Cerebral palsy: an analysis of services for children with cerebral palsy

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CEREBRAL PALSY: AN ANALYSIS OF SERVICES
FOR CHILDREN WITH CEREBRAL PALSY

A THESIS
SUBMITTED TO THE FACULTY OF THE ATLANTA UNIVERSITY SCHOOL
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FOR THE DEGREE OF MASTER OF SOCIAL WORK

BY
INDIA WASH ROSS

ATLANTA, GEORGIA
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The development of this study is the outgrowth of an interest in cerebral palsy dating from 1939. "Johnny", a neighborhood baby was nearly two years old before his parents knew definitely that something was wrong with him.

As the months passed and "Johnny" failed to show an interest in standing or walking, his parents thought it advisable to take him to a pediatrician. He told them that the child was probably a spastic due to a head injury from the instruments used at birth. An orthopedic surgeon verified this diagnosis and told them that while spastic conditions often responded to treatment and surgery, they were never completely curable, and that to some extent "Johnny" would always be crippled.

Over a period of years, I have observed "Johnny" responding physically and mentally to treatment and a developmental program offered in a Cerebral Palsy Clinic. His parents have maintained an intelligent and understanding approach to "Johnny's" problem in helping him adjust to an environment and community that has little conception or understanding of a handicapped child, a child with cerebral palsy.
ACKNOWLEDGEMENTS

I wish to express appreciation to those who have made it possible for this study to be made through cooperative response to requests for material: Miss Velma Yowell, Research Analyst, Commission for Handicapped Children, Chicago, Illinois; Mrs. Arthur Larscham, Corresponding Secretary, New York State Cerebral Palsy Association; Miss Thelma Lawson, Supervisor Medical Social Service, St. Paul, Minnesota; Dr. C. H. Halliday, Chief, Department of Health, Baltimore, Maryland; Mrs. Billie Louise Crock, Health Education Consultant, Texas State Board of Health; Dr. Elizabeth Bryan, Medical Director, Services for Crippled Children, Department of Public Welfare, Columbus, Ohio; Dr. Marcia Hays, Assistant Chief, Department of Public Health, San Francisco, California; Mrs. Elizabeth Coolidge Barnett, State Supervisor of Spastics, Department of Education, Austin, Texas; Mr. Carl F. King, Administrative Assistant, Division of Services for Crippled Children, Indiana Department of Public Welfare; Mrs. Gertrude Bush, Executive Director, State Crippled Children's Commission, Trenton, New Jersey.

I also acknowledge my indebtedness to Miss Marie C. Freidline, Librarian, Commission for Handicapped Children, Chicago, Illinois, for the use of material from the Loan Library.

I am very grateful to Mrs. Zephyr Woodson, Instructor in the Atlanta University School of Social Work and Thesis Advisor, for her guidance and helpful advice.
CHAPTER I

INTRODUCTION

This study attempts to acquaint the student with some of the broader aspects of cerebral palsy and programs being developed. With this in mind, the writer has attempted to show the recent development of programs for cerebral palsy, and the attempt to educate the public to the existence of such programs in order that those children afflicted with this condition may not be the "forgotten children," and may be assisted to live more adequately and even creatively.

The Purpose of the Study

The main purpose of this study is to present the recent trends for establishing diagnostic centers for the treatment of cerebral palsied children, keeping in mind the role of the social worker in interpreting to the family and community ways and methods of assisting in the treatment of the cerebral palsied child.

Method of Procedure

Student relied for source material from the reports of the following State Commissions for Handicapped Children: California; Illinois; Indiana; New Jersey; New York; and Maryland. This material is supplemented by other published and unpublished articles, and current literature on cerebral palsy.

The Range of Cerebral Palsy

According to current statistics, between 200,000 and 300,000 Americans are afflicted with cerebral palsy. The range of this affliction like
those of infantile paralysis is visited mainly on children. Cerebral palsy ranks second only to post-poliomyelitis as a cause of crippling in children. Prior to the last decade relatively little was known about the diagnosis and treatment of the cerebral palsied. It has been stated by some authorities that because of the lack of recognition of the extent of crippling from cerebral palsy, children with this condition constitute the most neglected group among the physically handicapped.

It is interesting to notice that irrespective of rural or urban areas, East or West, North or South, it has been found through surveys in several states that there is an annual increment of seven cerebral palsied children per 100,000 of general population. One out of each seven dies before reaching six years of age. Therefore, there are six for every age group. From the foregoing figures, it can be assumed that there will be a constant case load of ninety-six cerebral palsied children under the age of sixteen for every 100,000 population. 

Etiological Factors

Damage to the brain and variations in the developmental structure of the brain are the causes of cerebral palsy. The name itself indicates the condition - cerebral - referring to the brain and palsy, inability to use muscles properly. The damage may result from hemorrhage in the brain owing

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to injury before, during, or immediately after childbirth; from malforma-
tion or faulty development of the brain; or from early injury, or disease
such as meningitis or encephalitis, which may produce scar tissue in the
brain causing cerebral palsy. ¹ Whenever one of these special areas is
damaged, the function which it controls is also damaged.

Due to an interference in the developing nervous system of the cerebral
palsy patient it is found after birth that the pattern of developmental be-
havior deviates from the normal. The abnormality may vary from "almost
normal with the slightest physical handicapping," from the standpoint of
self-sufficiency to that of a "sub-normal mentality to care for the
simplest personal needs," as described by W. J. Little in the first medical
paper published on this subject in 1843. ² Cerebral palsy is sometime
referred to as Little Disease.

The Mentality of Cerebral Palsied Children

It is often very difficult to determine the intellect of children with
cerebral palsy. Because of the lack of coordinated speech, drooling, fa-
cial grimaces, partial vision losses, inability to hear and similar losses,
children so affected have too frequently been unfairly judged as feeble-
minded. It has been demonstrated and proven, however, that approximately
seventy percent of these children have intelligence quotients of seventy

¹ "Exploring the Unknown," op. cit., p. 5.
² Preliminary Report of the New York State Joint Legislative Committee
per cent or higher.\footnote{1} This is indicative that most of them are educable. Furthermore, it has been definitely shown that many of them are actually of superior mental capacity.

J. Thomas McIntire, formerly Psychologist for the New Jersey Crippled Children Commission, following a study of the intelligence of 143 cerebral palsied children wherein he examined and re-examined his findings, submits the following trends with slight variations: superior intelligence, seven per cent; high average intelligence, twelve per cent; average intelligence, thirteen per cent; borderline intelligence, eight per cent; and feeble-minded, eighteen per cent. Regarding this study, Mr. McIntire feels that even when the borderline cases are included, the incidence of feeble-mindedness in this sample study is lower than estimates of early reports. The factors that have caused the cerebral damage resulting in the physical handicap of the subjects studied are also apparently responsible for the mental defects.\footnote{2}

The Five Types of Cerebral Palsy

"Spastic Paralysis" has incorrectly been used synonymously with cerebral palsy. Usually cerebral palsy is classified into three forms, namely: spastic, atetosis and ataxia. However, Dr. Phelps, Medical

\footnote{1} Phelps, Winthrop M., M. D. and Turner, T. Arthur, "The Fartherest Corner," \textit{op. cit.}

\footnote{2} McIntire, J. Thomas, Psychologist, "The Incidence of Feeble-Mindedness in the Cerebral Palsied," \textit{New Jersey State Crippled Children's Commission, Trenton, New Jersey.} Reported from the Proceedings from the American Association on Mental Deficiency, LXII: 44-50 (1938), (No. 2).
Director of the Children's Rehabilitation Institute, Baltimore, Maryland, gives five divisions of neuro-muscular crippling conditions in the general category of cerebral palsy. They are: spastics; athetosis, or the presence of involuntary motion; ataxia, or balance and primary disturbance of coordination; rigidity, or a stiff "lead" like condition of the muscles which differ from the "springiness" of spasticity and tremor.1 The two most common types of cerebral palsy are the athetosis and the true spastics.

Those Who Can Be Salvaged

It is to be remembered that practically all cerebral palsied children have been handicapped since birth; they have not had a chance to form primary action patterns before acquiring their disability. Frequently they have complicating handicaps involving speech, sight or hearing. All these factors indicate the need of great skill in evaluating the child's potential intelligence.

It is likewise worthy of note that the most tragic of neglected cases are not the cerebral palsied feeble-minded, but rather the children of normal or superior intelligence, sensitive, possessed of normal desires, affectionate, ambitious, whose disability has cut them off from normal opportunities.2

When it is realized that more than seventy per cent of all cases of cerebral palsy are of a moderate degree of severity and that the majority of these individuals have intelligent quotients of seventy or more, it can be seen that more than half of all such children can and do profit physically and mentally from adequate care and treatment. The fact that many of


the more severely handicapped cases can also profit to some extent by treatment would seem to thoroughly justify the expense and time of treatment.
CHAPTER II
TREATMENT AND REHABILITATION

Through study and clinical work with cerebral palsied children, there has developed in recent years an understanding of the nature of cerebral palsy which has opened new channels for the care and education of these children. Regardless of the accepted fact that the damage done to the brain cannot be repaired, knowledge and skill in the diagnosis and treatment of the cerebral palsied child have challenged the public, and given parents a faith and hope that these children can be rehabilitated to live useful and purposeful lives. The child with cerebral palsy has the same needs as those of a normal child, with additional training in learning how to supply his own needs.1

Dr. Winthrop M. Phelps who is skilled in his work in muscle training in cerebral palsy has proved that there is a tremendous amount that can be done in rehabilitation both physical and psychological.2 Many authorities agree that the treatment of cerebral palsy is a long and difficult process, invariably involving more than surgery. There may be a group of handicaps instead of a single disorder. Motor handicaps and sensory disturbances, such as, impaired hearing and vision may be present in the same individual. It sometimes takes five to ten years or longer to rehabilitate one child.


Dr. Earl R. Carlson, a specialist in the field of cerebral palsy who
is a spastic, makes theory a reality. He stresses the importance of
treatment started at an early age in order to eliminate wrong motor habits
and the tendency to become neurotic, even psychotic.1 Much effort is now
being expended through state and local programs to restore the cerebral
palsied child to a useful and satisfying position in society. Each child
rehabilitated lessens the problem of the adult. Those who work with these
children must remember that a certain percentage of the cases either cannot
respond to muscle training or can respond only to a certain degree. The
drive for independence becomes the opening wedge to make training and
rehabilitation a successful possibility.

Following is a case history which supports the importance of treatment
and rehabilitation. This is the story of a cerebral palsied child who
achieved a remarkable degree of rehabilitation largely through his own
indomitable will.2

He could not walk or talk until he was four years of age. He
spent those years sitting in a buggy in his front yard protected by a
big bulldog. He was regarded as mentally deficient, and surgeons
were reluctant to treat him. However, after the surgical lengthening
of his heel cords and the application of plastic casts for six months,
he was able to crawl. At six years he began to walk and play with his
younger brother. He did not learn to dress himself until he was seven
and it took years to solve the problem of tying his shoe laces. At
seven he started to school, despite the involvement of his right arm
and leg and his severe speech difficulty. It was not until he was in
the eleventh grade that he could read out loud, while his handwriting
did not become easily legible until he was 21. Boy Scout and church
activities gave him increased confidence and he graduated from high

1 Carlson, Earl R., M. D., Born That Way. The John Day Company, New

2 Kessler, Henry H., M. D., Ph. D., Rehabilitation of the Physically
school at the age of 19. He worked in a gasoline station and at odd jobs, but at the height of the war when man power was in great demand he was unable to secure anything better than a job in a flower nursery at $75.00 a month and later a janitor's job at $100.00 a month.

Through a chance acquaintance he was given an opportunity for speech therapy and for advanced treatment by drugs. As a result, his tongue was loosened and he could speak without facial grimaces. Physical therapy improved his gait and posture. His weight increased and his whole general appearance changed, permitting him to find new friends and to achieve social acceptance. He entered a CPA course, courageously and confident of finding a definite place for himself in society.1

Factors in Treatment

Those who have specialized in work with cerebral palsied children agree that the rescue of these children from their social isolation is a complex undertaking.2 However, with proper treatment and training, these children respond favorably. How much is actually accomplished depends upon the ability of the individual and the adequacy of his training. It has been observed that children who have been well selected as to treatability can and do improve physically. Every cerebral palsied child must be studied, perhaps as long as three months before the actual intelligence can be determined.3 A training program for the cerebral palsied child can be divided into two parts: neuro muscular education; parent education.

Speech involvements, emotional hearing and sight difficulties,

1 Kessler, Henry H., M. D., Ph. D., op. cit., p. 7.


variants in degrees and kinds of motor involvements - all these require the constant team work of the specializing physicians, psychologist, occupational and physical therapy technicians, the public health nurse, the speech and sight specialist, the specializing teacher and the social worker - the latter because frequently there are social problems related to the child's adjustment in the family circle, in school, and in the community.  

Mental Tests

The Stanford-Binet test is found to be the most reliable in determining the rate of learning and mental capacity of the child. Since this test requires the use of language and motor skill, it is important that the test be administered by one who understands the disabilities caused by cerebral palsy. Dr. Perlstein, a pediatrician with years of experience in cerebral palsy, does not agree with many of the mental tests used exclusively in admitting children to training centers. Margaret A. Stanchfield, a medical social worker of the Crippled Children's Services, Minnesota, points to the fact that Dr. Perlstein accepts children at St. John's Hospital, Springfield, Illinois, for a trial period. If they are advantaged by training, they may continue there.  

Authorities estimate a ratio of fifty-four educable cerebral palsied children under sixteen for each 100,000 of the general population. It must be remembered that the cerebral palsied child has had his handicaps, in most instances, since birth. Therefore, in retraining it must be realized that many fundamental neuro-muscular activities do not function properly, such

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2 Stanchfield, Margaret A. "Medical Social Aspects of Cerebral Palsy." Public Health Nursing, Reprint (February, 1947).
as: speech, walking, vision, hearing, reaching and grasping. A lack of skill in handling the body deprives the child of opportunities for engaging in the varied types of big-muscle or physical education activities which play so large a role in developing organic power and in providing joyous activity which offers in later adult activity a satisfying form of recreation. The purpose of treatment is to assist the child who is awkward in his handling of things and lacks general neuro-muscular skills to develop to the extent of his capacity.

Physiotherapy and Occupational Therapy

Physiotherapy in cerebral palsy is the application of passive, active-assisted, or active motion, relaxation, massage and other modalities for the purpose of getting better and freer motion of the arms and legs, better balance concepts of walking, and so on. Occupational therapy is a form of therapy in which, for cerebral palsy skills of one sort or another are utilized to bring about the exercises which physiotherapy would do simply by having the child lie on a table and move the arm up and down. If an activity can be accomplished or a result produced through the medium of the child's maximum interest, then from the psychological standpoint the child will get more benefit from it. He will also be willing to cooperate for a longer period of time, and more forcefully.

The physiotherapists are primarily concerned with balance and walking, and the occupational therapists are concerned primarily with the use and function of the arms, speech therapists are concerned with speech.

The best results are obtained by close cooperation and the overlapping of physiotherapy and occupational therapy.

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Treatability

The traditional view was that a crippled child could not develop mentally beyond the limits of his motor experience. However, this view has been disproved by a number of demonstration projects which have established the fact that some of these children respond out of all proportion to their apparent promise. Since there is no particular relationship between the existing degree of the handicap and possible results to be obtained through treatment, if adequate programs continue to be developed these children can be reclaimed for a better and more productive life.

If Dr. Phelp's conclusion, that seventy percent of all cases of cerebral palsy have intelligent quotients of seventy percent or more, and that seven cases born annually per 100,000 population, at least four should be considered treatable, granting that they have intelligent quotients of seventy percent or more, it is important that throughout the nation programs and services be made available, whereby these children can be diagnosed, treated, educated and rehabilitated.

Provisions For Cure and Education

It is usually when the cerebral palsied child reaches the age of five or six years that their parents are disturbed about his development and education. At this point the child is brought to the attention of the hospital or physician for medical care. In a proposed program by the New

1 Carlson, Earl R., M. D., op. cit., p. 135.

York State Cerebral Palsy Association, it is recommended that through law, it should be required that all cerebral palsied individuals be registered with the State Department of Health upon completion of diagnosis.¹

In the last decade knowledge and skill in the diagnosis and treatment of the cerebral palsied has increased rapidly. At present a number of states, through legislation, are including the cerebral palsied as a state obligation. Apparently there is no reason for excluding these children from an existing program of State Aid to the Handicapped.

According to the New York Times, through the interest created by parent groups and organizations such as the National Society for Crippled Children and Adults, Inc., there has been an increase in the last year of treatment centers in the nation from twenty-two to forty-two. There are at present 120 organized parent groups throughout the country.² This does not mean, however, that there are forty-two adequate and complete state-wide programs for the cerebral palsied. It does indicate that there is an increasing awareness of a need for such services.

In some states there are limited state-wide programs for these children designed for the education of the parent.

Although progress has been made in the diagnosis and treatment of the child with cerebral palsy, facilities throughout the country for treatment and education are still limited. There are a few adequate medical and


training centers, namely: The Children's Country Home, Westfield, New Jersey; the Children's Rehabilitation Center, Cockeysville, Maryland; the James Whitcomb Riley Hospital, Indianapolis, Indiana; Dr. Earl R. Carlson's School of Corrective Motor Education, Long Island, New York; the Le Roy Center, Rochester, New York. In 1946, California established two Cerebral Palsy Diagnostic and Treatment Centers, one in San Francisco, and other in Los Angeles. There are also two Residence Schools for those children who are in need of special services, located in Red Wood City and Los Angeles.

Dr. Carlson stresses the importance of every educable cerebral palsied person having the right to an education regardless of the extent of the crippling condition. He recommends special schools for those whose handicap is too serious for them to be advantaged in a normal school environment. It is of paramount importance that the public be educated to the fact that regardless of the grimaces and drooling often seen in these children the majority of them, as has been proved by mental tests, have good minds, and educational possibilities are good if given the chance.

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3 California State Program for Children With Cerebral Palsy, California State Department of Education and Public Health (1946), Mimeographed.

Aspects of Rehabilitation

Granting that rehabilitation should be both physical and psychological, it is possible that in some cases rehabilitation can be that of handling a mild condition of cerebral palsy so that it is hardly noticeable to the untrained eye. However, in severe cases it is advisable to develop a knowledge of the handicap and a frank acceptance. In a rehabilitation program it is important that the medical and educational fields cooperate in a development program for the individual. Those persons who have been most successful in work with cerebral palsied children agree that the most adequate program would be one which includes all of the medical services in a closely knit unit, namely: physical training, academic training, medical care and opportunity for social adjustment. In order that the child may develop in all respects at a corresponding rate, these services should be carried out simultaneously.¹

The attitudes of parents are of great importance in the all-over picture of rehabilitation. The National Society for Crippled Children and Adults has done much to develop a nation-wide program for the cerebral palsied. In order to assure a sound program, the society has authorized a National Cerebral Palsy Parents Council. The objectives of the council are two-fold: fund raising (Easter Seal Sale) and education through books, motion pictures, pamphlets and radio programs. It is significant that new parent groups are coming into existence throughout the country.

Employment Opportunities

Spastic Review, a monthly publication for spastics by spastics (the term is used interchangeable with cerebral palsy) presented a list of ninety-seven positions in which those with cerebral palsy have been successfully and gainfully employed.¹ These positions include a wide vocational range from errand girl to bookkeeping; clerical work; accounting; linotype operator; librarian; machine operators of varied types; electrical engineer; dress designing; nurseryman; salesmen; teachers in schools from elementary to high; watch and clock repair; and statisticians.

It is generally agreed that rehabilitation for this group of children even to a slight degree is so important and means the difference between complete dependency and degree of leading independent and useful lives.

Legislation Through Social Action

Those parent organizations for combating cerebral palsy and which led to the formation of the national program for cerebral palsy were far visioned. It was their thought that the problem of cerebral palsy to be successfully combated called for the enlistment of the lay public with members of the medical profession in a widespread program to educate the community regarding the causes, prevention and rehabilitation. More intelligent knowledge of the subject, it was predicted, would lead to the establishment of needed agencies for treatment and education. Remarkable strides have been made. Much of the credit for results attained belongs to the voluntary association made up of an interested citizenship, both lay and professional.

Social legislation frequently leads to the establishment of adequate and worthwhile services.
CHAPTER III

STATE-WIDE PROGRAMS

Treatment of cerebral palsy is a long and difficult process, frequently involving much more than surgery. Many handicaps such as impaired hearing and vision, motor and sensory disturbances may be present in the same individual. Dr. Leon Sternfeld of the New York State Department of Health points out that after diagnosis, an "evaluation" of each case is necessary in order to determine the following factors in treatment:

The type of qualitative motor defect (spastic, athetoid, ataxia, rigidity, tremor), the degree of handicapping, the parts of the body involved, the amount of involvement, the developmental lag from the normal, the presence of associated or independent defects (other congenital malformations of organs, such as heart, defects of the eyes and ears, etc.), and the social situation of the patient and patient's family.1

Dr. Ann De Huff Peters2 agrees with the thinking of many, that the care of cerebral palsied children is inadequate in many areas. However, a few states and some organizations are doing a good job in this field.

In 1945, the United States Office of Education and the Children's Bureau prepared jointly and released simultaneously a memorandum to the forty-eight states asking for information of services in each respective state for children with cerebral palsy were either non-existent or inadequate. In some states where highly developed resources existed, "few children could


be taken, the waiting lists are long and the costs are prohibitive. "Some states offer medical and physical services with inadequate educational services. "The total picture showed spotty, insufficient and inadequate services. " A need was also shown for therapists, medical social workers, child psychiatrists and special teachers. 1

Granting that all existing services for the treatment and care of these children are inadequate everywhere, that cerebral palsy ranks second only to post-polio myelitis as a cause of crippling conditions in children; that treatment, care and rehabilitation is a long and difficult procedure; that the cost of private care is prohibitive to all but a few, it is apparent that provision for facilities for the care of children with cerebral palsy is a problem for both state and local health officials.

Through proposed legislation or statutory law, studies and projects for children with cerebral palsy have been made available through federal funds administered by the United States Children's Bureau under the Social Security Program on a federal, state and local level. 2 Funds in other states have been made available on a state and local level. 3

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1 New York State Joint Legislative Committee to Study the Problems of Cerebral Palsy, op. cit., pp. 21, 22.


3 New York State Joint Legislative Committee to Study the Problems of Cerebral Palsy, op. cit., p. 32; California State Program for Children with Cerebral Palsy, California State Department of Education and Public Health; and Linch, Lawrence J. "An Ideal State Program for the Cerebral Palsied." Reprinted from The Crippled Child, XXII: 5 (February, 1945), p. 143.
Analysis of Existing State-Wide Programs

New Jersey

In 1936, the Children's Bureau selected the state of New Jersey as the site of the first demonstration center for cerebral palsy. It is interesting to notice that two of the present recognized authorities in the field of cerebral palsy were chosen to help organize and work with the clinic held at Vineland, New Jersey: Dr. Phelps who is at present Medical Director of the Children's Rehabilitation Institute, Baltimore, Maryland; Mr. McIntire, formerly psychologist for the New Jersey Crippled Children's Commission.

Since the opening of this cerebral palsy clinic in December, 1936, other such centers have been established in the state. Dr. Phelps held two diagnostic clinics monthly during the period from 1936-1941. In 1941, in-patient units were established at the Children's Country Home, Westfield and the Hospital and Home for Crippled Children, Newark. The Hospital and Home for Crippled Children were used for out-patient clinics, as well as the A. Harry Moore School in Jersey City. With the exception of the clinic at A. Harry Moore School, these units were closed during the war period due to a personnel shortage. Diagnostic clinics were continued twice monthly followed up by regional nursing supervision in the field.

In 1946, two state-wide cerebral palsy treatment centers were opened, one in Trenton and one in Elizabeth. Consultation service is rendered to

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2 Ibid.
schools, agencies and families upon request from the Nursing Division. The proper fitting and adjustment of braces are given constant attention. Advice is also given concerning standard and improvised equipment and training techniques to be used in the care of cerebral palsied children. Through statutory law the Board of Education is authorized to provide transportation to and from school, either within or outside the school district for any crippled children in classes for crippled children.

During the ten years since the inception of the cerebral palsy program in the state, an attempt has been made to evaluate the problem in terms of present-day needs, keeping the following aims in view: to maintain continuous surveys throughout the state, so that information will be current on the nature and extent of the problem; to organize personnel and physical facilities for medical examination of patients; to establish and maintain treatment units adequate to provide the services received by the patients; to classify patients on the basis of proper placement with respect to treatment facilities.

The work of the Division has been organized so that there are three main aspects of its functioning: administrative, clinic and post-clinic procedure, and consultation service. The administrative includes not only the numerous details involved in solving the problems of the cerebral palsy cases in the state, but also passing on information to professional people in other states and countries who wish to learn from the pioneering work that has been done in New Jersey. This additional work has involved correspondence and conferences. Visitors have come to observe and discuss the problem from Boards of Education, Hospitals, student bodies in nearby universities. There have been visitors from the Federal Government, from Kentucky, Oklahoma, Virginia, California, Texas, New York, Hawaii, and London.

The development and growth of cerebral palsy clinics in New Jersey are significant in that a number of states have based their respective programs on the New Jersey plan. It is also significant that Dr. Phelps who helped establish the first cerebral palsy clinic in New Jersey, worked with other State Commissions in establishing and developing services and programs for

the care and treatment of children with cerebral palsy.

Indiana

In 1936, plans for a clinic for the treatment of children with cerebral palsy were presented to the Social Security Board. At this time it was estimated that there were approximately 500 children in the state afflicted to some extent by cerebral palsy. Over a period of time, 300 of these children had been out-patients of the Riley Hospital. However, it was found that the counties could not finance a program for hospitalization of these children because of the length of time necessary for specialized training due to the prohibitive cost of such services.

During this period six cerebral palsy cases were selected by the orthopedic staff as a research experiment. Through records and moving pictures it was proved that four cases showed that the plan was satisfactory and worthy of extensive development for larger groups if funds could be made available. Two of these cases developed sufficiently to be accepted by the School for Crippled Children.1

In 1937, under the provision of the Social Security Act, the State Department of Public Welfare established a clinic for the treatment of cerebral palsy. The James Whitcomb Riley Hospital is the only children's hospital in the state of Indiana. The by-laws of the hospital required that all services be free of charge and only those patients be admitted for treatment who could not pay, who were under twenty-one and residents of Indiana. However, provisions have since been made for those who can

1 Kahmann, Winifred Conrick, O. T. Reg. "The Project for the Treatment of Cerebral Palsy at the Riley Hospital." Reprinted From Occupational Therapy and Rehabilitation, XVII: 2 (April, 1936).
These patients are referred by private physicians, committed through the State Department of Public Welfare and pay a fee directly to the hospital.

The cerebral palsy clinic correlates physical, occupational and speech therapy into a single program. Through experience it has been found that five children can be handled best in a group by three therapists. The patients are seen through three different methods: the clinic review system; the out-patient program; and the intensive training program. The total patient load since 1937 is 1,629. Some of these children have continued under treatment, others have been discharged for having attained maximum improvement or having reached the age of twenty-one years.

If training is indicated the child is referred to the cerebral palsy clinic where he is treated under the doctor's recommendations. The psychologist is the first person to see the child in the cerebral palsy clinic. Young children are seen at three or six months' intervals; older children are seen at least once a year. In the cerebral palsy clinic, parents are instructed how to carry out suggestions and exercises at home until the next clinic visit.

As a preparation for adult life, older boys and girls are given vocational guidance based on the use of standard aptitude and vocational tests. Through an agreement between the State Vocational Rehabilitation Division services are offered for vocational rehabilitation.

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2 Ibid.
Throughout the state of Indiana, the public health nurses in cooperation with the doctor and the cerebral palsy clinic visit the homes of patients on clinic review and supervise home treatment. Through the "Clinic Review" system cases of hundreds of children throughout the State are followed by hospital orthopedic clinics. The child usually returns periodically to the orthopedic clinic where he is re-examined by the doctor who recommends further treatment. A physical therapist works in cooperation with the nurse in field services.¹

The medical social worker provided by the State Department of Public Welfare for the cerebral palsy program has offices in the James Whitcomb Riley Hospital.² In addition to working with social problems of crippled children, she makes her services available to parents and others interested in the cerebral palsy child. The medical social worker secures the cooperation of other agencies, teachers and nurses. She shares the responsibility of case finding and boarding homes for those who cannot be cared for at home.

Maryland

In 1939, Services for Crippled Children placed ten cerebral palsy cases in the Rehabilitation Institute conducted by Dr. Winthrop M. Phelps. One of these children has remained in the Institute since the inception of its


² "Cerebral Palsy Clinic, James Whitcomb Riley Hospital," Division of Services for Crippled Children, Indiana State Department of Public Welfare, Indianapolis (June, 1946), p. 3, (Mimeographed).
program in 1939. A child is admitted to the Diagnostic Center for a trial period of three months, if he is advantaged by the treatment he is retained as a pupil. Since the staff ratio is almost one to one, the opportunities for care and treatment are excellent.

Dr. Halliday, Chief of the Maryland Department of Health states that 400 children with cerebral palsy on the official register live in the counties of Maryland, exclusive of Baltimore. He believes there are about 500 in Baltimore city.¹

During 1947, the Baltimore City Health Department and the Maryland State Department of Health entered into an agreement for services for children with cerebral palsy.² The program will be conducted by the Baltimore City Department of Health and the Baltimore City Department of Education. Services will be provided for cerebral palsied children in two schools for handicapped children. A sum of $8,592.00 will be paid to the Baltimore City Health Department by the Maryland State Department of Health.

Initially, three classes are planned with a maximum of fifteen children in each class. Any cerebral palsied child under twenty-one who meets the educational requirements of the Baltimore City Department of Education will be admitted to the special class. Children are recommended to be admitted from five years up to twenty-one. Only ambulatory and chair cases will be admitted.

¹ Letter from Dr. C. H. Halliday (Chief, Department of Health, Baltimore, Maryland, February 16, 1948.)

² "Cerebral Palsy Program," Draft of Agreement Between the Maryland State Department of Health and the Baltimore City Health Department (1947) (Mimeoographed)
All children will be admitted to the school for a trial period, during this time psychological tests will be given and all recommendations will be considered. Counselling and rehabilitation services will be given, the cerebral palsy children will be guided, trained and placed for vocations through these services.

The medical director and his staff will have special training and experience in cerebral palsy. For each fifteen cerebral palsy children there will be one teacher, one therapist and one matron. Speech, physical and occupational therapists will be provided at the school. Hearing aids will be provided when indicated. Nursing services will be provided. A medical social worker will give consultative service to the staff, the child, the family and assist in the selection and use of any needed foster homes. Dental services will be provided as part of the program.

Transportation of children from their homes to school will be provided by school buses, the children will be accompanied by an attendant.

In order that high standards be maintained and the content of services be carried out the State Services for Crippled Children may provide consultative and advisory services with periodic reviews for evaluation of services to cerebral palsy children.

California

In 1945, the California State Legislature appropriated funds for the establishment of a state-wide cerebral palsy program.1 This program has been in operation since 1946. The program is administered jointly by the

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1 Information Circular, California State Department for Children with Cerebral Palsy (September, 1946). (Mimeographed).
Authorities estimate that there are about 8,000 to 10,000 children with cerebral palsy in the state of California. At the present time, 1,426 cerebral palsy cases are known to the Department of Public Health. There are two cerebral palsy centers for diagnosis and treatment, one in San Francisco, the other in Los Angeles. Private physicians may refer cases to the center, or referrals may be made through the crippled children services field clinic, by arrangement through state and local health departments. Medical and surgical treatment and physical therapy are available in the cerebral palsy centers. The clinic is maintained on an out and in-patient basis. These services are available to children under twenty-one years of age who are residents of the state.

There are two residence schools located in Northern and Southern California, respectively. These schools afford intensive medical treatment and analysis of the educational, social and emotional development of each child. How long a child remains depends upon the needs of the individual child. Upon discharge and return to the local community, recommendations are made for continued treatment and education. The residence school in the Northern area has facilities for fifty children. The one in the Southern area has facilities for ten children. Both schools provide for medical supervision, physical and occupational therapy, medical social services and special education. Special classes are being developed in the public schools in various parts of the state for education and physical therapy of these children. All personnel will have special training in the handling of cerebral palsy cases. Local health department personnel will cooperate in case finding and follow-up.
New York

After two years of intensive study that has included numerous hearings over the state, visits to clinics and consultation with leading specialists, a Joint Legislative Committee to Study the Problems of Cerebral Palsy recently had filed its report with the New York Legislature.¹

The New York State Cerebral Palsy Association, with a membership of nearly 2,000, presented the Joint Committee with a "Suggested Program on Cerebral Palsy."² This suggested program generally follows the pattern of existing state-wide programs discussed earlier in this Chapter, namely: Methods of case finding; diagnostic centers; hospital home, residence schools; field services; out-patient clinic; vocational guidance; rehabilitation services; trained personnel; family participation; cooperation of Department of Health and Education.

Pending inception of a state-wide program for cerebral palsied children as recommended by Governor Thomas E. Dewey, that at least one center should be made available immediately at which, in addition to specialized diagnosis and treatment, there will be a source of continuing research in this relatively new field. Le Roy Center was started in 1947 as a result of the committee's preliminary report. The Le Roy Center is financed by: the University of Rochester; the State; a grant from the National Foundation for Infantile Paralysis; the gift of a nineteen-acre estate by private individuals.


The New York State Department of Health has on its register 4,628 cases of cerebral palsy. 1,000 additional cases are cared for in institutions under the Department of Mental Hygiene. During the school year 1945-46, 471 cerebral palsied children were enrolled in special classes throughout twenty-five cities and villages in New York State. It is estimated that there are 17,000 cerebral palsied children under twenty-one in the state.

Faced with a paucity of available services, many of the programs in New York have been started by local affiliates of the New York State Cerebral Palsy Association. Support has come from the New York Association for Crippled Children. In 1947, these groups were responsible for the opening of the Cerebral Palsy Pre-School Center for cerebral palsied children at Lenox Hill Hospital. The New York Association for Crippled Children and Adults, and the Cerebral Palsy Society of New York helped to equip the Center.1

In addition to the center now in existence at Rochester, the New York State Joint Committee has recommended six special cerebral palsy centers for diagnosis and treatment:2 three to be located in New York City; one to be located in Buffalo; one to be in Syracuse; and one in the Albany area. A State Hospital Home is recommended for those cerebral palsied children who have normal intelligence but extremely severe handicaps.

It is unnecessary to alter the administrative pattern of the medical rehabilitation program in order to expand it to provide more adequate care for cerebral palsied patients. There is, however, need

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2 New York State Joint Legislative Committee to Study Cerebral Palsy OP. cit., p. 3.
for providing more adequate facilities for diagnosis and care of such patients which, in turn, implies a need for training additional professional and technical personnel in the specialized techniques required in the cerebral palsied case. No changes are essential for the operation of a cerebral palsy program since present legislation is broad enough to include this condition with other physical handicaps.1

Illinois

The Illinois State Commission for Handicapped Children has proposed to the State Legislation that a demonstration center for the training of children with cerebral palsy be established in Chicago.2 It is suggested that this program could be under the direction of the Illinois Surgical Institute for Children of the University of Illinois, with assistance from the State Division of Services for Crippled Children, the Illinois Commission for Handicapped Children and other social agencies and treatment sources in Chicago.

If Dr. Phelps' conclusion that 70% of all cases of cerebral palsy have intelligence quotients of 70 or more, is applied to the 2,738 registered cases in Illinois, there are in the state more than 1,900 such children capable of profiting from rehabilitative measures.3

A few of the larger cities in the state of Illinois have provision for special education for crippled children's schools or classes. The excess costs of such provision over the costs of educating normal children, up to $300,000 per year have been accepted by the state as its responsibility. However, it remains for the local school district to initiate such an

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1 New York State Joint Legislative Committee to Study Cerebral Palsy, op. cit., p. 3.


3 Ibid., p. 11.
Illinois has no centers or institutions adequately set up to meet the needs of cerebral palseid children. Clinics are held in some hospitals. The children are examined and recommendations are made for their care and treatment. Dr. Perlstein who is outstanding in his methods of speech therapy for cerebral palseid children conducts a clinic for these children at the cerebral palsy unit at St. John's Crippled Children's School and Hospital, Springfield, Illinois. In the clinic the children are examined and recommended for treatment according to individual needs. Dr. Perlstein recommends that speech therapy is most effective when carried on with other types of therapy, that is, physical and occupational.2

The Michael Reese Hospital in Chicago also offers clinic services to children with cerebral palsy, diagnosing and recommending treatment on an individual basis.

None of these facilities, however, constitute a complete and adequate center where all aspects of the cerebral palsy problems can be studied, children cared for, and methods of treatment and education established, nor where technicians can be trained to extend the procedures to others in need.3

The proposed plans for a cerebral palsy program in Illinois includes:

1. case finding
2. cerebral palsy centers
3. field clinics
4. hospital-home

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The Elements of a State-Wide Program

During the past ten years great progress has been made by all State Crippled Children Agencies in meeting the needs of children with various orthopedic handicaps, but in general little progress has been made in meeting the needs of children with cerebral palsy. Due to the limited number of trained personnel in this field, insufficient knowledge of just what should be done for these children and lack of sufficient funds to develop comprehensive programs, it has not been possible except in a few states to carry out a satisfactory plan of services for the children with cerebral palsy.

Dr. Phelps supports the foregoing statement with the fact that at the Children's Rehabilitation Institute, for eighty children who are being cared for; between ninety and one hundred people are employed to meet their needs. This number of employed personnel is not sufficient.

Through an analysis of the programs for cerebral palsyed children in the states selected for this study, it is apparent that provision of facilities for the care of these children conforms to a general pattern which prevails interchangeably throughout the respective states.

Case Finding

The early discovery of cases among cerebral palsyed children is

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2 New York State Joint Legislative Committee to Study the Problem of Cerebral Palsy, op. cit., p. 21.
imperative if best results are to be obtained. It is important that case finding be constantly kept in the minds of all people, especially physicians, nurses, social workers, teachers, organized citizen groups and the general public. In this way immediate treatment can be insured.

To promote a case finding program, the reports from private physicians, school records, social service index and special surveys should give the names of children who are crippled or who are suffering from conditions that lead to crippling. In order to facilitate this work, provisions for reporting birth injuries and congenital malformation on birth certificates have been made in twenty-five states and in the District of Columbia.¹

Dr. Arnold Gesell, Chief of the Yale Clinic of Child Development, states that, "The behavior of a tiny infant is so revealing that simple psychological tests given in his crib, will tell the trained expert how the child will grow." He states further that "During the baby's first year, it is possible to detect nearly all cases of idiocy, brain injury, defects of the senses, or motor defects, and serious personality abnormalities."²

Factors in Prevention

Although science, medicine and surgery have made remarkable strides and progress in reducing the incidence of crippling from birth injuries, cerebral palsy still presents a baffling problem. In order to prevent the condition of neuro-muscular disorder caused by the injury to the brain in cerebral palsy, the local health department with the cooperation of maternal


² "As the Twig is Bent," Newsweek (December 1, 1947), p. 52.
and child health; public health nursing and health education attempt to educate the public regarding the problem. The State Department of Health is an administrative agency, it is concerned with the health standards and practices of the local departments. It maintains the same services that the local departments maintain and renders services to the general public through local departments.

Eligibility

Any child under the age of twenty-one with cerebral palsy who is a resident of the state is eligible for treatment and care in a clinic. The patient can be admitted through the medical center, the local health department or through the State Department of Public Welfare, either on a pay or non-pay basis.

Trained Personnel and Organization

Because of the special professional skills required to help these children, we should continue to stress the need of medical specialists in this field; as well as occupational and physical therapy technicians trained in the special procedures necessary in cerebral palsy. Moreover, we should continue to work toward a better distribution of such professional personnel throughout the country.

The need for trained personnel to work with cerebral palsied children is great. New Jersey reported that two cerebral palsy clinics were in the process of being equipped and would be opened as

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soon as some of the personnel completed their training.

The New York State Department of Health has received approval for a grant of Federal funds from the Children’s Bureau for a five-year training program for the training of special personnel.

The James Whitcomb Riley Hospital, Indianapolis and the Children’s Rehabilitation Institute, Cockeysville, Maryland are two centers where good courses in the treatment of cerebral palsy are available.

Many of the state-wide programs studied have included the broader aspects of organizations as those included in the hypothetical state as outlined by Dr. Phelps and Mr. Turner, as follows:

The cerebral palsy program would be built up within the framework of the already existing program for crippled children. Staff members with special training in cerebral palsy would be developed in a central institution.

Children would be referred from out-lying clinics to the central observation clinic. After observation, they would be referred back to the district clinic with recommendations for care. Foster homes might be used for selected children in connection with the observation clinic to free beds in the central institution. District clinics could be held on specific dates with the special staff present to suggest follow-up care. On the evening of the clinic dates, parents might attend instruction courses conducted by staff member.

Since it is apparent that programs for the care of cerebral palsied children are inadequate and it has been proved through survey and research by mental testing and physical diagnosis that approximately 70% of these children having intelligence quotients of 70 or above can be trained;


3 New York State Joint Legislative Committee to Study the Problem of Cerebral Palsy, op. cit., p. 38.

educated and rehabilitated, plans throughout the country should be made to
give these children optimum care and training. Private and public agencies
are cooperating splendidly to accelerate a much needed program, however,
because of the prohibitive costs for necessary services, the need for a
state-wide program is inevitable. Through such a program thousands of un-
fortunate children can be assisted to live a useful and more adequate life.
CHAPTER IV

THE ROLE OF THE MEDICAL SOCIAL WORKER IN DEVELOPING POSITIVE ATTITUDES

Interested people and groups of people all over the country are working in an integrated effort to make it possible for cerebral palsied children to develop their potential abilities, thereby making it possible for them to become independent and useful members of their communities. To help these children develop to the fullest of their capacities is the job of the physicians, the public health nurses, the physical occupational and speech therapists, the medical social worker and the teacher.\(^1\)

In order for one to work successfully with cerebral palsied children, there are certain medical social aspects about which more should be known: what the child thinks; what he feels. There should be an awareness of the erroneous common public belief that these children are feeble-minded as well as of the discouragement that they meet.

In working with these children it is of paramount importance that the medical social worker clarify her own feelings regarding attitudes toward the cerebral palsied child. In order to be honest it is important that we accept these children wholly. It is necessary to think deeply and clearly in order to be free of any basic fears or inadequacies in dealing with the cerebral palsied child. We must handle our own negative attitudes and do something about them before we can attempt to develop positive attitudes in others who work and live with these children.

Are cerebral palsied children different from normal children? My answer is, No. Basically they are no different from all children; they think and feel and dream of the future just as any normal child, and allowing for their physical handicap we should expect just as much of them as a normal child. But I must qualify that statement. First, many of these children are retarded and, second, we must know how to allow for the physical handicap. By retarded, I am not referring to any lack of mental capacity, but to the fact that they have been born with a physical handicap. Unlike having poliomyelitis or becoming crippled later in life, these children have never known anything else. Each step of their development is usually slower than that of the normal child. By the time the cerebral palsied child has reached the age of four, for example, he may be one or two years behind the normal child in mental and physical experiences, the amount of time depends upon the severity of his condition.1

The final goal for cerebral palsied children is not the restoration of the physical handicap to normalcy because this cannot be obtained. Therefore, the ultimate goal is the development of a citizen who can earn an independent useful existence and have some chance at real happiness in the world.2 Because of the skills that the medical social worker has acquired through training, experience and growth in understanding social factors, she can do much in the treatment of social factors that interfere with the individual in achieving a useful, satisfying place in his family and community. A happy outlook on life is as important to the cerebral palsied child as physical rehabilitation.

Realizing that these children will have to live in a real world, a world that is often hard and not too kind, but a world where people derive

1 Stanchfield, Margaret A. "Medical Aspects of Cerebral Falsy," Reprinted from Public Health Nursing (February, 1947).

pleasure from achievements and independence, a medical social worker can do
much to assist the cerebral palsied child in preparing for such a realistic
world: by assisting the child to accept his physical handicap with a rea-
listic frankness; by helping him to move on and not desire to remain an
infant; she can aid him in realizing that mentally he is not handicapped,
and physically he must learn to do things in a different way by realizing
that growth and development hinge greatly on his desire and will to move on.

The medical social worker is first of all a social worker and realizes
how important it is to assist the cerebral palsied child in developing a
sense of personal worth.

The Family Group

Granting that children afflicted with cerebral patlasy are discovered,
carried to diagnostic centers, educated or re-educated and rehabilitated,
there still remains the problem of the emotional adjustment of the indi-
vidual child and often the total family. In the entire picture of adjust-
ment to life, attitudes of parents are probably the most important single
items of influence. Dr. Carlson feels that parents are in need of treat-
ment as much or even more than the child. Parents too often await the
miracle of healing, allowing the child to develop serious emotional malad-
justments due to the fact that he is not subjected to the same educational
and disciplinary influences as other children in the family.¹

The trained medical social worker is constantly aware of the fact that
parents need constructive attitudes and emotions to give effective help to

York (1941), p. 17.
These children. Many parents make a good emotional adjustment and are able very soon to begin measures towards rehabilitation. Others succumb to shock, discouragement and bewilderment, floundering in destructive feelings of fear, worry or resentment and may fall into unhealthy states of mind regarding the child. These undesirable slants of mind may be: feelings of guilt; over protection; and rejection.

Through her skills, the medical social worker is equipped to help the parent to look without emotion at what seems to be an unconquerable circumstance. With this help, the parent can realize that there is no reasonable basis for feelings of guilt. Thus the medical social worker removes vague, suspicious feelings that the parent is responsible for the calamity, thereby helping to change attitudes that obstruct the child's progress. Embarrassment in the thought that the child is physically and mentally different can be overcome.

When the medical social worker can find the particular worry or fear that the parents have, and explains it, a valuable step has been taken toward helping the child as well as the parent. Many a cerebral palsied child has, in the past, been hidden away an entire life time from all but his family. The child with cerebral palsy needs to have a feeling of security and of belonging, this is essential to harmonious development.

The problems of children often bring to the surface the deep-seated feelings of parents. If parents find difficulty in working through their own feelings with intelligence and understanding, it is the job of the

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1 Hanser, Ruth. "The Parents' Role in the Cerebral Palsy Problem," Orthopedic Hospital, Los Angeles, California (July, 1946), p. 3.
medical social worker to see that they are started in the right direction in clarifying their thinking. Since the attitude of the child toward his handicap is based on the attitude of those in his immediate family group, it is important that the medical social worker knows as much about the entire family as possible. The presence of a handicapped child in the family group must of necessity have some special effect. The handicapped child requires a large share of attention as well as concern and personal service. It is important that the medical social worker helps to minimize sibling rivalry as much as possible.

If adequate interpretation is to be given, it is necessary that the medical social worker understands both the child and the parents' point of view. If there is any resistance to treatment, it is important that the medical social worker learns the reason in order to remove any barriers to treatment and rehabilitation. If the condition is arrested a doctor considers this a "good outcome." It is important that the medical social worker interprets this to the parent and child in order that orthopedic surgery will not be a disappointment to those expecting a miracle. If the child is helped in some degree, this to the doctor is a "good outcome," and it is up to the medical social worker to interpret this "degree" of improvement to the child and parent. Disappointments are difficult to erase, but an adequate interpretation leads to understanding and growth and acceptance.

1 Stanchfield, Margaret A. "Medical Aspects of Cerebral Palsy," op. cit.

Objectives can be achieved only if the child's medical treatment is integrated with his growth and development, in social adjustment, education and vocational training. When making plans for social treatment the medical social worker must learn or know the necessity of considering the medical needs and probability of carrying them out. It is important that the family carry out all recommendations and return the cerebral palsied child to the clinic at the time requested. Failure to follow through on recommendations can sometimes retard the child several months and even years.

Ignorance of parents as to orthopedic conditions and emotional needs of the cerebral palsied child is indicative of immaturity or inadequacy. Those parents whose emotional acceptance of these children is complete provide the child with a sense of security which saves him from feelings of inferiority. It is important that the medical social worker assists the parent in being free from fear of surgery, a fear that the child may never be economically independent or able to take his place in the social scheme of things.

In evaluating the social status of these children the medical social worker must be aware of the initial trauma of their ego. The children develop varying degrees of progress as a result of their physical capacity, drives, attitudes and effect of rehabilitation upon them. A parent with a

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strong super ego can best assist these children in developing strong super egos, which is important for ultimate growth and achievement.¹

Community

It must be realized that many people are uncomfortable and often patronizing in the presence of the cerebral palsied child. It is not too easy for the layman to be at ease in the presence of a child who is drooling, going through types of facial contortions and jumbling words in order to form sentences. The child would often be more relaxed and speak with more ease if we could lose our own self consciousness and over-anxiety in the presence of these children.²

In order to meet the challenge of serving the child with cerebral palsy it is necessary and expedient that we have the acceptance and support of the public in order to develop adequate programs. This can be done through the utilization of radio, the press, citizens groups and conferences.³ These means of facilitating the understanding of the child within his community develops sympathetic attitudes and understanding of the problem. The medical social worker who avails herself to these avenues of approach to the public and the community is in a strategic position


² Stanchfield, Margaret A. "Medical Social Aspects of Cerebral Palsy," op. cit.

to interpret and advance the cause of the cerebral palsy program. In this program, expertise and trained personnel are required at all times in coping with the problem adequately and successfully. The thoughtless, callous ways of strangers and even neighbors and friends toward a child with cerebral palsy can often be amazing.  

Through the concerted efforts of such organizations as the National Society for Crippled Children and Adults, and Cerebral Palsy Parent Groups, much is being done to interpret to the community the problem of cerebral palsied children and the possibilities for the development and rehabilitation of these children through treatment and education.

In 1936, The Children's Bureau Advisory Committee on Services for Crippled Children, recommended that hospitals participating in the program should have at least one qualified medical social worker on the staff in order that such services might be available to children where medical services were made available through the State.

At all times there should be a cooperative relationship between the doctor, the nurse and the medical social worker and other members of the medical personnel, as a part of the process, a means rather than an end. Conflicts and maladjustments manifest themselves in various ways to the doctor, the nurse and the medical social worker. The doctor sees the child from the clinical viewpoint, the nurse gives treatment to the child in a

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1 Hanser, Ruth. "The Parents' Role in the Cerebral Palsy Problem," op. cit.
family setting, the medical social worker listens to the parent discuss her feelings about the child in an interviewing booth. Regularly planned conferences afford an excellent opportunity to help the child and clarify one's own feelings in gaining a better understanding of and respect for other skills. It is necessary for the doctor, the nurse and the medical social worker to understand what each recognizes as the needs of a cerebral palsied child. In this way the needs of the whole child can be met and it is only in this way that the child can be assisted to lead a useful and independent life.¹

CHAPTER V

SUMMARY

Authorities in the field of medicine who have specialized in work with cerebral palsy children agree that cerebral palsy is caused by damage to the brain and variations in the developmental structure of the brain. The damage is the result of hemorrhage in the brain due to injury before, during and after childbirth. The functions which the damaged area controls is also damaged.¹

It has been estimated that there are 200,000 to 300,000 Americans afflicted with cerebral palsy. These figures are based on surveys in several states which have proved the fact that there is an annual increment of seven cerebral palsied children per 100,000 of general population. With one death out of each seven, it can be assumed that there will be a constant case load of ninety-six cerebral palsied children under the age of sixteen for every 100,000 population.²

During the last decade through research and study much knowledge has been gained concerning the diagnosis and treatment of children with cerebral palsy. More than half of these children can and do profit physically and mentally through adequate care and treatment. Authorities have estimated


a ratio of fifty-four educable cerebral palsied children under sixteen for each 100,000 of the general population.¹

Through clinical work and study, authorities have agreed that the treatment of cerebral palsy is a long and difficult process, however, there is a tremendous amount that can be done in rehabilitating these children providing that they are reached at an early age, namely: two to three years of age.²

It has been proved that seventy percent of these children have from normal to superior intelligence;³ that over half of them are educable and can be trained to lead useful and creative lives;⁴ that case finding at an early age is of paramount importance; and that trained personnel should be employed to work with these children. It has been estimated also that we shall always have 56,000 patients under the age of twenty amenable to medical assistance at all times;⁵ and that throughout the country there is a

¹ Phelps, Winthrop M., M. D. "When a Child has Cerebral Palsy," The Child, a report, XI: 12 (June, 1944).


great need for more adequate treatment and educational facilities. These facts the student has found through study of materials received from twenty-seven states, six of those chosen for analysis in this study reveal that action varies from the appropriation of a relatively small sum of money to more adequate provisions for the construction of specific diagnostic, treatment and educational facilities. State Societies for Crippled Children are very conspicuous in their interest in the field of cerebral palsy. Private philanthropy, interest and support are as much to be desired in meeting the challenge of cerebral palsy as they have been welcome and effective in dealing with problems presented by tuberculosis and poliomyelitis.1

Those individuals who have had experience in working with the cerebral palsied child have agreed that because cerebral palsy is such a complex proposition, the most adequate program would be one which included all of the needed services in a closely knit unit. That is: the academic training; the physical training; and the medical care. It has been recommended that the clinics be used as a training center for those interested in work with cerebral palsied children;2 that an effective state plan for meeting the needs of cerebral palsied children can be carried out within the administrative framework of existing programs of services for

1 Carlson, Earl R., M. D., op. cit., p. 172.
2 Phelps, Winthrop M., M. D. "Let's Talk About Cerebral Palsy," op. cit., p. 11; Cerebral Palsy Clinic, James Whitcomb Riley Hospital, State Department of Public Welfare, Indiana University Medical Center (1937-1947); and Perlstein, M. A., M. D. "Professional Training for Cerebral Palsy," New York State Joint Legislative Committee to Study the Problems of Cerebral Palsy (1947), p. 42.
crippled children.¹

Since the aim of treatment is to evaluate the needs of each child carefully and to attempt to develop his physical and mental capabilities to their fullest extent; mental tests should have clinical value only in that they present an objective analysis of the child's mental condition, which by its clarity will reduce the conflict of opinion and give a sound and convincing basis for educational and rehabilitative plans.²

Since the cerebral palsied program is a medical program with a social goal, the medical social worker is an important member of the staff. The medical social worker works in a liaison capacity between the community, the family and the agency. She works closely with the patient and his social environment. She interprets to the parent and the child the necessity of strict adherence to the treatment recommended, helping him to realize that he is an important factor in the treatment of his condition. Helping restore the cerebral palsied child to the best possible physical and emotional adjustment is of paramount importance to the medical social worker.

There is no miracle that can restore a damaged brain to its normal function. However, through the cooperation of the medical team, the parents, the community and special teachers, the cerebral palsied child can be assisted to be a useful and happy member of society. The future development of centers depends upon the degree of community responsibility in making


the best type of services available to the child with cerebral palsy.

Dr. Carlson believes that every human life has its purpose, and even the most hopelessly handicapped can be useful to society.¹

I have sometimes been embarrassed by being hailed as an example of what the handicapped person can do if he determines to overcome his difficulties. But what I have accomplished is really due to the help and guidance, throughout my life, of a host of teachers and friends. They kept me struggling against my difficulties and encouraged my belief that, by making the most of my opportunities, I could help other spastics to free themselves from the shackles of their handicap and to become useful citizens.²

² Ibid.
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