too, the other children are all in school now, and the parents realize that a few mistakes do not mean that the child is not going to learn. The other children are most interested in the progress and were just as happy about his excellent test scores, this past June, as were the mother and the teacher.

4. B.E. another child who had no schooling previous to home instruction, is now in regular school. The first year, she had one thirty-minute lesson per week, the second year, two thirty-minute lessons weekly. The third and fonrth years, she had two one-hour lessons per week, the usual allotment of time per pupil.

B. Developed a lung abscess following tonsillectomy at the age of four years. Nine months later, the abscess was opened by surgery. For three years, she had a drainage tube from her lung, necessitating daily dressings. In the summer of 1942, the tube was removed and the opening was closed by surgery. For another year, she was kept out of school due to the doctor's fear that measles, mumps or whooping cough, which cause coughing, might damage the repairs he had made. In September, 1943, he certified that the

child was completely cured, and could return to school with no special restrictions. However, the mother was unable to consider the child cured and made daily trips to the school to complain that the child was not given consideration. Realizing that, in order to help the child adjust to a school situation, we were going to have to humor the mother, the assistant superintendent and the supervisor of special classes, advised transfer to the special class at Salisbury. However, here again, the mother felt that the child was not given enough special attention, and she placed her in a small private religious school in the neighborhood. A Catholic, she did not dare place her in the parochial school because a neighbor with whom she had had trouble had an aunt who was a nun,and she feared that the neighbor would ask the nun to see that the teachers at the parochial school "took a pick" on B. A most unhappy woman, she feels that the neighbors hate her; when the teacher's car had a flat tire in front of the home, she said that the neighbors had cut the tire. She has a need to get her emotional satisfaction from the child, as her husband is in bad health, and she unable to trust strangers to treat the child kindly. Many times during the home instruction period she was so disturbed that she was unable to let the lesson proceed, but spent much of the time telling how the world abused her and persecuted her. Realizing that, in order to help the child, she must "wait out" these interruptions in order to try to let the mother release her emotions, the teacher tried to help the mother to interest herself in helping with the arithmetic drill. Apparently, the mother had feelings of guilt about the delay in getting proper treatment for the child, as she seemed to be projecting her feelings by blaming the

doctors. Also, she rejected the child and attempted to compensate by over-protection. An attempt to get her to go to the Mental Hygiene Clinic, by the supervisor, was a deadly insult; she said that if she had to go to that clinic the teachers at school would have to go, too. All that was the matter was the teacher at the first school the child entered; her treatment of the child was keeping her from doing good school work anywhere. Perhaps the child will get no further education, says the mother; she has enough education to enable her to read anything she wants to, and to make change, and that's all she needs.

With the mother so ill, it is a very bad outlook for the child. However, she did profit during Home instruction, and the mother still calls the teacher to tell her how badly the world treats her. Having no friends and no relatives in the city, she seems to need some outlet, and although the teacher has scant feeling of success in her attempts at helping the mother, she does feel that the child's home instruction was worth while. Test scores follow;

Metropolitan Achievement Tests

Primary III Battery, June 1941

Reading 2^{1} Word meaning 2^{2}
Arith,Fundamentals 1^{6} Arith,Problems 0

June 1942
Reading 3^{3} Word meaning 2^{5}
Arith.Fundamentals 2^{6} Arith.Problems 0

June 1943
Reading 3^{9} Word meaning 3^{9}
Arith.Fundamentals 3^{1} Arith.Problems 2^{7}

The child had very poor number concepts, never having played with other children, due to fear of contagion while she had the drainage tube in her back;

and had never been allowed to handle money. When the child entered the fourth grade last September, she did acceptable work in everything but arithmetic.

5. B.K. had three years of home instruction, during an illness diagnosed as anemia, covering the seventh, eighth, and ninth grades. Of definitely superior mental ability[1] she went to the Bureau for high school entrance examinations, scores in which follow:

New Standard Achievement Test, Advanced, Form V.

Paragraph meaning	- well above 11th grade
Word meaning	- well above 11th grade
Dictation , spelling	- 9^0
Language usage	- at least 11^0
Literature	- well above 11th grade
History and civics	- 9^8
Geography	- above 10^0

Columbia Research Bureau Algebra,Test 2, Form B (revised)

Part I	(Equations)	78th percentile	for public schools at end of 1st year
PartII	(Problems)	75th percentile	

6. D.P. also had the same instruction as B.K. The two girls had their lessons together, as they were neighbors whose back yards adjoined. However, D.'s I.Q. was 89, as determined by the Kuhlmann-Anderson group test routinely given sixth grade pupils.

D. is a sweet girl and very pleasant to work with. She had sufficient mental ability to get the 9th grade work, but she was ill much of the time, as she was a severely handicapped rheumatic heart patient. In addition, her brother retard-

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[1] Mental age 18^4 at chronological age 17^3, as determined by Revised Stanford Binet, Form L at the Bureau of Research.

ed her by doing much of her algebra homework. D. could do the class work as each new step was taken up, and she brought in her home work with an acceptable degree of success, but it was not until after she had failed in the algebra test t the Bureau of Research that she confessed that her brother had done the homework and she had merely copied it. She had been told many times that she did not have to cover the courses in the regular time, but could take two years for the grade, if necessary, but she refus d to allow any special considerations and thought she was solving her problems by letting her brother do her work. The same refusal to make allowances for her physical limitations has increased her handicap, as she has had her fourth attack of rheumatic fever recently. With care, she might have avoided recurrent attacks and consequent further damage to her heart. Achievement test scores follow:

New Standard Achievement Test, Advanced, Form V.

Paragraph meaning	10^1
Word meaning	- above 10th grade
Dictation	8^2
Language usage	- above 10th grade
Literature	8^2
History and civics	8^1
Geography	6^6

The fact that no geography was taught during the three years of home instruction explains her low standing in that subject.

Columbia Research Bureau Algebra, Test 2, Form B

Part I (Equations)	6th percentile	for public schools at end of 1st year.
Part II (Problems)	22nd percentile	

The psychologist suggested another Algebra test before school opened in the fall, as D. was quite nervous when she got to the Bureau of Research, and Algebra was the first given.

D. was almost eighteen when school opened in the fall, and she refused to attend regular school. Instead, she enrolled in a private night business school and attended for a year. She took a position the following fall.

SUMMARY

SUMMARY

Home Instruction for white Louisville children was started in 1938, as a part of the special education program of the Louisville Public Schools. As the first year was not typical of the present set-up, data for only the past five years, 1939-40 to 1943-44, inclusive, are included in this study.

Any child eligible to attend Louisville's public schools may have Home Instruction if his physician certifies that a physical handicap prevents his attending school.

During the past five years, eighty-four children were enrolled in Home Instruction for periods ranging from two months to five years. Of the seventy-two children who had been discharged from Home Instruction prior to June, 1944, 62.5 per cent were enrolled for one semester or less, and 29.2 per cent for six months to one year before returning to school. Eight of the twelve who had not been discharged were expected to enter school in September, 1944.

Children were referred for Home Instruction by various agencies and interested persons, as well as by parents. Causes of referral of these crippled and delicate children included eighteen different handicaps. Two-thirds of the pupils were classed as delicate. Rheumatic Heart Disease caused 34.5 per cent of all referrals while poliomyelitis caused 11.9 per cent.

The homes of the pupils were scattered over the city, with nearly every neighborhood represented. The teacher travelled 800 miles per month in her car.

Conditions affecting the success of the child's school work were entirely favorable in 55.6 per cent of the homes. In only 13.6 per cent were conditions so unfavorable as to jeopardize the child's success.

Many doctors, nurses and medical social workers feel that Home Instruction has a definite therapeutic affect, not only because it gives the child a feeling that he is keeping up with his school work, but also because it enables him to compete with his classmates upon an even basis when he returns to school.

Cooperation of the families with the suggestions of the physicians was unfavorable in only 10.7 per cent of the cases. Complete cooperation was found in 28.9 per cent of the cases, while 44 per cent were following almost every suggestion.

The families of the Louisville Home Instruction group follow the pattern of the father as breadwinner and the mother as housekeeper, in most cases. The occupational groups follow faiτly closely the same percentages shown for Louisville families, with the exception that the group "operatives and kindred" is much larger for the Home Instruction group.

The size of the families of the Louisville Home Instruction group was somewhat larger than those of Sample D of the United States Census of 1940, but the homes were

slightly less crowded.

Grade placement of the Home Instruction pupils ranged from 1B to 12A, with almost half of the cases in the third, fourth and fifth grades. Many of the pupils were overage because of frequent absence during school enrollment.

Achievement was excellent for most pupils. With the exception of beginning reading, the gain in educational age greatly exceeded the gain in chronological age in nearly all cases. This was in agreement with results in other communities having Home Instruction.

CONCLUSIONS

Home Instruction is an effective means of carrying on the child's education while he is unable to attend school.

Pupils having Home Instruction usually make at least as good progress as they were able to make while attending school.

While the families of the Home Instruction pupils of the past five years were slightly larger than average, in other respects the families and homes of these pupils were not exceptional.

Pupils who need Home Instruction are likely to be found in any school district.

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APPENDIX

LOUISVILLE PUBLIC SCHOOLS

DEPARTMENT OF HEALTH AND SAFETY EDUCATION

PHYSICIAN'S STATEMENT ABOUT PHYSICALLY HANDICAPPED CHILD

Name of Child _ _ _ _ _ _ _ _ _ _ _ _ _ _ Date of Birth _ _ _ _ _

Address _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Parent _ _ _ _ _ _ _ _ _ _

Diagnosis _

Prognosis: Good _ _ _ _ _ _ _ _ Fair_ _ _ _ _ _ _ _ _ _ Poor _ _ _ _

Remarks _

SCHOOL PLACEMENT REQUESTED BY PHYSICIAN: (Check only one)

- - 1. Home Instruction (for those children who must remain in bed or be confined to their homes for a period of at least one year).

- - 2. Assignment to a class for cardiac and orthopedic cripples. (Cardiacs, Classes II and III, orthopedic cripples who cannot attend regular school because of severity of crippling; hemophiliacs; etc., etc.)

- - 3. Assignment to regular school with physically normal children. (Please note specifically if there are any activities in which the child should not engage.)

_ _

_ _

_ _ _ _ _ _ _ _ _ _ _ _ _ _ _
M. D.

_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _
Clinic

_ _ _ _ _ _ _ _ _ _ _ _ _ _
Office Address

_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _
Social Worker

_ _ _ _ _ _ _ _ _ _ _ _ _ _
Date

TO THE PHYSICIAN:

Please return this form to Miss Mary May Wyman, Board of Education, 506 W. Hill Street, Louisville, Kentucky. If you wish information about school arrangements, please call Miss Wyman, MAgnolia 3083.

Copy of form used by Bureau of Census, Louisville Public Schools, for reporting to Department of Health and Safety those children who have withdrawn from regular school, due to illness.

REPORT OF WITHDRAWAL*

Date _ _ _ _ _ _ _ _ _ _ _

Name _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ School _ _ _ _ _ _ _

Address _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Grade _ _ _ _ _

Date of Birth _

Name of father _

Name of mother _

Reason for withdrawal _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

_ _

_ _

*Make out this report when a child has withdrawn without a transfer notice. Send original copy to the attendance officer. The duplicate is to be retained by the principal or teacher in charge of the school.

Copy of file card used by Department of Health and Safety

Child's name _ _ _ _ _ _ _ _ _ _ Address _ _ _ _ _ _ _ _ _ _

Date of birth _ _ _ _ _ _ _ _ Parent _ _ _ _ _ _ _ _ _ _ _ _

Referred by _

Reason _

_ _

Physician _

Previous school experience _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

S. S. X. _

Mental tests _

_ _

_ _

Disposition of case _

_ _

_ _

_ _