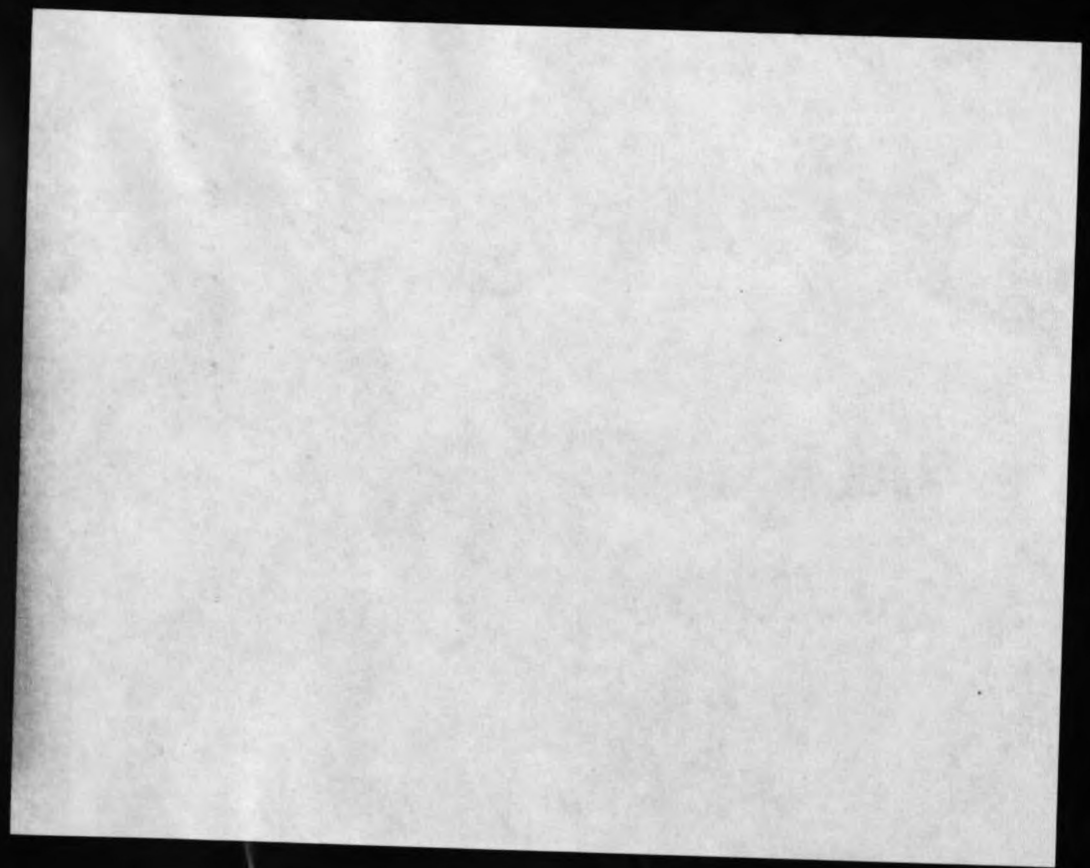
AN EVALUATION OF CHANGE IN INTELLIGENCE, SOCIAL BEHAVIOR, AND PERSONALITY OF A GROUP OF EMOTIONALLY RETARDED CHILDREN.

by

Norman Walton Thomas

August, 1958



AN EVALUATION OF CHANGE IN INTELLIGENCE, SOCIAL BEHAVIOR, AND PERSONALITY OF A GROUP OF EMOTIONALLY RETARDED CHILDREN

A Study of Five Children in Family Care Placement at Lapeer State Home and Training School for the Mentally Retarded at Lapeer, Michigan

by

Norman Walton Thomas

A PROJECT REPORT

Submitted to the School of Social Work
Michigan State University
in Partial Fulfillment of the
Requirements for the Degree
of

MASTER OF SOCIAL WORK

August 1958

Approved: Lucille K. Barber
Chairman, Research Committee

Director of School

G47225
12-28-67

ACKNOWLEDGMENTS

Regretfully, I can mention only a few of the many people whose guidance, interest, and unfailing support, helped me to complete this project. I wish to express my deep gratitude to the faculty of the Michigan State University School of Social Work, especially my project committee, Dr. Lucille Harber(Chairman), Dr. Myrtle Reul, and Mr. Manfred Lilliefors, whose untiring efforts helped me to reach a professional level in social work through this project.

My sincere appreciation is acknowledged to the Medical Superintendent of Lapeer State Home and Training School, Dr. A. T. Rehm, whose approval made this project possible.

Finally, the deep interest of the Lapeer State Home and Training School Social Service Department and the family care staff, especially the Family Care Supervisor, E. Beryl Bishop, who shared important information unhesitantly, has been inspiring and deeply appreciated.

DEDICATION

To My Wife,
Whose Inspiring and Helpful Participation
Made My Professional Training Possible

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CHAPTER I

INTRODUCTION

With increasing skill in diagnosis, personnel of institutions are becoming concerned with the increasing number of committed children who are not actually mentally retarded but emotionally retarded. For the purpose of this study, the emotionally retarded child is defined as a child who from all clinical and psychological manifestations appears mentally retarded, but may have normal or near normal potential. The child is retarded because of what seems to be a lack of emotional growth.

Lapeer State Home and Training School, an institution for the mentally retarded, initiated a family care program thirteen years ago for selected patients. By definition, "family care is the care of patients who are wards of institutions or the state..., in homes not their own, payment being made for their care".[1] Since the adoption of the family care program, there have been continuous efforts to detect and treat the emotionally retarded child. No diagnostic criteria has been found. When emotional retardation is suspected, they are placed in a family care home as a treatment method.

Since the validity of family care as a treatment method for the emotionally retarded child has not been established, the primary pur-

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[1] A.T. Rehn, Ethelbert Thomas, and E. Beryl Bishop, "Survey of Family Care Programs in State and Provincial Institutions for the Mentally Handicapped in the United States, Canada and Hawaii on January 1, 1955," (Lapeer State Home and Training School: Department of Mental Health, 1956), p. 2.

pose of this project is to determine if family care is an effective treatment method. Five cases of apparent emotional retardation have been selected from the family care program for this purpose. This was done by determining if there had been apparent positive change in the areas of intelligence, social behavior and personality. The five cases have been described in detail to illustrate the patterns of development.

Although there is need to evaluate foster care treatment for all types of patients who participate in the family care program[2], this could not be done because of the length of time involved. The emotionally retarded child was selected because natural question arises regarding the effect of institutionalization for a child who is not actually mentally retarded, and because of the writer's personal interest. Also, this problem is the concern of other agencies as well. These children may be found in agencies placing normal children, hospitals for the mentally ill, children's homes, and training schools for delinquent children. Private counseling agencies and child guidance clinics also meet this problem.

Emotional retardation is not a new concept. Pseudo-feeblemindedness (or pseudo-imbecility) has been a common term applied to this kind of limited functioning, but it seems to be a general term including many etiological factors. Arthur[3], Doll[4], Bijou[5], and

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[2]See Appendix A.

[3]Grace Arthur, "Pseudo-Feeblemindedness," American Journal of Mental Deficiency, LII (October, 1947) pp. 137-42.

[4]Edgar A. Doll, "Feeblemindedness Versus Intellectual Retardation," American Journal of Mental Deficiency, LI (January, 1947),pp. 456-59.

[5]S.W. Bijou, "The Problem of the Pseudo-Feebleminded," Journal of Educational Psychology, XXX (October, 1939), pp. 519-526.

Guertin[6], have all described various etiological factors. Guertin mentions two, "personality disorder", and "delayed maturation", both of which seem to be similar to the presented term of emotional retardation. However, A.D.B Clarke and A.M. Clarke[7] maintain that the term pseudo-feeblemindedness should be applied only to those cases where an erroneous diagnosis of mental retardation has been made, not where there is a lack of emotional growth.

It will be assumed in this project, for purposes of clarity, that emotional retardation is an etiological factor under the general heading of pseudo-feeblemindedness.

There are further difficulties in clarifying emotional retardation because of other terms that are used (not necessarily in relation to the mentally retarded) such as emotionally disturbed, childhood schizophrenia and mental deficiency combined. To illustrate the complexity of differentiation and the overlapping of symptomatology, several authors are quoted regarding some of the above groups. Lauretta Bender[8] describes the schizophrenic child as follows:

> Thus, some schizophrenic children are regressed, retarded, fixated, blocked, inhibited, mute, autistic, withdrawn, physically asthenic, puny, or under-developed, unsocial, unable to relate, concretistic in their thinking ...

Such a child could behave as an emotionally retarded child.

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[6]Wilson H. Guertin, "Differential Characteristics of the Pseudo-Feebleminded," American Journal of Mental Differential, LIV (January, 1950), pp. 394-98.

[7]A.D.B. Clarke, and A.M. Clarke, "Pseudofeeblemindedness-Some Implications, "American Journal of Mental Deficiency, LIX (January, 1955), pp. 507-509.

[8]Lauretta Bender, "Schizophrenia in Childhood-Its Recognition, Description and Treatment," American Journal of Orthopsychiatry, XXVI (July, 1956), pp. 499-506.

Bergman, Waller, and Marchand[9] differentiate the defective child from the schizophrenic:

> Most reports suggest that the one fundamental difference between the defective child and the schizophrenic child is that the defective child gives evidence of retardation at birth or in early childhood, whereas the schizophrenic enjoys a period of mental efficiency superior to that which brings him to clinical attention...

For the autistic child, Kanner[10] states:

> During the past ten years, we have become acquainted with a circumscribed syndrome, now known by the name of early infantile autism, which shows itself in extreme withdrawal and obsessiveness beginning as early as in the first two years of life.
>
> Most of the autistic children are functional idiots when they are brought for examination at 3 or 4 years of age. They do not talk, do not respond to other people, have temper tantrums when they are interfered with, have peculiar stereotyped motions, and are not accessible to any kind of testing.

Eisenberg and Kanner[11] note, "that the process autism was not one of 'withdrawal from formerly existing participation' with others, as is true of the older schizophrenic child...", which would make a differential diagnosis very difficult.

Bruno Bettelheim[12] lists "apparent retardation" among numerous patterns such as sexual disturbances, learning inhibitions, motor distur-

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[9] Murray Bergman, Heinz Waller, and John Marchand, "Schizophrenic Reactions During Childhood in Mental Defectives," American Journal of Mental Deficiency, LII (March, 1947), pp. 79-85.

[10] Leo Kanner, "Feeblemindedness: Absolute, Relative and Apparent," Nervous Child, VII (October, 1948), pp. 365-397.

[11] Leon Eisenberg, and Leo Kanner, "Early Infantile Autism," Journal of Orthopsychiatry, XXVI (July, 1956), pp. 556-66.

[12] Bruno Bettelheim, Love is Not Enough, (Glencoe, Illinois: The Free Press, 1950), pp. 3-375.

bances, insomnia, fears and anxieties, hyperactivity, obesity and over-eating, vocal-inhibitions, self-destructive tendencies, and thumb-sucking that are symptomatic of emotionally disturbed children.

The five cases of emotional retardation which are presented in Chapter IV, show very similar characteristics, but there are also some significant differences. The following quotations by Cassell[13] seem applicable to all terminology. He states that, ". . .the problem is what is feeblemindedness and what is childhood schizophrenia. It is a gross understatement to say that we in the field do not agree as how to identify either condition".

He concludes that the problem might be, "one of cause and effect where the one category gradually and imperceptibly shades into the other."

It is hoped the presented cases in chapter IV possibly will become useful in future attempts to identify some common characteristics of emotional retardation, and eventually provide a method for early differential diagnosis from the types mentioned above, besides differential diagnosis between emotional retardation and actual mental retardation.

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[13]Robert H. Cassell, "Differentiation Between the Mental Defective with Psychosis and the Childhood Schizophrenic Functioning as a Mental Defective," American Journal of Mental Deficiency, LXII(July, 1957), pp. 103-107.

CHAPTER II

HISTORICAL BACKGROUND AND CURRENT OPINION

The Emotionally Retarded Patient

Historically, the mentally retarded were thought to be affected by evil spirits along with the deformed and mentally ill. There were very poor facilities for the care of the mentally retarded, if any, and there was no process of differentiation between them. During the first part of American history, Walter A. Friedlander[14] states that, "Mentally disturbed and feeble-minded patients--children as well as adults--were usually left with their families and without special care".

With such adverse conditions and lack of concern for the patient, it would seem unlikely that the concept of emotional retardation existed at this time. The fact that mental retardation was considered hereditary brought about much concern by Goddard. This led to social methods of preventing reproduction. Since about World War I, there has been a gradual change in thinking, and programs have been initiated to place the mentally retarded back into the community. Together with this, there has been more individualization and a deeper concern for a diagnostic evaluation in order to determine effective treatment.

Research has been done to dispel false ideas about the mentally

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[14] Walter A. Friedlander, Introduction to Social Welfare, (Englewood Cliffs, New Jersey: Prentice Hall Inc., September, 1955), p. 85.

retarded, such as the studies by Marie Skodak[15], and Harold M. Skeels and Irene Harms.[16] These studies brought out quite conclusively that environment had a great deal to do with children born to mentally retarded parents, disproving that all children born to retarded parents are retarded.

The specific problem of the etiology of the emotionally retarded child has appeared only within the last two decades. Probably the first systematic research was done by Harold M. Skeels and Harold B. Dye.[17] They based their project upon a postulate of Binet, who wrote in 1909:

> Some recent philosophers appear to have given their moral support to the deplorable verdict that the intelligence of an individual is a fixed quantity, a quantity which cannot be augmented. We must protest and act against this brutal pessimism. We shall endeavor to show that it has no foundation whatsoever.

Findings by Skeels and Dye, relevant to this project were:

> A change from mental retardation to normal intelligence in children of preschool age is possible in the absence of organic disease or physiological deficiency by providing a more adequate psychological prescription.
> Conversely, children of normal intelligence may become mentally retarded to such a degree as to be classifiable as feeble-minded under the continued adverse influence of a relatively nonstimulating environment.
> An intimate and close relationship between the child and an interested adult seems to be a factor of importance in the mental development of young children.
>
> The possibility of increasing the mental capacity of 'functionally' feeble-minded children should be considered as an essential objective in setting up an individualized treatment

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[15] Marie Skodak, "Intellectual Growth of Children in Foster Homes," Child Behavior and Development, ed. Roger Barker, Jacob Kounin and Herbert Wright, (McGraw-Hill Book Co. Inc., 1943), pp. 259-78.

[16] Harold M. Skeels, and Irene Harms, "Children with Inferior Social Histories: Their Mental Development in Adoptive Homes," Journal of Genetic Psychology, LXXII(May, 1948), pp. 283-94.

[17] Harold M. Skeels and Harold B. Dye, "A Study of the Effects of Differential Stimulation on Mentally Retarded Children," Proceedings and Addresses of the American Association on Mental Deficiency, XLIV(1939), pp. 23-24.

and educational program in a school for feeble-minded.

This study provided a basis for Family Care as a possible treatment method.

Michal-Smith[18] points out his interpretation of the current literature on the emotionally disturbed and pseudo-feebleminded child:

> Some children are so emotionally disturbed that they appear to be mentally retarded. Because their behavior is so closely akin to that of the severely retarded, some authorities say that the two conditions cannot and should not be differentiated. They point out that the psychotic behavior of some of these children or the behavior which seems to be extreme frustration is also a consequence of mental retardation and that to assume normal or superior intelligence is unrealistic.

His personal opinion is that, "Pseudo-retardation environmentally caused, in many cases, if caught in time can be corrected".

"Extreme poverty, emotional problems, physical handicaps or simple educational problems can cause pseudo-retardation".

It seems to a certain extent authors have accepted emotional growth as an important factor in mental retardation, but there is some pessimism toward the need of differentiation diagnostically or in treatment between the pseudo-retarded and those actually retarded.

Family Care

Together with mentally ill patients, the care of mentally handicapped patients in private homes seems to have originated several centuries ago in Gheel, Belgium. This plan spread gradually to other countries but it did not come into existence in the United States until 1931 when the Newark State School in New York state developed a program similar to the

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[18] Harold Michal-Smith, The Mentally Retarded Patient, (Philadelphia: Lippincott, 1956), p. 20.

Gheel system.[19]

The literature on the whole reflects a favorable attitude toward family care but it is still in the exploratory and descriptive stage. There is no literature containing any real effort to measure the value, nor to determine what kind of patients can best profit from such a program.

Despite knowledge of both the emotionally retarded child and of family care programs there is no author within the literature covered who mentions the possibility of family care itself as a treatment method for emotionally retarded children.

In view of the historical perspective, it is important that a summary of the development of Lapeer's family care program and its present structure (as of September, 1957) be given because it is conceivable that organization, spirit, and staff development directly affects the personality, social behavior, and intelligence of a child, and the reporting thereof.

The program has now been in operation for about thirteen years. From 1944 to 1950 the program was carried on by a regular social service worker above and beyond the regular duties of the Social Service Department. (Assignment was based on whoever was covering Lapeer County for the institution.) There were no graduate workers in the department during this period. It was difficult for any worker to devote time to individual work with any of the children. Adjustment depended much upon the child and the ability of the foster-care parents.

In 1950, an experienced worker was placed in charge of family care on a full-time basis. As the caseload grew, this worker introduced the position of Family Care Worker, which was filled by a practical nurse

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[19]Horatio M. Pollock, "Requisites for the Further Development of Family Care of Mental Patients," American Journal of Mental Deficiency, L (October, 1945), pp. 326-29.

who was already employed at the institution and had experience in caring for mentally retarded patients. More workers were added in later years, all of them being familiar with the patients before assuming their new role. There are a total of five at the present time.

The family care worker supervises the family-care homes, reports on the patients' progress, transports the patients to and from the institution when medical, dental, or optometric care is needed, and works closely with the social workers to bring both disciplines of nursing and social work together for the benefit of the patient.

The social worker primarily investigates and licenses prospective family care homes and screens the referred children for placement. Determined by need and time, the social worker may carry a small caseload of children considered to have some potential for development. There were two social workers as of September, 1957, one coming during 1955, and the other in 1956. The worker who originally started on a full time basis administers the program at the present time.[20,21]

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[20] E.B.Bishop, "Family Care: The Institution," American Journal of Mental Deficiency, LIX (October, 1954), pp. 308-16.

[21] E.B.Bishop, "Family Care: The Patients," American Journal of Mental Deficiency, LXI (January, 1957), pp. 583-91.

CHAPTER III

METHODS AND PROCEDURES EMPLOYED IN THIS PROJECT

The five cases presented in thisstudy were chosen from a total of eight considered emotionally retarded as this term was defined in Chapter I. Because of the mass of detail in the institutional records, all eight cases could not be presented in detail. Those selected were chosen by placing names of all eight children on concealed separate slips of paper and selecting five at random. Such a small number of cases cannot be statistically significant.

The records on patients at the institution give a complete but general picture of growth and movement. Only important events are recorded in detail. Also the work load for any particular observer may vary at different times. The cottage reports[22] are usually annual routine reports made out by cottage supervisors to give a general picture of the child. Their validity may be questionable because of differences in observers and discrepancies in what a child can do and what the child is allowed to do. For example, the child may never have an opportunity to learn to comb his hair or take a bath, having this done routinely by the staff. Consequently, with these three variable conditions, the records vary in useful material for this project during the periods covered.

Personality, social behavior and intelligence were selected as criteria, to illustrate emotional and intellectual growth, which is the

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[22] See Appendix A.

concern of this project, as opposed to physical growth. Because of the abstract nature of these criteria, direct or statistical measurement will be impossible, with the exception of intelligence where there is standardization of psychometric examinations. However, even here there are difficulties that arise. There are many variables in a testing situation and an I.Q. is at most only a good estimate of intellectual functioning. The patient may not feel well during the testing period or there may be extreme fear of the testing situation. The nature of the personality and orientation of the psychometrist is a concomitant factor also. In the five cases chosen, there was no uniformity in giving these examinations, that is, one child may have been tested every year, another child every two or three years; therefore, a continuing growth process in intelligence in some cases cannot be seen too clearly.

The school grades were used where possible to supplement the psychometric examinations. However, the marks cannot be considered an accurate measurement because there are different attitudes among teachers and school administrators in handling mentally retarded youngsters. Some teachers may mark sufficiently high to encourage the child, others may treat the child the same as the rest, and still others because of their negative attitudes toward mentally handicapped children, may purposely mark low. These same attitudes may exist in administrative philosophy also.

In regards to social behavior, the main difficulty lay in the area of terminology since each observer may have different meanings for a particular descriptive term, or a child's action may have different meaning to each of the observers. Also, there remains the possibility that a particular child reacts differently to different observers. For this reason it was felt that description should not be narrowed to a single

observer, but to all observers with definite reference to nurse, doctor, psychologist, social worker, teacher, foster mother, or natural parent where possible. Another difficulty is that many of the child's actions are not fully described in the record. It was impossible to obtain more explicit information because the particular observer was unable to recall situations specifically.

Other limiting factors are the veracity of reports about the child prior to admission, and the accuracy of reports from the cottages while the child is in the institution. Parents may be anxious to have their child admitted in order to relieve their responsibility. Other parents may continue to minimize their child's defect in the face of necessary commitment. Subjective opinions and comparison to normal behavior are often made together with overstatements and/or understatements of the child's ability. In the cottages at the institutions there is little possibility of individual observation because of the small number of staff to the number of patients.

Personality is the most difficult to assess because it includes a wide variety of elements and in some ways intelligence and social behavior can be considered part of the personality picture. The problem of including both within a structure of personality, and at the same time differentiating the personality growth process, was accomplished by taking into consideration the total picture of intelligence and social behavior and interpreting the possible inner feelings and attitudes toward situations. In this way, personality actually becomes a separate criteria because despite a gain in social behavior or intelligence (outward or surface criteria), there may be no gain or even a loss in personality growth. Explained another way, a child can show graciousness and cooperation, but

it may be a defense against losing love and acceptance. The limitation to such an approach is that it is primarily assumption, and validity cannot be definitely established.

The institution uses certain terminology in its reports. Untidy refers to the incontinence of the bowels and bladder, and tidy means the opposite. The cottage refers to the regular building that the patient occupies. The nursery is a special building for children usually five years of age and younger. Trainability means the patient is capable of training for some simple vocation such as housework, baking, farming, etcetera. Wherever the word foster appears, it refers to the family care placement. A classification chart is included in Appendix A to define the diagnoses that are given for each child.

No information of the foster home or the character and personality make-up of other family care patients in the same home is given because such recording is not the purpose of this project. This report is interested only in what the child appears to be, without consideration for his total environment. Only in cases where the staff outright questioned the value of the foster home, was this mentioned. Most of the statements in the data are directly from the records. It was necessary to obtain further data during the process of the study since more explicit information was necessary for interpretation. This information was obtained from the supervisor of family care.

It is assumed in this project that with these particular children there has been an emotional deprivation causing regression or retarded growth. After treatment, it must be remembered that it cannot be determined whether a child who scores an I.Q. of 85 or 90 has actually this original biological potential or whether this is the effect that is left

from deprived circumstances. During the second emotional growth so to speak, much of the content, culture, and education of early life has been missed.

The presentation of data is divided into four periods. The "Social History Prior to Commitment" includes the birth history and subsequent development up to the commitment order. The section "Commitment and Admission" covers the commitment order, the intervening period between commitment and admission, and the admission process which includes a general observation of the child, a medical examination, and a psychometric evaluation. The "Institutional Period" covers the growth and development following admission up to placement on family care. The section "Family Care" includes all reports during each year up to either discharge from the institution or the present time, September, 1957.

The evaluation of this data is given in Chapter V, "Interpretation". The conclusions follow in Chapter VI.

CHAPTER IV

PRESENTATION OF DATA

Sally

Social History Prior to Commitment. --Sally is a white child, born April 22, 1947, the first child, with a brother born a year later. The mother was the informant. There was excessive vomiting during the pregnancy, ether anesthetic at delivery, and twelve hours labor. The delivery was spontaneous and the birth weight was seven pounds, three ounces. There was no evidence of birth injury.

She was bottle fed until fifteen months of age, teethed at ten months, sat without support at six months, talked in words at three years, walked alone at sixteen months, and was toilet trained at two and one-half years. She was described as large for her age. The only childhood disease was measles.

The father hit her, and yelled at her. Sally feared her father. Her mother and father were divorced when Sally was about three years of age, after which she was placed in a boarding home. The boarding parents would not keep her because she cried all night. The mother seemed interested in Sally, but found it difficult to care for her children after the divorce. Sally got along with her brother and all other children. Except for destructiveness, her behavior seemed good, with no temper tantrums, restlessness or over-activity. She was affectionate.

Other factors in the social history included: An unstable paternal

grandfather; a paternal uncle committed to an institution for the mentally retarded; a half-sister in the first grade at the age of eight; an emotionally unstable paternal step-grandfather who was alcoholic, sexually demanding and lazy; and a father considered to be of no more than dull normal intelligence.

Commitment and Admission. --Sally was committed to Lapeer at age three and one-half. The commitment order read as follows:

> She cannot talk. Walks with difficulty. Cries constantly. She cannot feed herself. She is not toilet trained. Diagnosed...as mental retardation,...She does not act in any way like a normal child.

Sally was admitted to Lapeer at the same age as commitment. Her physical appearance was stocky. She was diagnosed as familial.[23] She was a neat child, responded fairly well, was tidy, fed herself, ate very well, brushed her teeth, said quite a few words, played well with the other children, was very quiet, and easily managed. The doctor described her as a child with a slightly dull expression who was fairly cooperative. She cried often, and was unable to respond to questions. She was well nourished with no medical problems. The psychometrist described her as a defective looking child. She was able to follow simple directions and was fairly well developed in language. During the testing situation, she was rather uncooperative and very hyperactive. It was only with difficulty that her attention was obtained and held. Her I.Q. was 63 on the Kuhlmann-Anderson Intelligence Scale, with a social quotient of 90 on the Vineland Social Maturity Scale.

Institutional Period. --Sally remained in the institution for one year and eight months. Six months after admission she was described as being a

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[23]This is a diagnostic term used by Lapeer. See Appendix A.

neat, clean and tidy child who spent her leisure time playing with other children. She made friends easily, was not destructive or ill tempered. She could not wash her face, brush her teeth, take a bath or comb her hair. She was described as an ugly appearing child.

One and one-half years after admission, Sally played with toys as well as other children. She could lace her shoes, but could not tie them. She could put on her own clothing and button it. She could brush her teeth but could not wash her face, take a bath or comb her hair. She slept and ate well. Sally continued to make friends and to be managed easily. She talked to attract attention.

Just before placement, she was described as a pleasant child with no temper tantrums or destructive tendencies. She played well with other children. She may have masturbated. Her speech was indistinct, and she did not care about her appearance. She maintained strong ties to her mother, and seemed to understand why she (Sally) could not stay with her. She tended to be clinging to adults who paid attention to her. The record comments that there were "some inner feelings of hostility".

Family Care. --Sally was placed on family care one year and nine months after admission at five years and three months of age. Sally seemed to show continued identifications with the children at the institution. During the first year of placement, Sally remained in her original home. She shook rugs and dust mops, cleared the table after meals, sang songs and remembered significant or outstanding events. She seemed happy and contented, and needed little entertainment. She was well behaved, but sly. She seemed to have a phantasy life. Another child in the home, placed before Sally, was jealous of Sally's presence at first, but it was reported later that they were adjusting to each other. Later it was

learned that Sally played sexually with the other child at night. This activity stopped when Sally was placed in a separate bedroom. However, there was a renewal of masturbatory practice. Toward the end of the first year Sally began to seek more and more attention and became upsetting to the other child. The natural mother kept in contact with the agency during this period. Sally did not attend school.

During the second year of placement, Sally was placed in her own home for one month upon the mother's request. The brother was jealous when Sally first returned home. A good adjustment was reported soon afterward. However, Sally was unable to remain at home because of household difficulties. She was placed on family care again upon her return to the institution, but in a different home. She colored between lines and the foster mother was in the process of teaching Sally to read, print, and count. She rebelled against orders, but responded to kindness. She played doctor with a doll, and also played mother to the other child in the home. She followed the foster mother like a shadow. She enjoyed Sunday school. Her speech defect seemed to be disappearing. She made the beds and wiped dishes. She was forgetful. She played well with the other foster child; at least, there was no outward jealousy. On the Standard Revision of the Stanford-Binet Intelligence Test-Form L, Sally earned an I.Q. of 79. The psychometrist indicated that her speech was becoming distinct enough to be understood. Because of this, the psychometrist felt there was a better psychological adjustment, together with an ability to concentrate and think better. She showed potential normal intelligence, but her speech defect suggested that her emotional problems were not entirely alleviated.

During the third year, Sally was able to clean her room, wash and dry dishes, set the table, dust and sweep. She seemed to have more pride in personal cleanliness and neatness. The other child missed Sally when

Sally was in school. She began kindergarten at seven years of age and was doing fairly well as reported by the teacher. She colored well in her school books. During the next half year, she passed into the first grade.

During the next year there was another child placed in the home. She "differentiated" the family care worker from the foster mother and was easily managed. She was not as forgetful. She played nicely with the other children as well as with neighbor children, but was shy with adults. She passed into the second grade with "B's" and "C's" on her report card, and showed consistent improvement. Her speech was much improved.

During the fifth year, Sally became a definite favorite with the foster mother. She passed into the third grade with an "A" average and went to her own home to live with her mother and step-father. She was subsequently discharged as not mentally defective.

Mary

Social History prior to Commitment. --Mary is a white female child, born February 15, 1947. There was a sister born in 1949, a sister in 1950, a brother in 1951, and a brother in 1952. The mother and grandfather were the informants. There was a twelve-hour labor with a normal delivery. She gained well.

She was breast-fed, weaned at one and one-half years of age (unknown whether from breast or bottle), and had all her teeth at two years of age. She contracted chicken pox at two years of age, and measles at three and one-half years of age. There was a convulsion for a period of two hours at age six and one-half years of age, with the following symptoms: starey eyes, apparent unconsciousness, inability to control urine, bitten tongue, and loss of leg control. This was diagnosed as epilepsy. Another seizure

followed soon after, with confusion, and inappropriate statements. During the following month, there were occasional mild seizures with confusion again. At a children's clinic no pathology could be found, and a diagnosis of degenerative nervous condition was given. She was given a sedative and fed by a tube. At a children's hospital, about two months after her first seizure, she was completely uncommunicative and out of contact with reality. Her movements were purposeless. There were athetoid movements of extremities, drooling, spasticity, and rigidity.

Before this experience, Mary had normal play habits. She got along well with her brothers and sisters, taking responsibility for their care most of the time. She was considered normal in every respect until her first seizure. Her mental age was above her chronological age at three years of age.

She lived with her parents in the paternal grandparents' home. It was described as filthy and cold. The food was inadequate. Her father was considered lazy. He also had a violent temper. Her mother seemed ignorant in household matters. Mary was placed in a boarding home for a short time at age two as a result of a neglect charge against the parents.

Other factors in the social history included: A paternal grandmother who was lazy and alcoholic; a maternal uncle who was crippled and believed to be of low mentality; a father described as nearly alcoholic and of low mentality with anti-social attitudes and psychosomatic difficulties (that is he had complaints without apparent organic findings); and a mother who was rated very low average on an intelligence test. After Mary's admission to Lapeer all children were taken away from the parents and placed for adoption.

Committment and Admission. --Mary was committed to Lapeer at age six years and nine months. The findings of a children's hospital and a physician's

report respectively are as follows:

> Our studies have revealed the presence of a severe degenerative central nervous system disease for which there is no effective treatment. It is our feeling that she requires symptomatic and supportive care and that this can best be provided in an institution for the care, custody and treatment of such mentally diseased persons.
>
> This child has a severe type of degenerative central nervous disease which is progressive and for which there is no cure. She required 24-hour a day care and continuous sedation to control convulsions. She remains in a comatose state and is a custodial care patient ...

Mary was admitted to Lapeer at six years, ten months of age. She would not talk, had to be fed, and would not move, except her arm occasionally. She was untidy and would not do anything. A medical examination two months after admission indicated her cooperation as nil, there was no speech, and only a prone posture. A psychometric test one month after admission indicated that she required 24-hour a day care, remained in a comatose state, was totally unable to cooperate, and lay in a fetal position. An I.Q. of one was given arbitrarily for statistical purposes.

Institutional Period. --Mary was in the institution eleven months. The first cottage report was four months after admission. She could not dress, or lace and tie her shoes. She was bottle fed and given a sedative. She wore diapers at all times. There had been no progress since admission. From the seventh month to the eleventh month, there was a noted change. She began to respond to one nurse who spent a great deal of time talking with her and rocking her. She began to push herself into a sitting position and later began to talk, saying words with an apparent association to her past. Her speech became "repetitious". Soon she began to notice things about her. She began to ask for simple things such as juice. When her speech became more fluent, she began to curse violently. Then

she walked. This was a period when she was quite difficult to manage. She began to talk in sentences and by the tenth month she was talking quite rationally.

A social worker who became quite interested in Mary after admission, noted the possibility of emotional retardation because her eyes appeared wild and fearful, unlike the severely retarded child.

A medical report one year after admission described her as a child with pleasant facial expressions, good development, good cooperation, fast but distinct speech and good response to questions. She was hyperactive and very irritable.

At the time of placement, she still had severe temper tantrums. Although she entered into play activity, she did not seem to involve herself emotionally. According to the record, she seemed to have some inner feelings of hostility.

Family Care.--Mary was placed on Family Care eleven months after admission at seven years, nine months of age. She remained in the same home continuously. At first she did not feel she was responsible for even simple tasks around the home. During the first year she maintained good relationships with the foster parent's children who were older than Mary. She enjoyed the outdoors and the freedom to run about. She displayed a strong temper and at times was grumpy, stubborn and commanding. She talked briefly to the foster parents about her past experiences and considered her parents as mean. She attended peer groups with the foster mother. Her appearance changed to rosier cheeks and sparkling eyes. She began gaining more confidence and was able to enter games with less fear of making mistakes. She began to take advantage of a permissive home environment. She seemed secure and happy. She became interested in learning words and began school on a part time basis at the age of eight. During the summer

she picked strawberries and went swimming. She washed and dried dishes, set the table and made her bed. She enjoyed being sick because of the attention. During this period, Mary was visited by relatives whom she had always liked. She related well to them. More of Mary's background was related to her and she seemed to have a good amount of understanding. On the Standard Revision of the Stanford-Binet Intelligence Test-Form L, Mary earned an I.Q. of 87, but she felt she could have done better. The psychometrist felt she was upset during the test. On the Bender Gestalt Test, it was observed that she was highly disorganized and very infantile in her personality make-up. Also, she seemed to have a low frustration tolerance. On the Children's Apperception test, it was felt she was reaching out emotionally toward family living. She passed into second grade.

During the second year she complained of minor aches and pains occasionally. There were no organic findings. She got along better with other children in school and did not talk as loudly in class. There were further contacts with the same relatives to whom she appealed very much. She passed into third grade. She was discharged from the training school at eleven years of age as not mentally defective.

Emma

Social History Prior to Commitment.--Emma is a white female child, born June 7, 1941. The mother, social agencies and hospitals were the informants. Emma was born at home, with a physician in attendance. Labor was normal, but she was premature with a birth weight of five pounds.

Emma was in the hospital in an incubator for the first three months after birth. She remained at five pounds for the first four months because she was unable to retain food. Later she was bottle fed and weaned at two years of age. She teethed at one year and sat without support at

two years of age. She was described as a very listless, pale looking baby at eleven months of age.

Emma recognized the family members, but was annoyed when cared for or handled. Her only play activity was to look around the room blankly. She had temper tantrums and was difficult to control. She was affectionate.

Emma's parents were on relief when she was born. It was reported that her parents seemed interested in her welfare and the home was pleasant. The mother worked two nights a week to help financially. (It is not known if this happened after Emma came home or not). Her father was sent to prison when she was three years old. Her mother went to a medical hospital soon afterwards and Emma was placed in a "nursing home" until her admission to Lapeer.

Other factors in the social history included: A paternal grandfather who may have had syphilis (mind "completely gone" according to the mother); a paternal grandmother who had syphilis; a maternal great-aunt who was mentally ill with a diagnosis of dementia praecox, paranoid type; a maternal aunt who was mentally ill with a diagnosis of dementia praecox, catatonic type; a mother who had four miscarriages; and a sister who had been committed to an institution for the feeble-minded.

Commitment and Admission. --Emma was committed to Lapeer at two years and two months of age. The commitment order and one physician's report respectively read as follows:

> This child, aged twenty-six months, shows considerable retardation in physical growth and mental development. There is a marked motor deficiency in the lower extremities; she cannot walk, stand, or creep. Her mental reactions are either missing or very sluggish.
>
> This patient has the typical facies of a mongolian idiot and her reactions and expressions are typical of that type. She is two years old and cannot walk and is incontinent of urine and feces. Her reactions toward her surroundings are abnormal.

Emma was admitted to Lapeer at three years of age. The nurses observed her to be of average size, untidy, unable to feed herself, unable to talk, but imitative of sounds. She crawled and seemed to be learning to walk. There was a noticeable stiffness in one leg. She was pleasant, sleeping and eating well. The doctor described her as poorly coordinated, and small for her age. She was well nourished and healthy. A psychometric test was not given at admission.

Institutional Period. -- Emma was in the institution one year and two months. She was classified as familial.[24] Her mother visited occasionally. One year after admission, the psychometrist described her as attractive and tidy with understandable speech. She was accustomed to playing alone. She was able to feed and partially dress herself. She was inquisitive, alert, very careful of toys, and "submissive (asked to play with an object)". On the test she reproduced simple block formations, named common objects, and pointed out pictures. She scored highest on picture memories. She placed the simplest puzzle together rapidly and was so enthusiastic over play material that she ignored instructions, following her own ideas. The psychometrist felt she had ability beyond that shown by the test if she had had the usual experiences. Her motor coordination was sufficiently good for her to receive credit for performance. Her I.Q. was 65 on the Cattell Infant Intelligence Scale and 69 on the Merrill-Palmer Scale.

A cottage report one year and one month after admission described her as healthy, tidy, able to feed herself, able to recognize food she liked or disliked, and able to dress herself. She played better alone than

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[24] A diagnostic term used at Lapeer. See Appendix A.

with other children. She slept and ate well. She was a little stubborn at times. She talked and pretended to do all the things that were done in the hospital. She liked men better than women.

At the time of placement, she was described as a docile, pleasant, agreeable, and submissive child. She internalized her hostile tensions and conflicts at moving into a family care home. She tended to be solitary in her play activity. She valued material objects and repressed emotional feelings for relationships.

Family Care. --Emma was placed on family care one year and two months after her admission at four years and three months of age. During the first three months, she seemed to be in a daze, reverted to baby talk, and was unable to follow simple directions. She seemed to be tense in a close family relationship. However, she was likeable, well behaved, exceptionally good natured, appreciative, happy and quite alert. She feared being taken away from her foster home. She did not forget the institution, holding imaginary telephone conversations with the people of the institution. She dressed herself but could not tie her shoes or comb her hair. She was helpful by picking up things around the house. She helped the foster mother wrap her foot when the foster mother had arthritis. She would play by herself with toy dishes and imaginary friends. She did not enunciate clearly during this year and it was noticeable that she stuttered and stammered worse when excited. She talked quite fast. She was described by the psychometrist as attractive, responding readily, but with "indistinct speech as a result of baby talk". She still had a tendency to follow her own ideas rather than those of other people. She was unable to dress herself completely or wash her face and hands unassisted. She could care for her own toilet needs. She played cooperatively at the kinder-

garten level. On the Standard Revision of the Stanford-Binet Intelligence Test-Form L, she earned an I.Q. of 77. She earned a social quotient of 94 on the Vineland Social Maturity Scale.

During the second year, there were few reports. It was indicated that she did not seem to stammer and stutter as frequently. She was not as stiff-legged when she ran. She started school in kindergarten and reportedly liked it.

During the third year, a picture of a human skeleton, sent her into hysterics. She claimed it was Satan. After one-half year in kindergarten, she was passed into the first grade at seven years and six months of age. She was able to print her name, copy some of the alphabet and a couple of words, and seemed to be doing well in school. The psychometrist described her as a pretty, curly-haired child who was friendly, cooperative, and very concerned about cleanliness. Her attention span was short. During the examination, she was concerned about when she was going back to the foster home. She assembled the manikin quite rapidly. She demanded constant reassurance and encouragement. She earned an I.Q. of 95 on the Standard Revision of the Stanford-Binet Intelligence Test-Form L, and a physical quotient of 96 on the Grace Arthur Scale-Form I.

During the fourth year another child was placed in the home. Emma received a Christmas card from her mother. Emma felt she had no friends at school. She lied, made up stories and "would go all to pieces when teased". She apparently masturbated until her genitals were sore. Her behavior and performance in the home varied considerably from week to week. She had a bad temper and her general mood determined her ability for the day. She did not get along too well with the children in school, but her academic work was good. She was second in her class in word and phrase recognition,

and learned to color better. She got along with the other child in the home, and was able to go anywhere with the family. She was in the second grade during this year. The psychometrist described her as a neatly dressed, friendly girl who was able to speak alertly and distinctly. She was easily confused and exhibited a very unstable functioning ability. She was impulsive and quick with answers. She earned an I.Q. of 77 on the Standard Revision of the Stanford-Binet Intelligence Test-Form M, and grade 1.4 on the American School Achievement Tests. It was felt she should repeat second grade.

During the fifth year Emma went into a new school situation. She liked school and was anxious to attend after the summer vacation. She helped her foster father with simple farm chores and earned money for this. She obtained a "D" in arithmetic but did fairly well in the other subjects, especially reading. She passed into the third grade. The psychometrist described her as attractive, friendly, well motivated and cooperative. There was evidence of "deep-seated" emotional problems, and she seemed to be denying her real status by taking the name of the foster parents. She had difficulty with space relationship items. Her I.Q. was 75 on the Standard Revision of the Stanford-Binet Intelligence Test-Form L.

During the sixth year, there was another new school situation. She played outdoors considerably and got along well with other children. She started band and seemed musically inclined. The piano teacher was enthused by her ability to memorize as well as read music. She took six lessons during the year. During the middle of the school year, she received an average of "C" in her class. Two months later she received two "A's", two "B's", and "C's" in the remaining subjects. On the American School Achievement Test she received an over all 2.4 level, with a 2.8 level in

reading, a 2.2 level in language and a 2.6 level in spelling. She was promoted to fourth grade.

During the seventh year, there was no report with the exception of the psychometric examination. She seemed to have faulty reasoning ability on both practical and abstract planes of thinking. There was fairly good association in free and controlled situations, and she expressed herself quite well. Her memory span was relatively unimpaired. She earned an I.Q. of 80 on the Standard Revision of the Stanford-Binet Intelligence Test-Form L. She passed into the fifth grade.

During the eighth year, it was noted that she did not understand her connection with the institution, and did not know she had a mother and sister. She would become overly disturbed by newspaper articles about polio epidemics, fires, and wrecks. She called the foster mother, "mother", and her own mother, "the lady". She was growing very fast physically, but showed no interest in boys or in using lipstick according to the foster mother. However, the teacher claimed Emma was very much interested in boys and tried out lipstick away from home. She continued her piano lessons with progress. The school requested her for band, but the foster mother refused. She attended summer camp. She did not belong to any Girl Scout troop or other group since the foster mother seemed resistant to this. She had her first menstrual period. She was doing very well in school, according to the foster mother. She had a remarkable memory, but she lacked insight and reasoning ability, according to the family care worker. She was promoted to the sixth grade. She achieved a grade level of 5.5 in reading and 4.9 in arithmetic on the American School Achievement Test.

During the ninth year, and also during the last part of the previous year, there was a growing concern on the part of the family care staff

toward the negative aspects of this home. It was decided to have Emma seen by a psychiatrist at the institution. However, treatment did not help. During this year, Emma's natural mother remarried and took her for a short vacation. Emma felt distasteful about visiting her natural mother, and it was felt by the family care worker and the psychiatrist that she was unable to allow herself to express any true feeling. The foster home seemed to be pulling Emma away from her natural family. She passed into the seventh grade. She did not have friends except in the classroom. It was noted that she became a member of a Girl Scout troop against the wishes of the foster mother.

During the tenth year, an attempt to work with the foster mother by the family care worker failed. Consequently, a decision was made to place Emma with her mother who had requested this plan. Emma seemed to have considerable conflicts about this plan, but finally agreed to go. Subsequently she was discharged as not mentally defective. Before discharge, however, plans were made to refer her to a children's clinic because of her personality difficulties.

Chris

Social History Prior to Commitment. --Chris is a white female child, born February 5, 1941, an illegitimate birth. The mother and a "nursing home" were the informants. Labor was eleven hours, with a breech delivery. Her weight was six and three-fourths pounds. She was vigorous and lusty. Her head was markedly asymmetrical and her eyes conspicuously crossed. One was set forward in comparison with the other one. She was bottle fed. Chris was in the hospital until three weeks of age, at which time she was transferred to a "nursing home". She remained there until her admission

to Lapeer at age three years and six months. During the latter part of this period, she did not get along too well with other children in the "nursing home". She had temper tantrums and was difficult to control. She was affectionate.

On the Cattell Infant Intelligence Scale, Chris earned a mental age of 4.6 months at 6.5 months of age. On November 25, 1941 her mental age was considered to be five months through informal observation.

Commitment and Admission. --Chris was committed at three years and three months of age. Two physicians' reports follow:

> Is very sluggish in her mental reactions and responds mechanically well with no initive [sic] of her own. She is not fit for adoption and needs persistent training. Her psychoanalysis [sic] shows her mental condition to be very low for her age of three and as compared to other children her age. She has spells of crying and pouting and is not interested in her environment.
>
> The subject is a 3-year old female who shows quite definite signs of mental retardation...Psychometric examination on at least two occasions has rated her intelligence quocent [sic] as approximately fifty-five.

Chris was admitted to Lapeer at age three years and six months. She could not dress herself, was believed to be tidy, talked a little, was quiet and friendly, and followed simple directions. The doctor described her as having a bright facial expression, well nourished and well developed. She cooperated well and spoke a few short sentences. Five months after admission the psychometrist described her as an attractive blond haired child who was a "show-off". She related experiences, however, her speech was marred by "immature childish talk". She dressed herself with help, fed herself, was tidy, and played cooperatively. On the examination, her highest score was identifying objects, obeying simple commands, and comparing sticks. She seemed brighter than the examination

indicated. She earned an I.Q. of 69 on the Standard Revision of the Stanford-Binet Intelligence Test-Form L, and a social quotient of 98 on the Vineland Social Maturity Scale. She was diagnosed as familial.[25]

Institutional Period. --Chris was in the institution one year and eight months. A cottage report five months after admission described her as careful with things, cheerful, obedient and able to play well with others. A report one year after admission noted she was able to dress and feed herself. She was tidy, neat, and clean.

At the time of placement she was described as a friendly, pretty girl with a "sweetness of personality", which was simple but sincere. She accepted her situation, was popular with the other children, and played well with them. She responded positively to being dressed up.

Family Care. --Chris was placed on family care one year and eight months after admission at five years and three months of age. She was in her first home only one month. During the first six months, she sometimes paid no attention when spoken to. She was in the process of learning to dress herself. The other boarding children seemed jealous of her.

During the following year, she seemed happy, could dress herself and take care of her own personal needs except for tying her shoes. She talked "quite a bit" (she was later described as an incessant talker) and made up to almost anyone who visited. She had difficulty in distinguishing between sexes. She went shopping with the family. She started kindergarten at the age of six. She was described as being well behaved in school. She was not interested in books, but she learned songs and sang quite well. She learned to count up to 25 or 30, draw and color.

During the second year, it was reported that the children in the home

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[25]This is a diagnostic term used at Lapeer. See Appendix A.

got along nicely. Chris seemed happy and adjusted. At age seven she was promoted to the first grade. It was recorded that she was helping another child in the classroom with her lessons.

During the third year, she seemed to be quite a tomboy. She attended a new school and it was noted that she got lost coming home the first day. At age eight she was promoted to the second grade. The psychometrist described her as attractive, healthy, friendly and a good conversationalist with more self confidence, who exhibited none of her former behavior difficulties. On the test, her vocabulary was at the six year level. She could not comprehend similarities and differences. Also, she failed to detect verbal absurdities. She achieved a reading grade of 3.1. Her I.Q. on the Standard Revision of the Stanford-Binet Intelligence Test-Form L, was 84.

During the fourth year she made her own bed, cleared the dinner table, dried the dishes and put them away cooperatively with two of the other foster children. She was able to swim and to go on trips with the foster parents. She also attended a bible school during the summer. She preferred dresses to blue jeans. Chris showed concern toward another child in the home who was not accepted for school. She seemed to have deep, sincere feelings for people. Those who met her wanted to take her into their home. According to the teacher, on one occasion Chris sat in school and stared blankly at times as if daydreaming. At other times, she talked to her neighbor student. She had difficulty in finishing her work. Later, it was reported, apparently by the same teacher, that she was well adjusted, and able to do average work in school. According to the foster parents, she was interested in school. Another foster child in the home who attended school, received higher marks than Chris. The psychometrist described Chris as a rather dull appearing child, small for her age, but friendly, cooperative, and alert in

responding to verbal items. She was slow in school work but persistent in her effort. She had good speech, good conversational qualities, and confidence in her undertakings. The psychometrist noted she was retarded approximately a year in her school achievement, but there had been an increase of twenty months in mental age since her last test. There was poor ability to analyze and organize situations, failure to detect both verbal and pictorial absurdities, and weakness in concentration and recall of digits. Her I.Q. was 91 on the Standard Revision of the Stanford-Binet Intelligence Test-Form M. She was promoted to the third grade at age nine.

During the fifth year it was reported that she was not a leader with other children. She took an interest in what other children liked but had interests of her own as well. She learned to comb her hair. She had a very nice singing voice, and also began piano lessons. She attended a girl's camp. A new teacher was unaware that Chris was from the institution. She did well in school, but had to work hard for her grades. On the American School Achievement Test, her abstract reasoning ability was better than her practical concrete reasoning. She scored a 3.2 grade level in reading, 3.6 in language, 2.8 in arithmetic and a 2.9 in spelling. Her chronological age was ten years. She was promoted to the fourth grade.

During the sixth year, Chris learned how to earn money by herself, and to use her own money to buy the things she wanted. She was able to buy lunch at school. She continued with piano lessons. Her I.Q. was 82 on the Standard Revision of the Stanford-Binet Intelligence Test-Form L, with inconsistencies in memory items and a somewhat limited vocabulary. She was promoted to the fifth grade at age eleven.

During the seventh year there were no reports.

During the eighth year, there were efforts to work with weaknesses of

this home. Chris showed happy emotion through tears. She picked out her own coat, paid the deposit herself and knew how much she had spent from her clothing fund. She continued to keep her sincere personality. She maintained a "C" average in school, and received and I.Q. of 89 on the Standard Revision of the Stanford-Binet Intelligence Test-Form L. The psychometrist described her as an attractive, soft spoken girl with clear speech who smiled rarely and needed to be encouraged to perform. She could not seem to get enough praise for performance. The psychometrist further stated that some of her failures were due, "entirely or partially to emotional tension, reflecting how tension constricted her life". Emotional difficulty was suggested by the examiner. However, at that time preparation was being made not only for a transfer to another agency, but also to another home.

The following year, at fourteen years of age, she was discharged as not mentally defective. She was transferred to another agency.

Ann

Social History Prior to Commitment. --Ann is a white female child, born August 15, 1938, illegitimately. Information was obtained from hospital records and a child guidance clinic. She was a full term baby with a normal delivery and labor. Her weight was seven or seven and one-half pounds, but was considered "puny and fretful". There was a depression over the left orbit, and a prominence of the right frontal bone. The parietal and occipital bones were symmetrical. The doctor indicated there was a congenital defect present at birth.

Ann teethed at seven months. There was no apparent improvement in the rate of mental growth. At nine months, she could not adjust to other

children. At thirteen months of age, the following was observed by the child guidance clinic: there was marked underdevelopment of the legs and feet; she was indifferent to surroundings; she waved her hands at the wrist; she slapped her head; she rocked back and forth; and she had a mental age of eight months. (Name of test is unknown.) At twenty-seven months of age, the following was observed by the child guidance clinic: she was indifferent to what was said; her motor coordination was poor; she teetered from side to side; she was unsteady on her feet; she could drink from a cup; she did not feed herself; and she had a mental age of fifteen months. On the Kuhlmann-Anderson Intelligence Scale, she was especially retarded in verbalization and social response.

During Ann's first year, she was in an infant "nursing home". Then she was transferred to a children's home in another area. She remained there until her admission to Lapeer on November 20, 1940. She became a court ward in March, 1939.

Commitment and Admission. --Ann was committed to Lapeer at one year and four months of age. The commitment order and a physician's report respectively read as follows:

> Child was cared for one year by the ... Hospital under the supervision of the court for most of that time and she has never developed normally. She cannot swallow food as a child should and her head is mis-shapen and her development is such that it appears that institutional care will be necessary.
>
> Child is 14 months of age and is unable at this time to sit well alone, does not stand even with support, does not walk or talk. Her mental age according to tests is 6 months. She bangs her head back and forth in her bed, has purposeless movements of her hands and is very difficult to feed.

Ann was admitted to Lapeer at age two years and three months. She appeared undernourished. She was able to walk, but unable to talk with the exception of the word, "mama". She was unable to dress or feed herself.

She was untidy. She sucked her fingers. She was "tentatively diagnosed as a congential cerebral anomaly".[26] The doctor described her as a dull and sickly child with poor development. She cried during the examination. The only medical findings showed an enlarged frontal lobe. A psychometric examination was not given.

Institutional Period. --Ann was in the institution four and one-half years. There was no report in the record until two years and two months after admission. At this time, she was considered a fairly bright child, cheerful, very active, and able to play well with other children. She was kind and thoughtful to others. However, on occasion she had a jealous temperament and was abusive to others. She tried hard to talk. Because or poor enunciation, she was difficult to understand. She was able to feed herself and help others dress. She was tidy. Four months later it was observed by nurses that she did not like to share her toys, and loved attention. She was quite stubborn at times. She was considered a child with limited mentality. She received an I.Q. of 68 on the Gesell-Binet Scale, and 97 on the Merrill-Palmer Scale, ten months after admission.

At the time of placement she was described as a pretty girl with a "sweetness of personality". She wanted to belong to someone. She was neat and clean. Her functioning was limited in simple tasks.

Family Care. --Ann was placed on Family Care three years and six months after admission at five years and nine months of age. During the first year, Ann was considered to be talkative, affectionate, and in need of outward affection. She conversed about herself. She seemed happy and contented, played well with the other boarding child and considered the dog and farm animals her friends. Later she became demanding and willful.

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[26]This is a diagnostic term used at Lapeer. See Appendix A.

She dominated the other boarding child but was fond of her foster parents. She attended church and learned simple church hymns. She could not pronounce all words clearly (observed by the family care worker). A psychometric examination two months after placement, described her as attractive, neat and clean. She repeated five digits in order, copied well and turned testing material into play material. She seemed to be alert to her surroundings, friendly and cooperative. She made self-initiated play opportunities. She received an I.Q. of 76 on the Standard Revision of the Stanford-Binet Intelligence Test-Form L.

During the second year Ann was in the process of learning to help with simple chores about the home. She had improved in her social behavior but she was still"bossy"toward her peers. She was described as having a fiery temper, but was learning to control it. There was no parental contact. The family care worker noted that she recognized signs along the road near the foster home, could read a little from her primer, count to 100, and print her name. At seven years of age, she attended kindergarten, earning a "B" average. She received and I.Q. of 84 on the Standard Revision of the Stanford-Binet Intelligence Test-Form L.

During the third year Ann was described as a good dish-washer, a good helper with other simple chores and ambitious around the house. She liked to work. She could pin-curl and comb her own hair and helped comb the other child's hair. She was in the process of learning to iron flat pieces. The other child in the home tormented Ann. She began to sleep by herself because there was too much commotion with the other child. The foster mother did not know whom to blame. She like school and her disposition was fair. She was promoted to the first grade at age eight. During the year she also went halfway through the second grade with good

marks.

During the fourth year, Ann could do some ironing, dust, wash dishes, make lunches at home for herself (sandwiches), keep herself clean and dress herself. She did not need any personal attention. It took the whole year for Ann to complete the second grade at age nine. She was fairly good in arithmetic, forgot some of her spelling words, but had a good report card.

During the fifth year Ann dressed nicely. She became involved in petty thievery from stores with other children in the neighborhood and accompanied another child in spending thirty cents stolen from the foster mother. It was not believed that Ann actually took the money. She joined a group club and went swimming at an inside recreation pool with this group, although she did not know how to swim. Her behavior at school was good and everyone liked her. She was industrious in school but complained about too much work. She was promoted to the third grade. A psychometrist described her as attractive with beautiful brown eyes, neat, clean, alert and happy with her home. She responded well to questions, maintained a fast and accurate performance and had increased her ability in all mental tests. She received an I.Q. of 87 on the Standard Revision of the Stanford-Binet Intelligence Test-Form L. Her performance tests were within the normal range. She defended herself, when asked why she was behind in school, by saying that she started late. The teacher considered the possibility of fourth grade during the first part of the year, but nothing was done about this. She received "A's" in most things, two "B's", and a "C" in citizenship. She was promoted to the fourth grade at age ten.

During the sixth year, Ann was able to go downtown by herself to the store and post office. She mowed the lawn, and earned fifty cents. She liked feminine-looking clothes. She seemed happy and had several friends

with whom she visited back and forth. Ann got along well with children older than herself. She seemed to be a very serious child, sensitive to other people's opinion. Other children continued to tease her. During the latter part of the year, Ann had an emergency eye examination. During transportation, characteristics of nervousness and insecurity were noted by the family care worker. Ann referred to the other child in the home as her sister, claimed the name of the foster parents and was afraid that she would not be liked by other children. She was frightened during the eye examination. No pathology was found. Ann was glad to get back "home" after the examination. The worker feared emotional difficulty because of the competition at school. However, a good adjustment was reported at school after the eye examination. She received an "A" in arithmetic, handwriting and citizenship. Her poorest marks were in elementary science and social studies. She was absent only ten days during the whole year. She was promoted to the fifth grade at age eleven. A psychometrist described her as attractive, clean, neatly dressed, of normal appearance, socially mature, alert in actions and speech, energetic and enthusiastic. She was able to recognize her limitations and did not try tests about which she was uncertain. Her comprehension, reasoning, and ability to detect incongruities were poor, and her memory for stories, designs and sentences was weak. However, she did well on organizing dissected words into meaningful sentences, and arithmetic. She was weakest in language and paragraph meaning. She read at a 3.7 grade level and had a 3.0 level in arithmetic. She took pride in her accomplishments.

During the seventh year, replacement was considered because the "emotional value" of this home had decreased for Ann. This was done,

though Ann expressed much fear of changing homes. When she was first placed in the second home, she would eat only cookies for a whole meal. Within three months, however, she was beginning to eat small servings of everything. She continued to go swimming, camped out with the Brownie group, attended all the school events and visited friends, but had difficulty with other children outside of the home. She acted to show off in groups. She cried frequently, pitied herself and seemed nervous, especially at night in her sleep (this was shown by her grinding her teeth). She did not act mannerly in stores and seemed to have no sense of money values. Later in the year, it was reported that she seemed less tense and happier. She was purposely placed in a Catholic school. She was called "teacher's pet" because she helped the Sister after school. She began taking instructions to become a Catholic. She seemed to be getting along fairly well in school except for her spelling, which was poor. An intelligence test was requested because Ann was using her eyes as an excuse when the work became too difficult, and it was wondered if the competition in the fifth grade might be too strong. The psychometrist described her as attractive, alert, normal, able to converse well and ask questions intelligently, cooperative, anxious to please and in need of reassurance on the test. Her total grade equivalent was 3.7 grades, with the highest scores in arithmetic, similarities and digit span. Her memory was superior, but her comprehension, vocabulary and information items were below average limits. She earned a full scale I.Q. of 85 on the Wechsler Children's Scale with a recommendation that she continue in the fifth grade. However, she was placed in the sixth grade at age twelve.

During the eighth year Ann was able to mow lawns, baby sit, do her own bedroom work and keep herself neat and clean. She wanted to take on

the responsibility of watching children at the beach. She did not complain to the worker about everything, seemed more poised and mature and was liked by the children of relatives of the foster home. She asked to go roller skating with friends. She was promoted to the seventh grade at age thirteen. She talked and chattered in class when she was supposed to be quiet, but was not considered a major problem. She maintained a "C" average, the first half of the year. At the end of the year she received an "A" in arithmetic, a "B" in English and handwriting, the rest were "C's".

During the ninth year, Ann's conduct in the home became excellent. She studied at night with another girl, ironed her clothes and did other small household chores well. She attended school dances, went to local movies, went with girl-friends to baby sit and learned to sing in Latin. She was resentful of correction. She was promoted to the eighth grade at age fourteen.

During the tenth year, Ann verbalized her loyalty to her first home and town. She baby-sat regularly, seemed to have more self-confidence, did not seem to resent supervision so much in school and confided in the Sister when she was in doubt. She was obedient, responsible, and dependable. She maintained a "B" average. She was promoted to the ninth grade at age fifteen.

During the eleventh year, Ann was placed in another home because this home was not allowing her "to grow". She painted the ceiling and helped with the housework. The family care worker felt that she acted and appeared more like any normal girl her age. She showed an extraordinary capacity to make decisions for herself. She could manage her allowance satisfactorily and expressed her likes and dislikes. During this year relatives were found, but they did not visit her.

At the present time Ann is in high school and will graduate in June, 1958. She seemed to be capable of choosing the right kind of friends. She was able to establish "feeling relationships" with people. She seemed to have made an emotional adjustment to her natural family. She has a respectable boy-friend. She recognizes her responsibility to support herself. She will be discharged from the institution as not mentally retarded and as self supporting upon graduation.

CHAPTER V

INTERPRETATION

Sally

Intelligence. --A psychometric examination was not given just before placement. However, Sally earned an I.Q. of 63 at three and one-half years of age, one year and nine months before placement. She began kindergarten at the age of seven, two years late considering the average child attends at age five. She passed into the first grade the following year, and during the second half of the first grade, she received "B's" and "C's" on her report card together with a report of improvement. She was promoted to second and third grades during the following two years. She was receiving an "A" average at the third grade level.

At the age of seven she received an I.Q. of 79 on the Standard Revision of the Stanford-Binet Intelligence Test-Form L. She showed normal potential intelligence. She was discharged as not mentally defective two years later.

There was a definite rise in I.Q., but it is not known how much of this increase can be attributed to family care because there was no measure of intelligence at the time of placement. Her improvement in school was remarkable.

Social Behavior. --Sally was no behavior problem when first placed on family care. She played well with other children and did not have temper tantrums. She functioned well as she readily accomplished simple

tasks. She was pleasant in manner to adults, but strong interpersonal relationships may have been somewhat marred because of her speech defect. Apparently she had no concern about her appearance.

Sally's behavior seemed to be more of a continuous growth process, rather than a change. Her speech was much improved, and the fact that she became a favorite with the foster mother suggests improvement in her interpersonal relationships with adults. Progress in functioning was exhibited by gradual accomplishments of more difficult tasks. She seemed to have more pride in personal cleanliness and neatness.

Personality. --At the time of family care placement, Sally gave some evidence of emotional difficulties in that she masturbated, had indistinct speech, did not care about her appearance and tended to be clinging to adults who gave her attention. Sally seemed to be masochistic in character. There was also an indication that she seemed to have inner hostility. She seemed unable to accept herself. Sally continued to show an identification with the institutional children after placement.

Sally seemed much improved in her emotional difficulties at discharge. Her speech defect disappeared, and there was no further mention of continued masturbation or a clinging type behavior. Her consistent improvement in school, her increase in intelligence as measured on standardized tests, and ability to concentrate better suggests an alleviation of tensions within. Her pride in personal cleanliness and neatness, and the fact that she became the favorite of the foster mother suggests she had begun to accept herself as a person. The fact that she was discharged as not mentally defective is evidence of positive personality change.

Mary

Intelligence. --A psychometric examination was not given just before placement, however, Mary earned an I.Q. of one at approximately seven years of age, eight months before placement. During the first year on family care she earned an I.Q. of 87 on the Standard Revision of the Stanford-Binet Intelligence Test-Form L. She began school on a part-time basis at the age of about eight, three years late considering the average child attends at age five. At the age of nine years and six months, she began second grade work. She passed into the third grade the following year, and was subsequently discharged as not mentally defective.

A great deal of Mary's intellectual development may have taken place at the institution. However, her successful participation in school and her ability to function successfully outside the institution indicates positive growth in intelligence. How much growth can be attributed to family care is not known because there was no measure of intelligence at the time of placement.

Social Behavior. --Mary seemed very weak generally in her interpersonal relationships at the time of placement. She did not include herself in play activity, was still fearful of strangers and strange situations, and had a low frustration tolerance with people. She displayed a strong temper and at times was stubborn, grumpy, and commanding. She was described as eating like a pig. She did not feel responsible for any household duties. She talked loud in school classes and exhibited obnoxious behavior with other students.

At discharge from the institution, she had changed in nearly all areas. She seemed happy in assuming certain responsibilities. She attended peer

groups and was beginning to learn how to make friends in a normal way. She got along better with other children in school and did not talk as loudly in class. Her temper tantrums diminished and she did not become upset as easily. She developed better eating manners. Apparently her interpersonal relationships became stronger as it was felt she was reaching out emotionally toward family living.

Personality. --At the time of family care placement, Mary seemed to be still quite distrustful, fearful, anxious, and lacking in self confidence. She was tense and was described as highly disorganized and infantile in her personality makeup. She seemed to have considerable inner hostility, and expressed this hostility in unconventional ways, such as temper tantrums, and stubbornness, together with a commanding or domineering attitude.

Upon discharge, her interpersonal relationships, as we have seen, seemed to be stronger, and she seemed to be a more secure and less anxious child. She changed to more conventional ways of expressing herself, verbally. Her total personality seemed more wholesome. She began to accept herself as a person and the other people around her.

Emma

Intelligence. --Emma earned an I.Q. of 65 about two months before placement. Sometime during the first year of placement she earned an I.Q. of 77. During the third year her I.Q. was recorded as 95. The fifth and seventh years showed an I.Q. of 75 and 80 respectively.

Her intelligence quotient was erratic throughout family care, but there was a substantial increase in her intellectual growth.

Social Behavior. --Emma was described at time of placement as a pretty child who was docile, pleasant, agreeable on the surface and submissive. She had

good speech before placement, but she began baby talk after placement. Her outward behavior toward adults seemed good, but she tended to be solitary in her play activity. She seemed dazed for the first three months in her placement and apparently found it difficult to function adequately. Her social quotient was given as 94 sometime during the first year of placement.

At discharge it was noted that Emma had no friends except in the classroom and attended very little group activity. She seemed to have good behavior in the home and in school. Her speech became distinct. There was no specific information concerning her functioning in regard to small tasks, but with her rise in intelligence quotient and continuous promotion in school, it seems possible to assume there was progress.

Personality. --At the time of placement, Emma apparently internalized hostility, tension and conflicts which revolved around moving into a family care home. Apparently such a move was very fearful for her because she was in a daze during the first three months, and baby talk was evident after placement. She seemed to be tense in a close family relationship. Emma tended to value external objects, repressing emotional feelings toward people. She seemed weak generally in her interpersonal relationships.

At discharge Emma had overcome her initial reaction to a foster home but apparently had developed different emotional maladjustments. She was seen by a psychiatrist, who felt Emma to be unable to express any true feeling. She did not have friends except in the classroom. She became overly identified with the foster family. Even though she was discharged as not mentally defective, she was referred to a children's clinic because of personality difficulties. There seemed to be no positive change in personality.

Chris

Intelligence. --The only intelligence quotient given before placement was at eleven months of age, at which time Chris was four months retarded. An approximate I.Q. of 55 was given on the commitment order, but there was no indication that this was obtained by proper testing methods.

Two months before discharge, Chris received an I.Q. of 89 at fourteen years and six months of age. There was a steady and consistent improvement in her intelligence quotient rate, as well as with her grade level through achievement tests. She began kindergarten at age six, and went continuously through the seventh grade. There were no marks reported, but her grades were considered average. There was substantial intellectual growth.

Social Behavior. --Chris seemed to have good social behavior at the time of placement. There were no behavior difficulties. She was clean and responded to being dressed up. She played well within groups, and seemed popular with other children. However, it was indicated that she would not respond sometimes when spoken to. The institutional report indicated she was able to dress herself, but the family care report indicated she was in the process of learning. There might have been a regression. Without further information her true functioning at this time cannot be evaluated.

Chris' behavior seemed to be more of a continuous growth process, rather than a change, because her behavior totally seemed good in the beginning. There was growth especially in functioning because she learned to swim, play the piano, sing, do simple tasks around the home, earn money, and spend it wisely. There were no behavior difficulties in school or at home at the time of discharge. Her interpersonal relationships seemed well established. She apparently got along well with children in school and her

teachers. She attended group activities. She impressed people considerably since they desired to have her in their home, and one teacher was unaware that she was from the institution.

Personality. --Chris was described at the time of placement as having a "sweetness of personality", which was simple but sincere. She accepted her situation and seemed to have no severe emotional problems. Her social behavior totally was good. Her lack of response sometimes when spoken to, could have indicated a defense against insecure feelings, or an inner feeling of hostility. There is not enough specific information to confirm this.

At discharge the psychometrist noted emotional difficulties, however, this examination was taken at a crucial time in her life; she was being moved from this home and discharged to a normal child placing agency. Without further information it is difficult to know how much effect this may have had upon the examination. Emotional difficulties are contra-indicated in her continuous growth of functioning, behavior, and intelligence. Also, it is indicated that Chris continued to hold on to her own simple and real personality, not following others. She seemed to be well liked and was not considered an institutional child. Placement with a normal child placing agency suggests growth in personality.

From this evidence it seems there was continuous growth in personality, but such a statement is guarded because of the psychometric examination just before discharge.

Ann

Intelligence. --A psychometric examination was not given just before placement, however, Ann earned an I.Q. of 68 three years, eight months before

placement. During the first year of placement, she received an I.Q. of 76. During the second, fifth and seventh years, she received I.Q.'s of 84, 87, and 85, respectively. She maintained about a "B" average on her last report in school, and was expecting to graduate from high school.

There was a substantial increase in her intelligence quotient, but it is not known how much of this increase can be attributed to family care because there was no measure of intelligence at the time of placement. Her intelligence quotient remained consistent, and the fact that there was continuous progress in school, together with her apparent ability to complete high school, indicates family care to have been a positive factor in her intellectual growth.

Social Behavior. --There seemed to be few behavior difficulties at the time of placement on family care. She played well with other children, but did not like to share her toys, and was stubborn at times. She loved attention and was affectionate. Her functioning seemed to be limited. She did, however, keep herself neat and clean.

At the end of the report, Ann had made tremendous progress in functioning. She could baby sit, mow lawns, iron, do her own bedroom work, date boys, and was expecting to graduate from high school. In other areas there was similar progress. She attended all kinds of group activities and achieved an excellent degree of social ability. She acted and appeared more like any normal girl her age. Her conduct, dependability, and courteousness were excellent according to graded reports from school. She recognized her responsibility to support herself and the institution was planning discharge because she was so capable.

Personality. --At the time of placement, Ann had a "sweetness of personality". There were some behavior problems, but no outward symptoms of

severe emotional difficulties. Her functioning seemed to be retarded.

At the end of the report, there was no doubt that Ann had developed considerably in personality. She was capable of making good decisions and choosing the right friends. Most important of all, she had learned to establish a feeling relationship with people. She maintained her individuality and made an emotional adjustment to her natural background. She recognized her responsibility to support herself, and the institution is planning to discharge her as not mentally retarded upon graduation from high school next year.

CHAPTER VI

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

The purpose of this project was to determine if family care is an effective treatment method for children admitted to Lapeer State Home and Training School who are considered emotionally retarded. This was done by determining if there was apparent change in intelligence, social behavior and personality in five emotionally retarded children who had been placed in family care homes. Intelligence, social behavior and personality were chosen as critia because they seem best to illustrate emotional and intellectual growth, as opposed to physical growth. There was no quantitative method of measurement used in interpreting the data. Interpretation was based on evaluation of facts recorded in each child's record. The lack of specific information in records was found to be a limiting factor for the interpretation of the data.

The results showed a positive change in the five children considered. Four of them were discharged from the institution as not mentally retarded. One will receive her discharge following graduation next year, since she is capable of self-support. Positive change was more apparent in intelligence and social behavior than in personality. Part of this was due to the lack of a clear picture of personality, however, it did seem that needs for personality development were greater than for intelligence and social behavior. The personality picture could become more apparent with further study of each foster home in relation to the child.

It can be concluded that family care was beneficial in bringing about positive change with the five children under consideration in intelligence, social behavior, and personality. However, further research is needed to determine the nature of the contribution of the family care program more precisely.

It is recommended: (1) An evaluation should be made of the recording methods in family care. This would mean adjusting recording techniques to meet both the institutional and family care needs. (2) More specialized and intensive service should be given in the area of personality development. (3) Further research should be conducted, especially in the area of the foster homes used, and the nature of the contribution of the family care program in helping these children. The latter would provide a basis of determining more precisely the service the institution and family care can give in treating the emotionally retarded child.

APPENDIX A

Number of Family Care Patients by Diagnostic Type

12-31-55 I.Q.		Familial	Mongolian	Developmental Cranial Anomaly	Progressive Nervous Disease	Natal Trauma	Post Infectious	Not Mentally Defective	Not Mentally Defective with Psychosis	Undifferentiated	Unknown	Spastic	M	F	T	Percent
0-19	M	2	1	1									4			
	F		1	1						2				4	8	4.47
20-29	M	3	3	4							1	1	12			
	F	5	7	1			1				1	1		16	28	15.64
30-39	M	12	5	1			1				1	1	21			
	F	19	5	6		1	1			1	2			35	56	31.28
40-49	M	6	2	4			1						13			
	F	8	2	3			2							15	28	15.64
50-59	M	7		1						1	1		10			
	F	6		2			2				2	1		13	23	12.85
60-69	M	2	1				1	1					5			
	F	7					2							9	14	7.82
70-79	M	5		1				1	1				8			
	F	3												3	11	6.15
80-89	M	2		1									3			
	F	1			1			3						5	8	4.47
90-99	M												0			
	F			1										1	1	.56
100-110	M							1					1			
	F							1						1	2	1.12
TOTAL	M	39	12	13	0	0	3	3	1	1	3	2	77			
	F	49	15	14	1	1	8	4	0	3	5	2		102		
	T	88	27	27	1	1	11	7	1	4	8	4			179	
PERCENT		49.17	15.08	15.08	.56	.56	6.15	3.91	.56	2.23	4.47	2.23				100.00

[illegible]

ETIOLOGICAL CLASSIFICATIONS
of the
COMMITTEE ON NOMENCLATURE

AMERICAN ASSOCIATION ON MENTAL DEFICIENCY

CODE NUMBER	DISORDER
60 - 79	Mental Retardation

Mental Retardation refers to that group of conditions which is characterized by:
(1) inadequate social adjustment
(2) reduced learning capacity
(3) slow rate of maturation
present singly or in combination due to a degree of intellectual functioning which is below the average range, and is present from birth or early age.

Mental Retardation is a generic term incorporating all that has been meant in the past by such similar terms as mental deficiency, feeblemindedness, idiocy, imbecility, and moronity, etc.

CLINICAL OR ETIOLOGICAL CLASSIFICATION:

The following classsification is based on the premise that mental retardation is basically a symptom complex resulting from a wide variety of conditions including not only defects of the central nervous system but also those in the psychological and sociological spheres. While the latter conditions are recognized as causative mechanisms in their own right, they may also and frequently do, play significant roles influencing the degree and nature of the mental retardation resulting from cerebral defects. The implication of this premise also involves the conception of mental retardation in many cases as a dynamic rather than static condition, amenable in many cases to improvement through treatment, even cure, through educational psychiatric and other therapeutic procedures even though the basic cerebral defect is irreversible, as a rule.

The specific categories listed include those conditions most commonly encountered. However, provision is made for the rare clinical types, and for conditions that may be adequately categorized in the future. It will be noted, that in general, the basis for the classification depends on etiological mechanisms, wherever possible.

60	Familial
61	Cerebral trauma
62	Cerebral infection, post natal (specify)
63	Congenital cerebral maldevelopment with Mongolism
64	Congenital cerebral maldevelopment with cranial anomalies (specify)
65	Congenital cerebral maldevelopment with phenylketonuria.
66	Congenital cerebral maldevelopment with congenital ectodermoses (specify)
67	Congenital cerebral maldevelopment with cerebral palsy

CLINICAL OR ETIOLOGICAL CLASSIFICATION (continued)

69	Congenital cerebral maldevelopment due to prenatal infections (specify).
70	Congenital cerebral maldevelopment - other forms (specify).
71	Congenital cerebral maldevelopment - non-specific
72	Progressive neuronal degeneration (specify).
73	Hypothyroidism.
74	Kernicterus (iso-immunization; other)
75	Due to convulsive disorder.
76	Psychogenic
77	Other post natal forms (specify).
78	Unkown.
79	Unclassified.

60 - Familial:

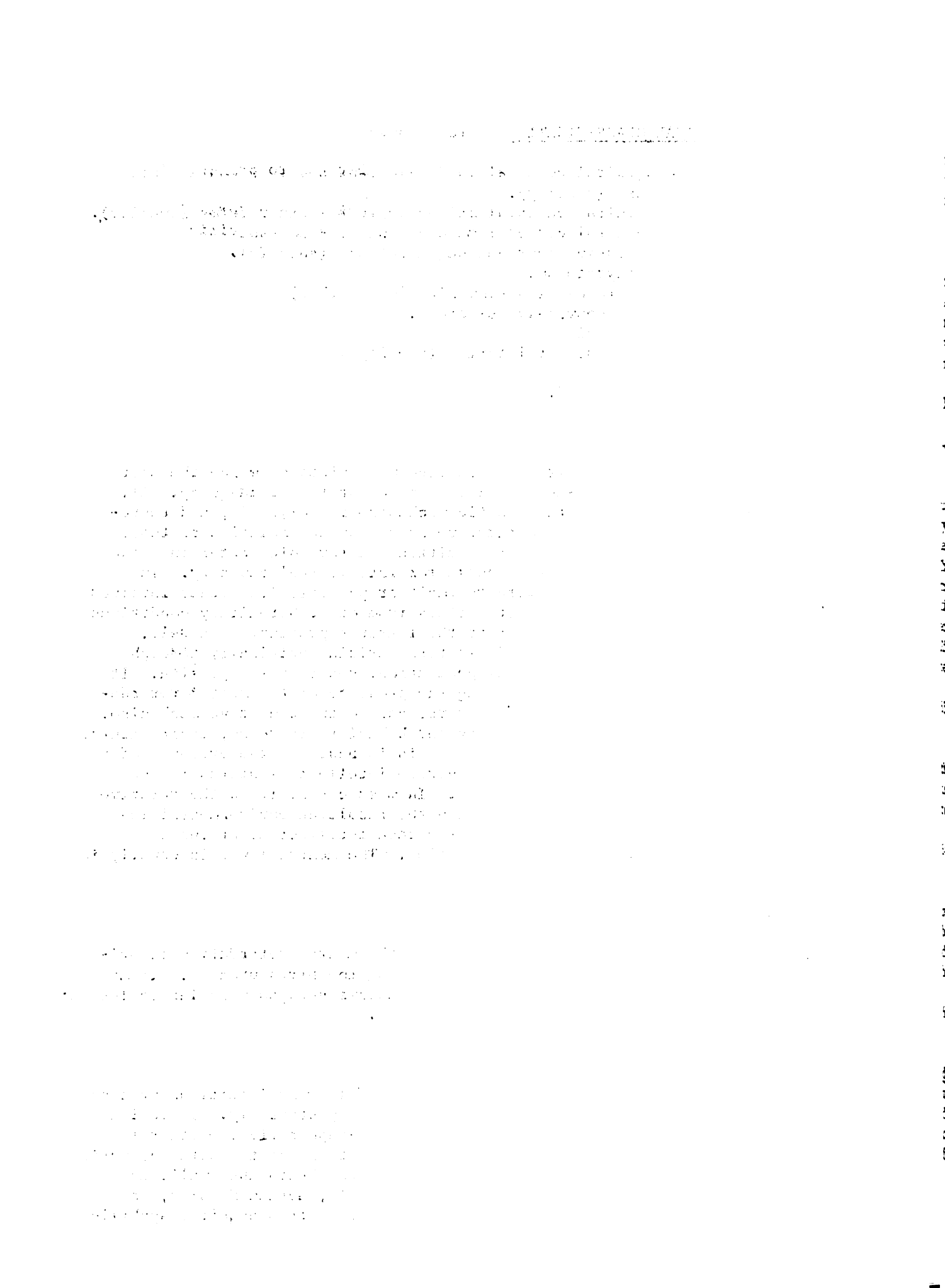
This category depends on multiple causative mechanisms of which the most distinctive is an inherited sub-average intellectual status or adequacy. All evidence tends to indicate that the genetic mechanism is polygenic, and represents either in a qualitative or quantitative sense, an accumulation of those items of the polygenic "intelligence" transmitting factor which determines the lower parts of the normal distribution curve for intellectual capacity. In other words, we are dealing here , with "normal" or physiological genes involved in the inheritance of intelligence. It differs from other hereditary conditions associated with mental retardation in that the latter represent, as a rule, clearly abnormal or pathological genetic factors, arising originally through mutations, and not present in the normal population, genetically speaking. It is infrequently the sole factor determining the presence of the mental retardation: Most commonly, other associated factors, add to the causative mechanism. These include factors such as: Personality and behavior disorders, environmental inadequacy, physical defects, etc. The diagnosis is based on the presence of a relatively similar degree and type of sub-average intellectual status in one or both parents and in most of the siblings. In most cases, it is the relative intellectual incompetence of the parents with the resulting environmental inadequacy which combine with the child's sub-average intellectual status to produce the clinical state of mental retardation. ' The mental level is usually in the borderline or mild category.

61 - Cerebral trauma (specify):

This category includes those cases in which the mental retardation is primarily the result of cerebral injury occuring during the birth process. It may and usually does involve multiple pathogenic mechanisms such as vascular occlusions, hemorrhages, anoxia, direct tissue destruction, etc.

62 - Cerebral infection, post natal (specify)

This category refers to cerebral abnormalities following infectious processes directly involving the brain, and occuring at any time postnatally. It includes all types of encephalitis, whether suppurative or non-suppurative, whether focal such as brain abscess, or more generalized such as that associated with the various meningitides or encephalitides. It does not include the brain abnormalities resulting from prenatal infections such as toxoplasmosis, German Measles, or congenital syphilis. However, cerebral lesions resulting from acquired syphilis



would belong in this category. It should be mentioned that serological evidence of syphilis in a mentally retarded person does not necessarily imply a causative relationship. Specific evidence of a syphilitic cerebral involvement should be required.

These eight categories include all conditions, acting at any time during prenatal life, which have interfered with the normal development of the central nervous system and thus are directly responsible for the mental retardation. Except for the category "non-specific", previously designated "undifferentiated" by many, all of the categories are readily recognizable, either on the basis of physical appearance or on the results of special tests and studies.

63 - Congenital cerebral maldevelopment with Mongolism:

64 - Congenital cerebral maldevelopment with cranial anomalies (specify):

This category includes the craniostenoses (premature closure of cranial sutures such as oxycephaly, scaphocephaly, etc.) hypertelorism, congenital hydrocephalus, macrocephaly, etc. Many of these conditions are genetically determined while in others, the etiology is either variable, or not established. This category also includes primary microcephaly, a hereditary abnormality of the brain associated with a characteristic cranial appearance. It must be differentiated from the secondary or symptomatic microcephaly which is a common accompaniment of many kinds of cerebral abnormalities, otherwise categorized. Similarly hydrocephalus may be due to various etiological mechanism and should be so classified.

65 - Congenital cerebral maldevelopment with phenylketonuria:

This is a condition easily recognizable by the presence of phenylpyruvic the urine which can be identified by a simple laboratory test. The condition is genetically determined, the responsible genetic factor being autosomal and recessive.

66 - Congenital cerebral maldevelopment with congenital ectodermoses (specify):

This category includes three conditions, namely tuberous sclerosis, neurofibromatosis, and cerebral angiomatosis. They are grouped together because they have considerable in common, i.e., genetically determined, cerebral dysplasia, tendency to tumor formation, involvement of many structures of the body including the skin, and a great variability of clinical manifestations.

67 - Congenital cerebral maldevelopment with cerebral palsy:

This category includes all cases with prenatal cerebral abnormalities not due to known causes, and presenting as one of the manifestations, a defect in motor function resulting from the cerebral defect. Cases of cerebral palsy due to such trauma, post natal infection, etc. would not be included in this category, but placed in its respective group as indicated by the etiological factor involved.

69 - Congenital cerebral maldevelopment due to prenatal infections (specify):

This category includes those cases in which cerebral abnormalities resulted from such prenatal infections as German Measles, congenital syphilis, and toxoplasmosis. Although these three are the most commonly mentioned, the possibility of other prenatal infections should be considered. The type of infection should be specified.

70 - Congenital cerebral maldevelopment - other forms (specify):

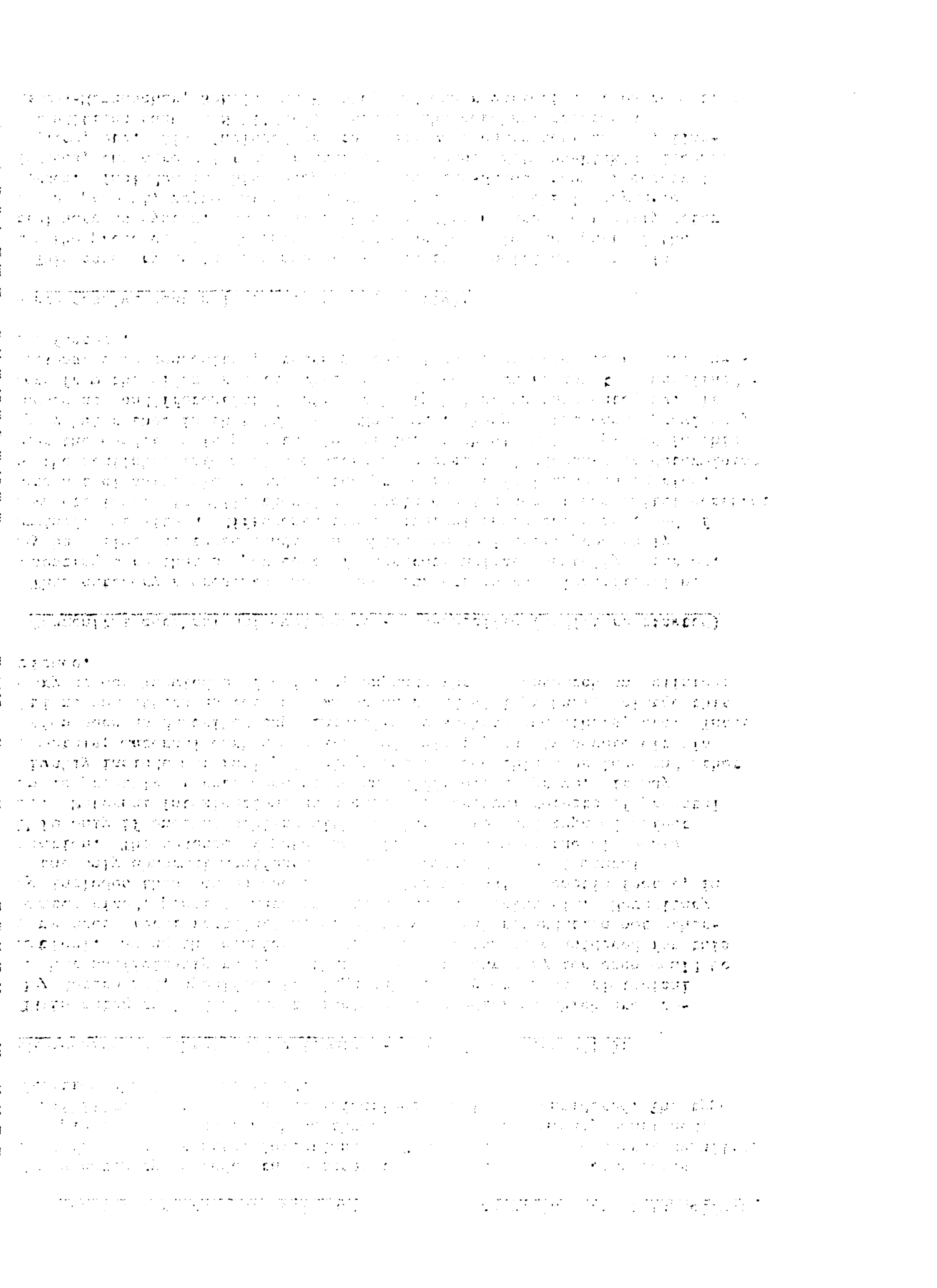
This category is designed to include the conditions which are prenatally determined, specifically diagnosable, many of known etiological basis, but sufficiently rare, so that a separate category for each would be impractical. Among the clinical conditions that can be considered for this category are: fetal irradiation, hereditary mental retardation not otherwise categorized, possible maternal intoxications, eclampsia. Hereditary idiocy includes those cases due to a specific recessive genetic factor, in which the only abnormal manifestation is a severe degree of mental retardation. The absence of pathognomonic findings make the diagnosis possible only if another sibling with similar degree and type of defect exists. Maternal intoxications as a cause of cerebral defects of prenatal origin is probably of rare occurrence and difficult to prove. It may conceivably include maternal poisonings due to such things as lead and other heavy metals; maternal carbon monoxide poisoning; possibly severe vitamin depletion such as described experimentally by Warkany and others, etc. These conditions and others as yet unknown or unproved will probably enlarge this category as our knowledge of etiology expands through research and clinical experience.

71 - Congenital cerebral maldevelopment - non-specific (undifferentiasted)

This category represents one of the largest in the classification, representing more than 30 per cent of institutionalized mentally retarded. It may be defined as those conditions which are definitely prenatally determined, but with no differentiating, clinical characteristics, and of unknown etiolgoy. It will, therefore, include all cases of congenital cerebral defects not classifiable in any of the preceding or following categories. Where the available information concerning a case is inadequate or determining whether the condition is prenatal in origin, it should not be placed in this category but rather in that labelled "Unknown". Many of the cases previously diagnosed as "undifferentiated" will probably belong in this category. It differs from the older grouping which represented a wastebasket or undefined conditions, some congenital, others postnatal and some even due to environmental factors.

72 - Progressive neuronal degeneration (specify):

This category includes a number of specific conditions having in common the presence of a degenerative process involving any part of the central nervous system. As a rule, these conditions are genetically determined and probably represent complicated defects in cerebral enzymatic processes. Included in this category are the Tay-Sachs group of cerebral lipiodoses, the cerebral form of Gaucher's disease, Neimann-Pick's disease, gargoylism, etc. Also included are the less well characterized demyelinating conditions such as Schilder's disease, the cerebral scleroses of Pelizaeus-Merzbacher, Schols and Krabbe, and other varieties of white matter



degeneration whether diffuse of focal; also various degenerating processes of a selective nature such as hepato-lenticular, Huntington's chorea, Friedreich's ataxia, etc. If possible, a specifying term should be included in the category designation.

73 - Hypothyroidism:

This category includes those cases of congenital cretinism and myxedema. It should be used only where the hypothyroid state can be considered causatively related to the mental retardation, rather than as an associated condition. The latter is almost always the cause when other endocrine deficiencies are present and explains the absence of a specific category for endocrine defects.

74 - Kernicterus (iso-immunization; other):

Kernicterus is actually a term originally used to describe a pathological cerebral picture. It has, however, been incorporated into clinical usage to describe the cerebral abnormalities resulting from iso-immunization due to the Rh or other blood factors, and to a variety of neonatal conditions, usually in premature and always associated with relatively high levels of bilirubinemia. The clinical manifestations of the surviving children may include in addition to the mental retardation various types of cerebral palsy, both of the hypertonic and hypotonic kinds, convulsive disorders, cranial nerve defects and aphasias.

75 - Due to convulsive disorder:

Epilepsy is frequently found as an associated clinical manifestation in most of the previously described conditions. In these, the epilepsy is either the result of the same cerebral abnormality responsible for the mental retardation or represents an added handicap due to other causes. There are, however, factors in the epileptic state itself that may, individually or collectively, lead to mental retardation. These include, the many psychological insults and deprivations stemming from the difficulties in social adjustment to which the epileptic individual is constantly exposed; the misuse of anticonvulsant drugs with resulting oversedation or unrecognized drug toxicity; and in certain cases, frequent head injuries due to falls associated with the spells. Moreover, while not generally accepted, there are some who believe that the cerebral dysrhythmia or the convulsions themselves may actually induce physiological or even organic brain changes which may result in temporary or permanent mental retardation if the convulsive state persists over an extended period. Regardless of the mechanism involved, whether one considers it an adjustment reaction, or a pathological cerebral state, this category has been set aside to include those cases in which it is felt that the presence of the convulsive state per se, represents the causative agent determining the mental retardation. While in most institutions accepting all types of mentally retarded individuals the incidence of epilepsy is probably over 15 per cent less than ten per cent of these will be found to fit into this category under discussion.

76 - Psychogenic:

This category includes those cases in which the mental retardation is basically a functional manifestation of maladjustment due to environmental factors, which may be psychological, sociological, or even physical, such as in the hard of hearing or the blind. This condition is without clearly defined physical cause or structural change in the brain. While these factors may, and frequently do play a role in most of the previously described conditions, they are essentially a secondary nature. In this category, however, they represent the primary causative agents which determine the exhibition of the symptom, mental retardation. On other words, we are dealing here with individuals, in which there is adequate genetic endowment as regards intelligence, no evidence of prenatal or postnatal cerebral injury or maldevelopment, and normal cerebral dynamics, physiologically speaking. They have previously been designated as the "pseudo-feebleminded" or some similar meaning term.

77 - Other post natal forms (specify):

This category includes diagnosable conditions, postnatally determined, many of known etiology, whose incidence is too infrequent to make a separate category practical. This includes those cases due to cerebral injuries resulting, usually, from some physical force directly or indirectly applied to the skull, occurring at any time after birth. In this category also should be placed such cases as those with lead encephalopathy, the encephalopathy resulting from carbon monoxide poisoning, cerebral changes associated with drowning or other types of asphyxoa, cerebral injury due to electrocution, prolonged insulin hypoglycomia, etc. The specific condition should be included in the diagnostic classification.

78 - Unknown:

This category includes those cases above in which the available knowledge is too meager or inadequate to allow for placement in any of the above designated categories.

79 - Unclassified:

This group includes those cases which may be classified in one of the stated categories when the study is completed, or reclassified as not mentally retarded. It should be considered only as a temporary category.

QUESTIONAIRE- COTTAGE REPORT NO. 1 **Form No. 10-217**

Date_____

M_____

Name_____Number_____Age_____

Religion_____

INTERESTS:

How does the patient spend his leisure time?_____

_____

CARE OF PERSON

Dresses Self

Laces shoes?____Ties shoes?____Put on clothes?_____Buttons clothing_____

What type of clothing does he wear?_____

Eats well?_____Sleeps well?_____

PERSONAL HABITS

Washes face?____Cleans teeth?____Takes own bath?____Combs hair?____Oders____Clean____

Clean in toilet habits Day?_____Night_____Soil_____Wet_____

Appearance Careless?_____Neat_____

SEX ACTIVITIES

Self?_____With others?_____Not observed_____

GENERAL PHYSICAL MAKE-UP:

Luetic?_____Chronic Gonorrhea?____Seizures?_____Deaf?_____Mute?_____Spastic_____

Blind?____Crippled?_____Describe_____

Is the patient frequently ill?_____Explain_____

Frail_____

Behavior

Doe the patient make friends easily with the other patient?_____

What does the patient do to attract attention to himself?_____

Does patient yell and scream frequently?_____ Does patient take from others?_____

Is patient destructive?_____

Is patient ill-tempered?_____

Is patient easily managed?_____

Is it necessary to restrain patient

[illegible]nt injury to self?_____

[illegible]vent injury to others?_____

Wh[illegible]titude of the family toward the patient?_____

Wh[illegible]gress has patient shown in the past year?_____

Mig[illegible] patient be cosidered for school or training?_____

Do[illegible]k this patient is suitably placed in your building?_____

Doe[illegible]assist with cottage work?_____

Exp[illegible]

QUESTIONAIRE-COTTAGE REPORT! (No. 2) **Form No. 10-218**

Date_____

M_____

Name _____ Number_____ Age_____

Religion_____

DAILY PROGRAM

School Part time?_____ Full day? _____

Industrial Work?_____ Under whom?_____

Cottage work What? _____ Day work?_____ No. days a week?_____

Does no work because of physical handicap?_____

INSTITUTIONAL ACTIVITIES:

Movies?_____ Dance?_____ Sports?_____ Religious Service?_____

INTRESTS:

What does the patient do in his spare time?_____

CARE OF PERSON:

Body Cleanliness:Odors?_____ Clean?_____ Appearance Careless?_____ Neat?_____

Does own laundry?_____ Does the patient keep clean without having to be told?_____

SEX ACTIVITIES:

Masturbation Never?_____ Occasionally?_____ Frequently?_____ Unobserved?_____

Homosexual practics: Never?_____ Occasionally?_____ Frequently?_____ Unobserved?_____

Hetrosexual practics: Never?_____ Occasionally?_____ Frequently?_____ Unobserved?_____

GENERAL PHYSICAL MAKE-UP

Luetic?_____ Skin disease?____ Chronic Gonorrhea?____ Deaf?____ Mute?____ Spastic?_____

Defective vision?____ Crippled?_____ Describe:_____

Is the patient frequently ill?_____ Explain:_____

Behavior:

Does patient have "chums" of his own sex? _____

How does the patient get along with other patient in his Cottage?_____

Does the patient like to fight and quarrel?_____

Does the patient steal?_____

Who are the patients friends?_____

Is the patient destructive?_____

Is this patient a problem in the Cottage?_____ If the answer is yes Explain:_____

_____

What does the patient do to attract attention to himself?_____

Does patient appear satisfied in the cottage?_____

Do you think this patient is suitably placed in your building?_____

What progress has the patient shown in the past year?_____

What do you predict for the patient in the future?_____

What is the patient attitude toward his family?_____

What is the attitude of the family toward the patient?_____

What is the patient's attitude toward cottage employees?_____

Is the patient satisfied with his institutional work program?_____

Might this patient be considered for day work?_____

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