1-1-1965

The Role of the Public Schools in the Education of Autistic Children

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THE ROLE OF THE PUBLIC SCHOOLS IN THE EDUCATION OF AUTISTIC CHILDREN

(TITLE)

BY

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PLAN B PAPER

SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR
THE DEGREE MASTER OF SCIENCE IN EDUCATION
AND PREPARED IN COURSE

EDUCATION 591

IN THE GRADUATE SCHOOL, EASTERN ILLINOIS UNIVERSITY,
CHARLESTON, ILLINOIS

1965
YEAR

I HEREBY RECOMMEND THIS PLAN B PAPER BE ACCEPTED AS
FULFILLING THIS PART OF THE DEGREE, M.S. IN ED.

6 Aug 65
DATE

[redacted]
ADVISER

8-6-65
DATE

[redacted]
DEPARTMENT HEAD

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ACKNOWLEDGEMENTS

The writer wishes to acknowledge his gratitude to several people for their invaluable assistance in this paper. For without their assistances and encouragements, it is rather doubtful if this paper would have been written.

To Dr. Paul Overton, my advisor, who gave me encouragement and help throughout the master's program. Also, for his invaluable assistance in advising and suggestions toward the completion of this study.

To Dr. Carl Green, my professor for whose class this paper is being written, I express whole hearted thanks for your patience and understanding.

To Dr. Arthur J. Looby, I wish to express my deepest thanks for suggesting that I consider this particular subject matter.

To Miss Kathleen Sullivan, who proofread and aided me throughout the writing of this paper. If it were not for Kathy, I sincerely doubt that I would have started or completed this paper.

To Mr. Roger J. Barry, whose friendship, companionship, and encouragement over the past three years can never be fully measured in any acceptable manner.

Finally, I wish to express a very personal thanks to Dr. Donald P. Garner and Miss Linda Sperry, whose sincere interests in my welfare has been greatly appreciated.

Throughout this study it was gratifying to find that there are still individuals who exhibit interest and give encouragement when it is least expected.

CHAPTER I

INTRODUCTION

This paper purports to investigate some of the theoretical concepts related to autism and the role of the school in educating autistic children. Thus, the problem of educating autistic children and who should assume the responsibility will be covered in this paper.

Since the concept of infantile autism is relatively new, a standard workable definition has not yet been established. Those who are associated with the field of mental health (psychiatrists, psychologists, physicians and others) have given working definitions of infantile autism. One such definition, as stated by Charles M. Solley and Mary Engel, is "The movement of cognitive processes in the direction of need satisfaction."[1]

The Times Educational Supplement magazine published an article on autism entitled "The Inner World." The article suggested that autistic children are unresponsive, withdrawn and uncommunicative. Often these children live in a dream world without the ability to form and maintain relationships with people. The article further stated that sensory and other physical or mental defects do not account for this disability.[2]

The last working definition, pointed out by Joan Elicker Richards, stated that early infantile autism is characterized by withdrawal symptoms and a lack

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[1]Charles M. Solley and Mary Engel, "Perceptual Autism In Children: The Effects of Reward, Punishment, and Neutral Conditions Upon Perceptual Learning," The Journal of Genetic Psychology, Vol. IIIC, (September, 1960), p. 77.

[2]"The Inner World," The Times Educational Supplement, No. 2490, (February 8, 1963), p. 250.

of contact from the first years of life. She also noted an obsession for sameness in the environment with the absence of language communication. The preference for a relationship with inanimated objects is a characteristic of autistic children.[3]

The definitions of infantile autism should equip the reader so that he might have an insight into the problem of infantile autism. As the reader progresses from one chapter to another, it is important that he become aware of the growing realization of the number of children affected by this illness.

Limitations of this study have been: (1) a limitation in available materials, and (2) a limitation in sources of information.

The first of five chapters in this study will deal with the problem of educating autistic children and who should assume this responsibility. A definition of autism has been given so that the reader will understand what is meant by autism. The last portion of the introductory chapter will be devoted to the limitations encountered in doing research.

In the second chapter three separate theories concerning autism and its accompanying syndromes will be discussed:

(1) The biological theory

(2) The environmental theory

(3) A combination of the biological and environmental theories.

It should be pointed out that there are more than three theories; however, for the purpose of this study, the three stated above are the most prevalent. There are as many syndromes as there are theories, however the writer decided that the three selected are the most easily understood syndromes for the benefit

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[3]Joan Elicker Richards, "Techniques Used in a School Program for Children Emerging from Early Infantile Autism," Exceptional Children, Vol. XXIX, No. 7, (March, 1963), p. 348.

of the reader. The syndromes can best be illustrated by reading the case study in chapter two on Margaret, who shows many of the typical symptoms of autism. It should be understood that not all of the syndromes are found in every autistic child. The remaining part of chapter two is devoted to a discussion of the three theories of autism. From this discussion it is hoped that educators will become familiar with the concepts of autistic behavior.

Chapter three is devoted to research and various treatment programs. Treatment centers are located at the University of California (Los Angeles), at Ann Arbor, Michigan, and at Hollymont, England. The types of programs presently being carried on at these centers will be discussed in this chapter.

In chapter four the role of the public schools and the need for a program will be discussed. It will be pointed out why the public schools should assume the responsibilities of educating autistic children rather than leaving it up to the parents.

A summary and conclusion will constitute chapter five.

CHAPTER II

ACCOMPANYING SYNDROMES AND THEORETICAL EXPLANATION

In 1943, Dr. Leo Kanner, Director of the Child's Psychiatric Clinic of Johns Hopkins Hospital, introduced the term "infantile autism" to modern psychiatry.[1] In studying the concept of autism in child development and psychiatry, we find that it was under investigation for quite some time before Kanner coined the term autism.[2]

John Haslam, in a textbook written in 1809, described a five-year old boy now identifiable as autistic.[3] In 1898, Sigmund Freud's concept of the "...withdrawal of libidinous cathexis from objects as a prerequisite of repression and fantasy elaboration of repressed material"[4] indicates his awareness of the problem. Pierre Janet, in 1903, "...spoke of a loss of the sense of reality."[5] "Bleuler in 1911 in arriving at the concept of schizophrenia, dwelt considerably on autism and autistic thinking as secondary symptoms. He spoke of it as a disturbance in consciousness in which there is relative or

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[1]Bernard Rimland, Infantile Autism, (New York: Meredith Publishing Co., 1964), p. 5.

[2]Lauretta Bender, M.D., "Autism in Children With Mental Deficiency," American Journal of Mental Deficiency, Vol. LXIII, No. 7, (July, 1959), p. 82.

[3]Rimland, loc. cit., p. 6.

[4]Bender, loc. cit., p. 82.

[5]Ibid., p. 83.

absolute detachment from reality and the inner life."[6] Carl Jung's concept of introversion touches upon the problem. "Witmer (1920) described a severly afflicted three-year old boy who appeared in many ways to resemble the autistic cases of Kanner."[7] And again, in 1921, Meyer and Richards reported a female child displaying syndromes now identifiable as autistic.[8]

> Jean Piaget (1936) saw autism and autistic thought as the first stage in the development (of the normal child) in intelligence. Thus he saw intelligence arising from sensory-motor phenomenon and undirected and therefore, autistic;...In an earlier contribution he defines autistic thought as subconscious since there is no conscious awareness of the aims pursued or problems to be solved, and it is not adapted to external reality but creates for itself a dream world. It tends not to establish truth but to satisfy desires but is expressed in images and symbols like myths...[9]

Dr. Leo Kanner, then, compiled the research of others, linked it with his own findings, and brought the problem of autism to the general awareness of society.

"In March 1954, a Congressional Committee...declared 'There is probably no more serious problem in the health field today than that of mental illness.'"[10] Each year, the Bureau of Census estimates, 840,000 children become markedly neurotic behavior problems. In every classroom of forty youngsters, two are potential psychiatric-hospital cases. Each year, about 1,000 children under the age of fifteen are sent to public institutions for the insane.[11]

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[6] Ibid., p. 83.

[7] Rimland, loc. cit., p. 6.

[8] Ibid., p. 6.

[9] Bender, loc. cit., p. 83.

[10] Stanley R. Dean, M.D., "Schizophrenia: Mental Crippler of Youth," Today's Health, Vol. XXXVI, No. 5, (May, 1958), p. 71.

[11] "Sick Young Minds," Newsweek, Vol. XXIX, No. 3, (January 20, 1947), p. 55.

However,

> It should be understood that early infantile autism is a very rare disorder. In 1958 (Dr.) Kanner wrote that he had seen fewer than 150 cases per year...Recently Kanner said...that only about one child in ten brought to him after being diagnosed as autistic by others are true cases of infantile autism...most of the children erroneously classed as autistic are cases of childhood schizophrenia.[12]

One of the major problems in dealing with autism is the failure of parents to report the devient behavior of their children. Society still places a stigma upon mental illness. "The stigma, born of ignorance and fear, that has always been attached to insanity, still overshadows our thinking, still makes schizophrenia taboo and off limits to society at large. The locked doors that have shut in our schizophrenics have succeeded in shutting them out of our minds as well."[13] Thus, there is a tendency to conceal disturbed children from society. This prevents the children from receiving the services which could aid them in becoming adequate members of society.

Another of the affects of the failure of the parents to report their autistic children is that it is impossible to make any accurate conclusions as to the specific scope of the problem. Medical reports from the United States as well as Canada, England, Belgium, and other nations throughout the world indicated the realization of the necessity to discover the causes of autism.

The syndromes of infantile autism can be witnessed in:

> The presence of the disturbance in early infancy, the strange pattern of motor and language behavior which is reproduced with incredible accuracy in case after case, the occurance in the same child of behavior typical of both genius and idiocy, and the complete absence of any evidence of physical or neurological defect have led many investigators to consider early infantile autism the most baffling of the behavior disorders.[14]

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[12]Rimland, loc. cit., p. 18-19.

[13]Dean, loc. cit., p. 71.

[14]Rimland, loc. cit., p. 1.

More specifically, the overt manifestations of infantile autism may be stated as such:

1. The child shows a gross and sustained impairment of emotional relationship with people.

2. He frequently examines parts of his body, often regarding them as perpetually new and strange.

3. He gets preoccupied with particular objects, collecting and examining them and forming attachments to a special object.

4. He resists any change in his environment.

5. His behaviour leads to suspicion of abnormalities of the special senses although there is no obvious physical cause, e.g., he can appear deaf, mute, insensitive to pain or to heat and cold.

6. He is the subject to great abnormalities of mood, e.g., outbursts of rage and distress.

7. His speech if present at all is very disturbed. The child frequently prefers to take a person by the hand and manipulate them--rather than convey his needs by speech.

8. His movements and general activity are disturbed in many ways.

9. On the whole the child is seriously retarded in the things he can do, although he frequently can do one or two things remarkably well.[15]

Those who have written on the subject of autism are, for the most part, in agreement with the syndromes as presented in this research paper. It is the writer's desire to present a more complete understanding of the symptoms of autism through Barbara Furneaux's nine points. With the understanding of autism, it is hoped that educators can "identify the children suffering from this illness, separating them from the deaf and mentally subnormal with whom they have frequently and mistakenly been included."[16]

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[15]Barbara Furneaux, "New Hope at Hollymount," The Times Educational Supplement, (Friday, April 24, 1964), No. 2551, P. 1066.

[16]Ibid., p. 1066.

To give a more accurate picture of the treatment of autism a case history is now introduced. This was conducted at Johns Hopkins research center. It will also "show the typical symptomatology and indicate the wide range of later development."[17]

> Case I. Margaret J. was brought by her parents on March 8, 1943, at the age of 5 years 10 months. She was referred with the complaint that 'she is a behavior problem in the sense that in a small public school she has made herself so objectionable that the school refuses to take her back.'
>
> The mother recalled that Margaret showed 'peculiar traits' when she was less than one year old. 'For instance, when we would sit on a certain chair upon which she did not like us to sit or which she felt should be occupied by another member of the family, she would scream. She always insisted on entering the garden through a certain door. She would notice when the dishes on a tray were not in the accustomed order.' She seemed friendly and smiled, but never looked at a person. She never addressed her parents as 'Mommy' or 'Papa.' She rolled a great deal in her crib and banged her head against the bars.
>
> Margaret was a planned and wanted child. The pregnancy was uneventful. She was delivered at term by low forceps and was healthy at birth. There was no indication of birth trauma. She was placed at the breast and given a supplementary feeding for 6 weeks. 'She always loved to eat' and presented no feeding problem, but drank little milk. She was easily toilet-trained. Past illnesses include a mild, uncomplicated case of measles and a 'cold with high fever way after she was one year old.' There was no history of injuries, operations or convulsions.
>
> Her general development was said to be slow. She stood at 10 months and walked at 22 months, after a phase of crawling. At 18 months an x-ray examination of the long bones ruled out rickets.
>
> She talked before she walked. She could repeat short sentences, but had no interest in making conversation. 'She did not use the right pronouns. She said 'You,' meaning 'I,' and still occasionally does. For a long time we were distressed because she did not use a definite Yes or No in an answer. When asked if she wanted milk, she replied, 'Margaret wants her milk.' 'Formation of plurals and tenses presented no difficulties.
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> At 3½ years 'she cried a lot and was given to tantrums. She would get up and touch things in the same order--every morning.' She was

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[17]Leo Kanner, M.D. and Leonard I. Lesser, M.D., "Early Infantile Autism," The Pediatric Clinics of North America, (August, 1958), p. 711.

entered in nursery school because it was felt that she was spoiled and needed more discipline. At the beginning she showed no interest in the other children, but stayed at the edge of the group or by herself, happily swinging or playing alone. After some time she improved sufficiently in her relationships to be tried in a public kindergarten. Her adjustment there was poor. Though she cooperated in music and rhythm, she could not become interested in reading. When a story was read at school, she paid no attention, giggled hysterically and disturbed the group. It soon became apparent that she would not 'make the grade.' Her career at this school was terminated abruptly when she urinated and defecated in a waste paper basket. 'She was quite hysterical about it and thought it was a good joke.'

In reference to more recent behavior, the mother said, 'She has the most amazing memory I have ever seen. She notices many details; for instance, she knows how many tiles there are in the bathroom. She has to hear a nursery rhyme only once, then recognizes the tune. She can tell Victrola records from the type of sealing...She counts very well, knows her colors, and can identify pictures, especially of airplanes. She draws well, usually with her left hand. She cuts with her right hand. She starts to read from right to left and sometimes looks at pictures turned upside down.

'Recently her behavior has changed somewhat. She used to touch the floor all the time, but got over that. Now she pops her eyes and giggles. She is terrified by an elevator. During the train trip to the clinic she was interested in everything; noticed people, and talked. She shows a particular interest in body discharges. She asked a taxi driver who cleared his throat, 'Did you have phlegm in your throat?' She is very observant and interested if somebody goes to the bathroom.'

Margaret is the younger of 2 children. The mother, a college graduate librarian, is a high-strung, intelligent person who worries a great deal and is devoted to her children and family. She describes her husband, a successful advertising copywriter, as 'not too warm a person who is considered by many people as conceited, but who is devoted to his family.' Both parents are sociable people and have many friends. The family is financially comfortable. There is one brother, William, who was characterized at that time as 'a perfectly normal boy who is in good rapport with people and makes friends very easily.'

Physical examination at our clinic revealed a well developed, attractive child, with abundant, coarse brunette hair. There were no physical or neurological abnormalities noted. X-ray examination of the skull was read as normal.

Margaret entered the consultation room without looking at any person and asked, 'Who is that?', meaning the examiner. She shook hands, but did not look at the person with whom whe shook hands. She was deeply absorbed in her play with blocks, with which she built a certain pattern. She showed good manual dexterity, using

both hands alternately. She named each of the blocks and was anxious to place them in particular positions to each other, following a certain purposefulness and certain rules, which she made up for herself. As long as she was left alone, she was completely happy and satisfied, talking to herself, plainly, but for the outsider, incoherently. From time to time she looked in self-abandonment into the air, asking. 'What made the ceiling crack itself?' When anyone interfered with her realm, by moving or taking a block, she became angry, shouted, 'Don't!', then jumped up, becoming aggressive, hitting and kicking, and showing her typical reaction of frustration mixed with anger. She put her fingers in her mouth and twisted her hair with the other hand, standing motionless and staring into space. As soon as one restored the changed or missing object, she snapped out of the reaction. This pattern of behavior could be provoked by any interference with her occupation.

In the second interview Margaret, upon returning, amazed everyone by demanding the same blocks. She recalled exactly the names which she had given them the day before and preceeded to arrange them in precisely the same pattern. She asked for the same puzzles and assembled them exactly as on the previous day. When given crayons and paper, she drew airplanes, while mumbling, 'Airplanes flying over Europe and the Philippines."

The next day, when seen in her hospital room, she was lying on her bed, sucking her fingers, and rolling in ectasy from side to side. She used personal pronouns correctly and showed a good vocabulary. She moved gracefully and quickly. A complete Binet test could not be given because of insufficient responsiveness, but the general impression was that she was of at least normal intelligence.

Placement in a special school was recommended, and this recommendation was accepted by the parents.

During an interview in February, 1944, it was learned that Margaret had returned to public school and had indeed made a surprising adjustment. She passed thereafter from the second through the sixth grades; then she entered a private school in upper New York State. There she was noted to be insecure, tense and anxious.

On a Wechsler Bellevue Scale, given in 1944, she attained a full scale intelligence quotient of 110.

She was seen again with her mother in December, 1953, at the age of 16 years 7 months.

She had made amazing progress and developed a great deal of insight into her own personality. She spoke of herself as 'a plugger' and indicated that she put considerable pressure on herself in order to do well. She said, 'Up to last year the fundamentals of learning have been easy because of my good memory, but this year it's the interpretation, and this is difficult for me.' She had ambitions to go to college and added, 'I may be hitching my wagon to a star.' About her relationships with other children she said, 'The girls in

> school are very nice and very friendly, and I have a good time with them. There are some points in which I am not close to them. I feel I'm not as mature as I should be; I don't have the interest in boys that most girls my age have.'
>
> In the fall of 1953 Margaret entered a well known women's college and graduated in 1957. She selected subjects in which rote memory rather than spontaneous production was essential. She took part in routine activities, though she made few, if any, real friendships. She is a serious, rather literal-minded young woman who augurs to do reasonably well in an occupation in which no demand is made on give-and-take relationship with other people.[18]

This case study illustrates what may be done to aid the autistic child through careful research and programming.

However, as before stated, the field is relatively new. Thus, a uniform standard for treatment has not been clearly set. Only through more intensified programs conducted on a large scale can we find satisfactory treatment.

Another approach to better understanding the characteristics of autistic children may be the use of theoretical explanations. Three schools of thought have been developed pertaining to the explanation of infantile autism. The biological, environmental, and a combination of the two appear to be the three most outstanding theoretical explanations of the causes of infantile autism. However, it is not feasible to overlook any new theory which might shed light on controlling the autistic child. The first two theories will be discussed.

The biological theory, as reported by Margaret Lovatt, points out that:

> Our recognition that we cannot 'cure' these children, is based

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[18] Ibid., p. 712-713.

> on the belief that there is a biological factor involved in the illness, and that environmental factors only alter and possibly intensify the expression of the disease. The possibilities of successful treatment, therefore, seem to vary with the relative degree of biological and environmental involvements.[19]

Another biological idea is "the hypothesis that autism may result from a rare recessive trait or be otherwise determined by biological factors."[20] In an article written by Dr. Jerome L. Schulman, he states: "We believe that there is an innate biological disturbance of brain function in the autistic child."[21] Dr. Schulman indicates two factors in biological theories. The idea of similar characteristics in the progenitors which is as yet an unexplainable hereditary element; and, secondary behavior disturbances are frequently superimposed upon the primary syndrome.[22]

The second school of thought presents the following seven arguments and assumptions for the acceptance of the environmental theory.

1. No consistent physical or neurological abnormalities have been found in autistic children which could account for their condition.

2. Many autistic children have been raised by parents apparently deficient in emotional responsiveness, which could have pathogenic effects on the child.

3. Certain children raised in hospitals, or orphanges, where maternal contact was sparse have been reported to show an undue frequency of emotional difficulties.

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[19]Margaret Lovatt, "Autistic Children In A Day Nursery," Children, Vol. IX, No. 3, (May, 1962), p. 104.

[20]Rimland, loc. cit., p. 51.

[21]Jerome L. Schulman, M.D., "Management Of The Child With Early Infantile Autism," The American Journal Of Psychiatry, Vol. CXX, No. 3, (September, 1963), p. 250.

[22]Ibid., p. 250.

4. The behaviors of the child--his indifference or aggressiveness, his refusal to speak (or 'elective mutism'), his apparent withdrawal from the outside world--are interpreted as signs of 'punishment' or 'retaliation' against the parents.

5. Certain incidents in the life of the autistic child appear to be pathogenic and permit the disorder to be traced to them.

6. Psychotherapy or otherwise placing the child in a kind and understanding environment has beneficial effects.

7. The high incidence of first-born and only children suggests that parental attitudes may be causative.[23]

The two theories, biological and environmental with the combination of both are the most prominent in the problem of autism.

The major disagreement among educators is the definition of autism. However, it is the writer's contention that a single specific definition is not as important as the understanding of the syndromes, the ability to recognize a child with autistic behavior, and the importance of educating autistic children.

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[23]Rimland, loc. cit., p. 42.

CHAPTER III

RESEARCH AND TREATMENT PROGRAMS

Because the concept of autism is still in it's early developmental stages, the actual treatment is done on somewhat of a trial and error basis. Several centers have treated children diagnosed as autistic cases, but a uniform method has not yet been established.

Perhaps one of the newest approaches has been taken by a research group at the University of California in Los Angeles. This team is headed by Dr. Ivar Lovaas. It is Dr. Lovaas' belief that "You have to put out the fire first before you worry how it started."[1] The researchers are making surprising progress in aiding their children to normal behavior.

The technique Lovaas is using

> ...is based on the old-fashioned idea that the way to bring up children is to reward them when they're good, punish them when they're bad...by alternating methods of shocking roughness with persistant and loving attention, the researchers have broken through the first barriers.[2]

There are some objections which may be voiced against Dr. Lovaas' mode of correction. Due to the fact that his program deals only with the immediate manifestations through a type of shock treatment, his success may be short lived. The failure to find the deep seated causes for the behavior patterns may prevent him from affecting a permanent improvement; however, this is but speculation. The fact that he has made some overt progress

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[1]"Screams, Slaps and Love," Life, (May 7, 1965), p. 90C.

[2]Life, loc. cit., p. 90A.

must be recognized and considered as a strong positive factor.

In Ann Arbor, Michigan, the medical staff of the Children's Psychiatric Hospital has dealt with the problem of autistic children. In this hospital, the

> ...general aim in working with these children has been to develop any ego capacities which seem ready to respond to further training. This training has involved many things: developing a physical skill, teaching academic skill, curbing negative forms of behavior, teaching more appropriate affective and behavioral responses, and clarifying confused conceptions.[3]

The development of readiness for an academic function such as reading or writing does not seem to be aided by pressuring the children to perform. The children need to progress emotionally before their academic abilities may be used.[4]

From 1957 to 1960, four girls, ages five and six were admitted to the Ann Arbor hospital and were treated according to the philosophy stated above. These girls were of average or above intelligence. They were trained to read, write and communicate verbally.[5]

In England, at Hollymount, in the Maudsley Hospital, researchers have been carrying on an extensive program, directed by Dr. Michael Rutter. The results of the program cannot yet be fully realized. However, of sixty-four children, twenty-five are still mute after ten years of treatment. "The bright ones appear to progress, but the dull ones just become duller still."[6]

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[3]Richards, loc. cit., p. 349.

[4]Ibid., p. 349.

[5]Ibid., p. 348.

[6]M. L. Kellmer Pringle, M.D., "Getting in Touch," The Times Educational Supplement, (April 10, 1964), p. 912

Later, eight of these cases displayed signs of a progressive degenerative brain disease, thus may not be included in the final report.

The method of treatment was not included in the available material. However, the fact that research has been done in the specific problem may stress the growing recognition of the importance of autism.

CHAPTER IV

ROLE OF THE PUBLIC SCHOOLS

The questions which must now be faced are: Who is responsible for the care of autistic children, and to what degree? Will the parents assume the responsibility at home, and if so, to what extent? What concepts should teachers understand in order to educate autistic children; exactly what department of the school should assume the brunt of the responsibility?

Researchers in the problem of autism have discovered that the parents of autistically disturbed children are generally more concerned with the arts and sciences than with their own children.

The symptoms of autism are usually found in the parents as well as in their children, for the parents have a definite deficiency in their own personalities. It has been pointed out by Dr. Leo Kanner and Dr. Leonard I. Lesser that

> The parents' behavior toward the children accentuates the emotional frigidity and mechanization of care. Maternal lack of genuine warmth is often conspicuous in the first visit to the clinic. Many of the fathers hardly know their autistic children. They are outwardly friendly, admonish, teach, observe objectively, but rarely step down from the pedestal of adulthood to indulge in childish play. Obsessive devotion to duty, rules and job serves most of the parents as a substitute for the enjoyment of life.[1]

The role of the mother is of primary importance in home therapy of the autistic child. Experience has shown that this is not a completely

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[1] Ibid., p. 723.

adequate means of handling mentally ill children.

> However much she (the mother) may love this child, she may not be able to do what's best for him; for, whereas love is important to all children, expert trained guidance is necessary as well for the mentally handicapped child. Even if she were so trained, the mother would probably be too exhausted by the whole situation to remember what she'd been taught.[2]

The parents can also benefit from having their autistic child in a pre-five nursery. In particular, the mother who most often carries the principal burden benefits. This could result in preserving the mother's sanity.[3] With the heavy burden of rearing an autistic child, it may be necessary for a mother to have a few hours each day, or even one day a week away from her child. She needs to restore her energy and enthusiasm.[4]

Educators that have come into contact with autistic children have had to develop many different concepts necessary for teaching the autistic child. One such educator, Dr. M. L. Kellmer Pringle stated, "If you want more technicians, teachers and scientists, then you must consider how to make the best use of underdeveloped intellects."[5] Much of Dr. Pringle's research has shown that "...children in residential care were retarded in comparison with children of problem families in nurseries, because they did not have enough contact and conversation with adults."[6] She further states that, "Among the children in residential homes, those with some sort

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[2]Hilary Haywood, "One in a Hundred," New Statesman, Vol. LXVIII, No. 1739, (July, 1964), p. 47.

[3]Ibid., p. 47.

[4]Schulman, loc. cit., p. 251.

[5]M. L. Kellmer Pringle, M.D., "Getting in Touch," The Times Educational Supplement, (April 10, 1964), p. 912.

[6]Ibid., p. 912.

of relationship with an adult outside the home were far more stable than those who had no adult friends."[7]

In our educational system,

> The familiar educational rule of meeting the child at his particular point of development in each area is of special importance. There is a wide spread of developmental levels in each child; although a child may be able to read first grade material (six year level), he may not be able to adequately differentiate himself from an adult (two year level).[8]

Thus, it becomes "necessary to provide experiences which will help the child develop or better integrate the needed concepts."[9]

"Teaching psychotic children who are emerging from early infantile autism increases the teacher's scope of operation beyond that ordinarily considered to be consistent with her role."[10] Therefore, it is "necessary to deal with much more than academic materials, because concepts usually developed early in life have not been absorbed or integrated by these children."[11]

It is entirely possible for the children, given the correct instruction through an intensive program, to adjust to the point that they may participate in a normal educational program.[12]

There is a therapeutic approach involving child care workers, recreational personnel, special school teachers and psychotherapists in which all are striving for one goal; to acquire emotional and intellectual freedom

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[7] Ibid., p. 912.

[8] Richards, loc. cit., p. 349.

[9] Ibid., p. 25.

[10] Ibid., p. 349.

[11] Ibid., p. 349.

from the darkness in which the autistic child has been shut all his life.[13]

Another concept which is exceptionally important involves individual attention within a school and the significant result it has on autistic children. Those children most concerned seem to have lost contact with the reality of the world around them. However, it is extremely important not to misdiagnose the autistic child as mentally deficient. This could result in his being institutionalized as a deficient.[14]

It has been found that pre-five nursery schools can be of the utmost importance for an autistic child as well as the normal child.[15] However, the teacher is now faced with the problem of how far back she must go in teaching pre-academic materials in an academic situation. A primary responsibility for the teacher is the acute awareness and the development of concepts needed by the child to advance academically. But, she must not go so far back in concept development that she is devoting all of her time socializing the child, leaving no time for academic training.[16]

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[12]Furneaux, loc. cit., p. 25.

[13]Anthony Davids, "Intelligence in Childhood Schizophrenics, Other Emotionally Disturbed Children, and Their Mothers," Journal of Consulting Psychology, Vol. XX, No. 3, (June, 1958), p. 162.

[14]Michael Rutter, M.D., "Getting in Touch," The Times Educational Supplement, (April 10, 1964), p. 912.

[15]Haywood, loc. cit., p. 47.

[16]Richards, loc. cit., p. 350.

CHAPTER V

SUMMARY AND CONCLUSIONS

Thus, the problem which autism poses to society is just being recognized as a separate serious threat. Dr. Kanner separated or isolated it from the layman's view of all-inclusive mental illness when he named it infantile autism.

As with any new problem, there are different views as to the causal factors. The two most outstanding of these concepts of origin are the biological theory and the environmental theory. There is a great deal of contention as to which of these theories is correct. Still others feel that autism is a result of both biology and environment.

However, the symptoms are constant and appear in any combination in autistic children. Briefly, they may be stated as such,

> ...profound withdrawal and lack of contact from the very first years of life, an obsessive demand for sameness in the environment, a lack of communication in the use of language and a preference for relationships with inanimate objects.[1]

Several research centers are attempting to discover a workable method for the treatment of autism. Again, it must be stressed that this is a relatively unexplored problem. The programs conducted at such centers as U.C.L.A., Ann Arbor, Michigan, and Johns Hopkins are making progress, but have reached no conclusive results.

The necessity, then, has arisen to provide a means of dealing with all

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[1]Richards, loc. cit., p. 348.

autistic children. The school system appears most likely to be the institution best qualified to recognize the autistic child and direct him towards proper treatment. Proper treatment may be accomplished through the work of a capable trained special education teacher.

What department within the school should accept this new challenge? Only one department seems qualified and capable, and therefore responsible for developing a program for autistic children. This responsibility rests with special education in the school system.

The special education services are staffed with responsible, qualified people capable of establishing a specialized program for autistic children. The director of the pupil personnel services may be the responsible person to initiate and supervise the program. Frequently, the regular classroom teachers are among the first professionally qualified people with whom the child comes in contact. Also, it is hoped that guidance personnel will recognize the problem and recommend the child for specialized treatment. Ideally, the school administrator through the director of pupil personnel services would coordinate the guidance services, the school clinical psychologist or area psychiatrist, and the teachers.

There are several reasons for this coordination; it is essential for the director to establish communications between himself and his clinical psychologist or area psychiatrist. The psychologist or psychiatrist will be the person who recommends the various individualized program for the child. Therefore, it is the director of pupil personnel services who must place each child in the program most beneficial for him. He will also be responsible for his supervision. The coordination of teachers of emotionally disturbed children within special education and regular classroom teachers would rest with the superintendent of the school district. The last reason

for this coordination between the director of pupil personnel and the teachers is vitally important for both. The teachers should be willing to give their full cooperation if the program is to be effective. For, not only will special education teachers be working directly with these children, but they will also be working with speech correctionists, speech pathologists, recreational personnel, guidance personnel and school nurses. All will be utilized in the specialized program for autistic children.

Why should the public schools assume the duties of educating autistic children? Why should special education be accountable for the intellectual growth of autistic children? These are but two of the many questions which will bombard the school system and special education if they should assume the responsibility of educating the children that have been diagnosed as autistic.

> To help alleviate this serious situation, the United States Public Health Service is planning a broad-scale children's program under the National Mental Health Act...Under the act, money will be granted to certain schools and clinics to train psychiatrists and to finance research. According to Dr. Robert Felix, the USPHS Mental Hygiene chief, funds will be set aside for all-purpose community clinics where children as well as their parents can receive guidance and helps.[2]

Another reason for assuring autistic children an equal opportunity to an education is based on the American belief that all children should have an equal opportunity for an education. Schools ought to be geared to provide the autistic child with the services necessary to aid him in his individual development.

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[2]Newsweek, loc. cit., p. 55.

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