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Do We Really Understand a Child Who Has Cerebral Palsy?*

What is cerebral palsy? How many have seen a child unable to control his legs and arms and immediately label him as an idiot? This condition has commonly been called Little's Disease or spastic paralysis. Actually cerebral palsy is an over-all term for three specific types of brain injury resulting from damage to the brain cells before, during, or after the birth process. Brain injury in this sense does not necessarily mean damage to the intellect, but rather to those parts of the brain controlling motion. The part or parts of the brain affected determine the amount of motion lost and the type of movement displayed by the child.

The three specific types are spastics, athetoids, and ataxics. To the lay person, all three types may look the same. However, each type is different and after careful diagnosis each requires a different kind of treatment. Occasionally there are combined types of the above. Complete diagnosis can be made only after a careful study of the case. Treatment must be individual for no two children are affected in an identical manner. The extent and nature of the symptoms vary. Sometimes only one extremity is affected, sometimes all four. Some children have a breathing difficulty or possibly the facial muscles are affected.

Description of Types

Spasticity is characterized by increased sensitivity to all stimuli, such as sudden sound, touch. Movements are stiff, jerky, and uncertain. Effort increases the motions. Emotional stress and strain cause the child to stiffen. Sensory impulses reach the brain but the patient does not have the ability to control certain movements while performing others. Spasticity may also be of the speech mechanism; of the facial muscles causing difficulty in chewing food; of the diaphragm, complicating breathing and in turn speech; of the swallowing mechanism, causing drooling. Treatment largely consists of muscle re-education, and relaxation under specialized supervision.

Athetosis is characterized by constant, irregular, uncontrolled movements. Movements seem to lack coordination and purpose. They may involve the facial muscles, the breathing apparatus, the speech mechanism as well as the extremities. Effort on the part of the patient to control his motions and emotional disturbance exaggerate the movements. In his attempt to control motions, the patient acquires an habitual tension. The motions, however, completely disappear in sleep. Thus, if tension is lowered and the child learns how to relax, he can be taught to control his motions. The muscles of the athetoid know how to perform normally and there is no need for specific muscle training as in the case of the spastic. The important point is to teach the *athetoid how to hold his relaxation constantly.*

Ataxia is the least common form of cerebral palsy. It is a disturbance of the sense of balance. There is no interference with motion as in the case of the spastic nor uncontrolled motion as in the athetoid. Special training is necessary to teach the ataxic how to steer his motion. Until trained, he cannot control falling. Since the balance mechanism is damaged, he must learn how to balance as one would learn any new skill. Sensation may be affected. There may be defects of vision, or a defect of the speech mechanism. There is no tension or uncontrolled motion when the child is at rest.

Distribution of Cases

According to recent studies, seven cases of cerebral palsy occur yearly per 100,000 population. There is no difference in the percentage of cases found in urban and rural populations. Economic or social status makes little difference. Cases are distributed fairly evenly and constantly throughout the United States. In 1946 there were 1,130 registered cases in the State of Minnesota under the age of 21 years.

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*By Margaret A. Stanchfield, Medical Social Worker, Division of Social Welfare, Medical Services Unit, Crippled Children Services.

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Minnesota's State Program

Since 1941, Minnesota has had a demonstration program for cerebral palsy children. A small group of rural children between the ages of 4½ and 8 are carefully selected, placed in supervised boarding homes in Minneapolis and entered at Michael Dowling School. Selection is made after a ten-day period of hospitalization for observation. The purpose of treating this small group of children is to enable them to return to their local schools and normal competition. For this reason great selectivity has been necessary. The results from point of view of treatment, educational and social gains have been satisfying but there is a great need for more extensive work with the cerebral palsy children.

Need for Understanding

There is no drama in connection with the cerebral palsied. We cannot publish a picture of a child with his face grimacing, his body contorting, and expect the public to be carried away with enthusiasm. We must concentrate on educating the public toward understanding what can be accomplished before much can be done for these children.

As professional persons, our first step is to analyze our own feelings. Are we uncomfortable, patronizing and ill at ease in the presence of a cerebral palsied child? Are we filled with pity or possibly revulsion? A child, anyone for that matter, feels what is going on within us. Even an infant is sensitive to our feelings toward him. Our words may be correct and carefully chosen. We may be doing a remarkable piece of work with our minds and our lips but all is lost if we are filled inside with pity or revulsion or frustration.

Suppose we do find within ourselves some of these attitudes, what can we do about it? Perhaps it is a basic fear of the strange and the unknown, a fear of our own inadequacy in coping with these cases. If it is fear, the remedy then is the gaining of understanding. No one ever fears the familiar, no matter how it may appear to the outsider. The layman and his attitudes are far more of a problem than the cerebral palsied themselves. We as professional persons are the pace-setters in these attitudes and we must know ourselves before we can lead the public toward understanding.

Evaluation of Intelligence

Aside from developments in treatment, we already have jumped one large social hurdle. That is recognition that these children have intelligence. It was not many years ago that these children were thought to be idiots. It is now believed that not more than 25 per cent are truly feebleminded. Mental testing is, however, difficult and there is much disagreement as to methods. Dr. Elizabeth Lord has written that we should use special tests. Her opponents say, how then can we rate and compare these children with normal children? Dr. Perlstein discounts the value of tests as conclusive evidence. He accepts children at St. John's Hospital, Springfield, Illinois, for a trial period. If they show ability to learn and to profit by training they may continue there. Many have found the Stanford-Binet test in the hands of an experienced tester to be adequate with few modifications.

The dangers of drawing personal conclusions as to the intelligence of a cerebral palsied child is a problem of such grave implications that it is frightening. We know of one four-year-old in this State who was so apparently feebleminded that he almost was institutionalized with the approval of all concerned. He was not a problem at that point and further steps were delayed. At the age of six, he was tested by an experienced cerebral palsied tester and earned an IQ of 108. We recently received the testing results of a child whose appearance and actions indicated a low intelligence level. Her IQ is 90 with a minimal estimate. These are but two of many examples. No matter how low in intelligence a child may appear to us, we should reserve an opinion and give him the benefit of demonstrating his abilities.

Are Cerebral Palsied Children Different from Normal Children?

Basically these children are no different from other children; they think, feel and dream of the future just as any normal child,

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and with allowances for the extent of their physical handicap, we should expect just as much of them as of a normal child. However, that statement must be qualified. In the first place, many of these children are retarded. Secondly, we must know how to allow for physical handicaps. The term "retarded" does not refer 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. Development is slower usually than that of the normal child. He may be one or two years behind the normal child in mental and physical experiences, the amount of time dependent upon the severity of his condition.

Following is an example of what is meant by retardation and by allowing for the physical handicap. Suppose a cerebral palsied child sets out to explore by crawling for the first time at the age of five. He tries to pull himself up by grabbing on to a hot radiator. He burns himself and screams. The parents and other adults present remark, "Poor Jimmy, he isn't very bright, any two-year-old knows enough not to grab a hot radiator." They forget that the two-year-old did the very same thing, made the same remarkable discovery, and the family ran to his rescue saying, "He has learned his lesson, he will never do that again." Neither will Jimmy, but notice the difference in response that he received. Total up a number of simple experiences such as this, some too simple even to be noticed by the unoriented, and one wonders just how much chance a child has who is of average mentality but retarded in development and experience. Child psychologists today stress the importance of the first five years of life as being the period when the emotional foundation is laid. Again we see the importance of education toward understanding of such children.

Planning for Cerebral Palsied Children

When we have gained an understanding of these children our next step is to plan for them. There are three avenues of approach. First, we can help them in their own homes; secondly, we can place them in foster homes located near a special treatment and educational center; and thirdly, we can place them in a boarding school having facilities for treatment and education. With the first of these possibilities our major concern is the parents. Dr. Carlson, himself a cerebral palsied, says that the parents need treatment more than the children. It is amazing how many "old wives" tales often have been absorbed by them. In the rural districts, in particular, many have never heard of nor seen a cerebral palsied child before. The parents are apt to think they have been singled out for some special punishment. Each parent often is overwhelmed by a silent feeling of guilt. They are hesitant to express their feelings but eager to have all the information possible as to causes, the numbers of cerebral palsied, etc.

When we can diagnose the particular worry or fear that the parents are experiencing, and have been able to explain it, we have taken a great step toward helping the child as well as the parents. Such feelings, unrecognized and untreated, have countless subtle ways of gaining outlet. For example, some parents completely reject the child and in order to cover up their rejection they baby him, anticipate his every want, and without realizing it they make him hopelessly dependent. Other parents are so filled with guilt that they spend their time and money shopping around for some miracle cure that will bring the child back to normal and prove that their guilt was unfounded.

Some parents are completely upset when faced with sending the child away from home for treatment. They recognize the value of such care but feel that they are "letting him down," and that there still must be some way left to help him in the home.

The reactions of parents are so many and varied that it would take volumes to describe them. But the fact remains, that each parent has his own inner conflicts on the subject. If they are unable to work through their own feelings with intelligence and understanding, it is our responsibility to see that they are at least started in the right direction in their thinking

A second method of aiding the child is through the use of a foster home. However, if we are to place the child in a foster home *to make possible treatment and education,* we then not only are faced with attitudes of the parents but also those of the foster parents. This, too, is a subject in itself and the social problems many and varied.

Thirdly, we may place the child in some type of hospital school. The advantages are manifold provided that such a plan is not confused with institutionalization. Rather the emphasis should be laid on individualized treatment combined with education, with the purpose of preparing the child to return to his own home and community better able to care for himself, understand himself and to cope with normal competition. By such a plan the child benefits from twenty-four hour supervision and treatment under specialized personnel. Selection of children should be based on the child's ability to profit by the experience.

Purpose of Treatment

No matter which approach we take in treating these children we should undertake it with the purpose of accomplishing one or more of the following purposes:

1. Rehabilitation to as great an extent as possible.
2. Free the child from the need for care by another person.
3. Assist the child to attain a satisfactory social adjustment.
4. Aid the child to help himself to keep occupied and to lead as full a life as possible.

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October 29, 1946	Public Welfare Manual Letter No. 86, Part VII, Ch. 2.
October 30, 1946	Public Welfare Letter No. 87, Part X, Ch. 4.
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November 13, 1946	Public Welfare Manual Letter No. 89, Part VIII, Ch.4.