The physically handicapped child in the United States

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http://hdl.handle.net/2144/17596

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THE PHYSICALLY HANDICAPPED CHILD IN THE UNITED STATES

A Thesis
submitted by

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(B.S. in Education, Boston University, 1928)
(M.A., Boston University, 1938)

in partial fulfilment of requirements for
the degree of Master of Science in Social Service

1941
School of Social Work
Feb. 1, 1942
244
APPROVAL PAGE

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MY NEW SPECTACLES

Two chips of glass
Before I never saw the stars
Nor butterflies with painted bars,
Nor blades of grass.

The yellow bees
I never saw, nor little birds,
But only heard their friendly words
From blurred green trees.

The world did seem
Vague, dull - I knew not why;
I only knew all earth and sky
Dim as a dream.

And then these bits of glass!
Oh, myriad Life! Oh, wonder sight!
Oh, jewelled world! Oh, star-hung night!
My soul goes dancing with delight!
Thank God for chips of glass!

Mary Carmack McDougal
PREFACE

Throughout the generations in both the animal and human kingdoms it has been usual for the adult to care for the needs of the child of the species until it is able to be self supporting. It is, however, in comparatively recent times that the handicapped child has received special recognition and attention from society. Provisions for children have usually been planned on a level for healthy children's participation while the blind, deaf, dumb, crippled, diseased, and mentally deficient child was expected to limp along as well as possible, almost always without the crutch of special planning and interest that was so urgently needed.

There are many types of handicapped children and all degrees of incapacity. There are thousands who are emotionally and socially handicapped because of broken homes, undesirable neighborhoods, unhealthy conditions, poor physical and mental heredity, and other deprivations, which make them inadequate to meet the responsibilities and hazards of an independent existence.
This thesis, however, will not attempt to study the above but will present the problem of the physically handicapped child and attempt to study the provisions and progress made with the surprisingly large number of such unfortunates who are forced to face life in this particularly tense, bewildering, and unsettled civilization.

My investigation into the problems and provisions for the physically handicapped child has included correspondence with the Departments of Public Health and Education in every state in the Union to determine how far society is recognizing the importance of the problems and making intelligent attempts to mitigate them. There has also been extensive reading and numerous interviews in an attempt to present in this study the most salient and pertinent issues, and a comprehensive picture of the situation today.

From 1874 when MaryEllen was brought into court, a case now famous, and was given the rights and protections of an animal, to the White House Conference bearing the title "The Children in a Democracy" there has been steady improvement in both the plans and provisions for the handicapped child. In
spite of this progress there are more than ten million\textsuperscript{1} children in the United States today who are physically handicapped in some way. Many have impaired hearing, others are totally deaf, blind or partly blind, crippled, tuberculous, have cardiac limitations, are diabetic, or are otherwise ill.

There are several connotations to the term "physically handicapped", but I believe that the one which is most inclusive and therefore best used in a study of this type is that published by New Hampshire which reads, "The term 'handicapped child' shall mean a child under twenty-one years of age, married or unmarried, whose activity is or may become so far restricted by defect or deformity of bones or muscles or the impairment of function thereof, or by other physical handicap, as to reduce his normal capacity for education and self support."\textsuperscript{2}

While I shall present a summary of the total history, present provisions, economic and emotional significance, and plans for the future of this problem, I shall stress the provisions and

\begin{itemize}
\item[1.] White House Conference, 1930, Century C., p. 222
\item[2.] Public Laws 116:40-47a (Laws of 1937)
\end{itemize}
needs of the child who is unable to attend any school or class because of his handicap. Special attention will be given to the fine work done by the Boston School Department, who instigated a plan for home instruction and carried it out successfully some time before the Federal government passed legislation on the subject. The work done in Boston was used as a model for other cities as they saw the need in their own communities.

Since my work for the past four years has been extensively with the physically handicapped child under the Boston School Department the cases presented will represent my own personal experience to a large extent.

There will be no attempt to list every public and private agency and provision for the handicapped child but rather to give a sort of "student's eye view" of what has gone on before and what might be expected to follow in the future. Everything possible will be included which is necessary to elucidate the emotional problems, the traumatic reactions, the economic and educational factors, as well as the esoteric and sociological implications of the physically handicapped child in the United States.
ACKNOWLEDGEMENTS

I wish to acknowledge with appreciation and thanks the prompt and courteous replies from the Departments of Health and the Departments of Education in answer to my letters of inquiry. Almost without exception, each letter was carefully written and much important material was given. In many cases literature and enclosures were supplied and one Superintendent of Schools (Bangor, Maine) referred my letter to Miss Lillian F. Wall, who was responsible for the first school in Maine for the Physically Handicapped Child and who was the first to interest the School Department and the citizens in Maine in the problem of these children and the need for education and special understanding of their problem. Miss Wall's letter to me told the story of the way in which she herself became interested in the problem and how she went about to secure some solution to it.
HISTORY

As early as 1601 the Elizabethan Laws showed some responsibility for children and the apprenticing of children came shortly afterward, an idea which was carried over to America.

There were two general methods of caring for the poor: outdoor relief and almshouse care, but in both these situations little if any special attention was paid to the physically handicapped child. In 1824 a Mr. Yates made an interesting study of the poor in New York State and he presented facts and made recommendations for almshouse improvements, which if followed would have been progressive and hopeful. In 1833 directors of various institutions urged the moving of children from the almshouse quarters for adults into separate quarters of their own, and in 1866 the State Primary School at Munson was organized for children who were unsettled.

During this time there was still no individualization of children's needs but in 1867 a Massachusetts agent recommended that the superintendent of the almshouses should "acquaint himself and keep records of the child and his emotional reactions and that no problem or behavior child should be placed
as young as a normal child but should be kept longer in the institution.

Local citizens were also interested in watching the treatment of children placed in the neighborhood and Dorthea Dix came out loudly about the lack of health and educational provisions in the almshouses.

By 1863 the retention of children in almshouses was forbidden and in 1875 a law was passed to remove all children from almshouses. Children who were boarded out were referred to a central agency, which is now the Division of Child Guardianship. Thus we see that there was a gradual movement by local, state, and federal authorities to at least recognize the problem of child welfare and to make slow efforts towards helping the handicapped child.

The Waverly Institute for the Feeble-minded, (1848), Perkins Institute for the Blind (1829), an institution for the deaf in Hartford in 1817, the New York State Children's Aid Society in 1855, the Boston Children's Aid in the same year, and the Society for the Prevention of Cruelty to Children in New York in 1874 were all indications of a new era for the care and protection of children. America copied...

1. Federal Art Projects, ...F.A. choral, Opportunity Schools, etc.
some of the ideas of child care from France and we were beginning to see the wisdom of teaching even feebleminded children a trade and self-care.

It seems to me that the case of Mary Ellen is extremely important not only because the final outcome was the organization in 1874 of the New York Society for the Prevention of Cruelty to Children, but because it brought the question of the handicapped child and its helplessness before the eyes of the general population. It was an issue which would appeal to the emotions of the voters and one that various "pressure groups" would pounce upon tenaciously. The church worker, Mrs. Wheeler, who went to the police about this tragic abuse of a child and who was advised by her pastor not to interfere and by her lawyer to drop the matter lest she be involved in a civil suit was not the type to give up easily when she believed she was right, and her visit to Henry Bergh of the New York Society for the Prevention of Cruelty to Animals has continued to bear fruit even today. As Jacob Riis said, "As I heard the story of little Mary Ellen again, that stirred the soul of a city and aroused the conscience of a world that had forgotten ... and as I looked I knew I was where the
first chapter of the children's rights were written, under the warrant of that made for a dog.\footnote{Handbook of the Society for the Prevention of Cruelty to Children} America may have been ripe for some such action but it took the stick-to-it-iveness of a far-seeing woman to popularize the rights of children, and to make it a national issue.

The next important milestone in the care of all children, which, of course, includes the handicapped child, was the first White House Conference called by President Theodore Roosevelt in 1909, which was concerned with the dependent child. Two hundred delegates gathered in Washington to discuss this problem and fifteen definite recommendations were made, among which were: that children should not be removed from their own homes for reasons of poverty; that the causes of dependency should be studied and, so far as possible, ameliorated or removed; that for children who must be removed from their own homes, foster homes in families are, as a rule, desirable; that institutions for children should preferably be on the cottage plan; that child-caring agencies should be incorporated, with state approval, and the state should inspect their work;
and most important of all, that a Federal Children's Bureau should be created "to investigate and report upon all matters pertaining to the welfare of children." As a result of this final recommendation the Children's Bureau of the Department of Labor was organized in 1812.

The Second White House Conference called by President Wilson in 1919, as the closing activity of Children's Year, was followed by eight important regional conferences. This second Conference added to the first the following five sections: economic and social basis for child welfare standards; child labor; health of children and mothers; children in need of special care; and standardization of child welfare laws.

The Third Conference, called by President Hoover in November, 1930, was attended by three thousand men and women, "leaders in the medical, educational, and social fields as they touch the life of the child."¹ This Conference included the subjects of the first two but took in not only the dependent child or the child in need of special protection, but all children in all their aspects,

¹. White House Conference of 1930: Foreword by Raymond Wilbur
including those social and environmental factors which are influencing modern childhood. This is one of the first steps of a preventive measure and as such should be recorded in a paper on the physically handicapped child. One of the four sections which was studied for sixteen months before the Conference was "The Handicapped", and the other three sections were "Medical Health", "Public Health and Administration", and "Education and Training."

The handicapped child was especially mentioned in the Children's Charter which was the pledge taken by the Conference delegates. It reads: "For every child who is blind, deaf, crippled, or otherwise physically handicapped, and for the child who is mentally handicapped, such measures as will early discover and diagnose his handicap, provide care and treatment, and so train him that he may become an asset to society rather than a liability. Expenses of these services should be borne publicly where they cannot be privately met." In another section of this same Charter we find: "To make available everywhere these minimum protections

1. Appendix, p. 82
2. Appendix, p. 84
of the health and welfare of children, there should be district, county, and community organizations for health, education, and welfare, with full-time officials, coordinating with a state-wide program which will be responsive to a nation-wide service of general information, statistics, and scientific research. This should include

(a) Trained, full-time public health officials, with public health nurses, sanitary inspection, and laboratory workers
(b) Available hospital beds
(c) Full-time public welfare service for the relief and guidance of children in special need due to poverty, misfortune, or behavior difficulties, and for the protection of children from abuse, neglect, exploitation, or moral hazard.¹

Private and public interests were gradually producing resources for child welfare and for the welfare of the handicapped child. Institutions for the deaf, dumb, blind, crippled, tubercular, and diabetic were being organized and improved. Provisions for the transportation of the handicapped to

¹. Appendix, p. 85-86
school was sometimes made by local authorities and special classes to teach trades were offered in some of the institutions. "The first public hospital devoted to the care of crippled children was established in Minnesota in 1897. The first state law which made provision for services on a state-wide basis was enacted in Ohio in 1919. By 1934, thirty-five states had made some provision for funds for the care of crippled children, although in several of these states the appropriations were so small that only a few children could be cared for. In relatively few states was it possible to conduct a state wide program providing diagnoses, medical and surgical care, hospitalization, and aftercare services for any substantial number of crippled children."¹ Thus we see that the provisions were haphazard and inadequate. It took the Social Security Act, which became a law in 1935, to produce systematic and adequate plans for this work.

"On August 14, 1935, the Social Security Act became a law authorizing Federal grants to the states for services for crippled children to be administered by the Children's Bureau of the United

¹. Facts about Crippled Children, U.S. Dept. of Labor, March, 1940
State Department of Labor. The first Federal appropriation for this purpose made funds available for grants to the States on February 1, 1936, and the States then began to submit plans as required in requesting Federal grants.

"By June 30, 1937, all the States, Alaska, Hawaii, and the District of Columbia had legislation authorizing an official State agency to carry on a program for the care of crippled children under the provisions of the Social Security Act. In the four year period since February 1, 1936, services have been established in every State. By an amendment to the Social Security Act approved August 10, 1939, Puerto Rico became eligible for Federal grants for services for crippled children beginning January 1, 1940." ¹

According to the Social Security Amendment the term "crippled children" means "children who are crippled or who are suffering from conditions which lead to crippling." It also states that "the major causes of crippling are infantile paralysis, congenital defects, birth injuries, accidents, rickets, osteomyelitis, and bone and joint tuberculosis. It

¹ Facts about Crippled Children
is recognized that there are many other types of crippling conditions among children for which little or no provision for care has been made, such as disabilities arising from impaired vision and hearing, rheumatic heart disease and diabetes. Except for certain congenital defects the causes of crippling or the crippled conditions which result are to some degree preventable. In the majority of cases proper treatment given in time will result in physical restoration or will materially reduce the child's handicap."

Since February 1, 1936, the amount paid to the States for services for crippled children during each fiscal year has been as follows:

Fiscal year 1936 ................ $732,482.33
Fiscal year 1937 ................ $2,011,606.04
Fiscal year 1938 ................ $2,694,376.33
Fiscal year 1939 ................ $2,987,914.77

Federal funds budgeted in approved State plans for the fiscal year ending June 30, 1940 .......... $3,412,755.37

The program of services which every State aims to provide through the crippled children's agency established under State law includes the following features:

1. Opus cit.
1. Locating all crippled children.

2. Providing skilled diagnostic services by qualified surgeons and physicians at state clinics located in permanent centers or held periodically in other centers so as to be accessible to all parts of the state.

3. Maintaining a state register of all crippled children in the state.

4. Selecting properly equipped hospitals, convalescent homes, and foster homes throughout the state and providing for the care of such crippled children at such hospitals and homes.

5. Providing skilled medical, surgical, nursing, physical-therapy, and social services for children in hospitals, convalescent homes, and foster homes.

6. Providing medical, nursing, medical social and physical-therapy services for crippled children at home who are not in need of hospitalization or who have been returned home following hospital or convalescent care.

7. Cooperating with other agencies in arranging for education and vocation training for crippled children.

8. Cooperating with professional groups, with private organizations, and with public and private agencies in providing services for crippled children.

9. Coordinating state and local services for the care of crippled children.

The purpose of the crippled children's program for each child served is to attain for him the "maximum physical restoration possible and to aid him to

1. Opus cit.
adjust to life at home and in the neighborhood and take advantage of opportunities for education and vocational training.¹

Some states through their departments of education provide funds necessary to cover the cost of special education for crippled children. Such costs include transportation of the child to the school, special equipment to aid children to surmount their handicaps or to be used in their physical training, teachers especially trained to work with crippled children, and teaching services for crippled children in hospitals or at home. This latter item is most inadequate, judging from my recent inquiries to the Departments of Education and the Departments of Public Health in every state in the Union.

When a crippled child reaches the age of sixteen, vocational training is made available from funds provided jointly by the State and Federal governments for the vocational rehabilitation of the physically handicapped. Provision is also made in a number of the States for vocational guidance to crippled children prior to the age at which they

¹ Opus cit.
may be accepted for training by the state vocational-rehabilitation service.

Thus we see that the making of the Social Security Act a law adds one more important milestone in the care of all children and especially the handicapped child in the United States.

In spite of the increased resources and interest in child care "it is important that social workers define more adequately their respective provinces, as well as to recognize the limitations of their resources. It is true that the growth of social agencies has provided a greater number of persons with care and treatment, but it is also true that much of the effort and time diverted into these channels has not been wisely spent. ... Social work that dispenses treatment without consciously attempting to record the response of clients to treatment is doomed to continue wasting time and money. ... If the future does bring effective and efficient social work with children, it will do so only if techniques of treatment are thoroughly tested."¹

During the year ending June 30, 1939, the

¹ Baylor & Monachesi: The Rehabilitation of Children p. 57
following services for crippled children were reported by the State crippled children's agencies:

Visits for medical service to diagnostic and treatment clinics..... 193,000
Children under care in hospitals..... 44,000
Days' care provided in hospitals....1,408,000
Children under care in convalescent homes................................. 6,300
Days' care provided in convalescent homes................................. 369,000
Children under care in foster homes.. 2,500
Days' care provided in foster homes.. 102,000
Visits by public health nurses...... 164,000
Visits by physical therapists........ 144,000
Children given medical social service 15,000
Children referred for vocational rehabilitation............................ 4,000

STATE REGISTERS OF CRIPPLED CHILDREN

1 Baylor & Monachesi: The Rehabilitation of Children, p. 57
2 Facts about Crippled Children - U.S. Department of Labor, 1940
The Fourth White House Conference was held in Washington on January 13-20, 1940. These conferences are clearing houses for child welfare of every sort and they give serious consideration to the health and care of the physically handicapped.

The chief problem now is careful planning for the education and training of the physically handicapped so that academic training and guidance is given as well as correction of their bodily defects.

It is also necessary to "teach the individual to break away from stock methods and apply methods which adapted to overcoming a particular child's defects."

1. J. E. Gallin: Education of Handicapped Children, p. 188
THE STATES AND THE HANDICAPPED CHILD

It was especially interesting to hear from the various states in reply to my inquiries and to learn their attitudes and provisions for the handicapped child. In some states their resources for this purpose are pitifully small and in others their provisions are well planned and seemingly adequate.

It is my impression that in the states where there were no provisions or very few provisions there is now going on a hasty attempt to put together some sort of plan and get it into action as soon as possible so as to become eligible for the Federal grants. It is, of course, necessary for each state to satisfy the rules and regulations made by the Social Security Board but I wonder if it is wise or possible for a standard set of rules to be applied. There are so many cultural and economic and social differences in the various states that it does not seem possible to make wise provisions under one main plan.

It was also interesting to learn of the various different local departments handling the problem. In Alabama, Wisconsin, Texas, and various
other states plans are made under the Department of Education, while in Montana, Ohio, New Mexico, and others they are made under the Department of Public Welfare. In South Dakota, Tennessee, Virginia, Alaska, Wyoming, and Puerto Rico the Department of Public Health have the responsibility. In Washington and Arizona the Department of Social Security is in charge, and in Missouri the University of the State makes and carries out the plans. Florida has a Crippled Children's Commission as does Oklahoma. In Massachusetts the State Department of Public Health is in charge of this problem.
MASSACHUSETTS

In spite of a careful study of the provisions of each state and at the risk of seeming prejudiced Massachusetts appears to rank the highest of all in its provisions for the physically handicapped child. Statewide clinics for these children are and have been conducted by the Department of Public Health. The Commonwealth has for years more than met the Federal requirement for financial participation by its maintenance of the Lakeville State Sanitarium for tuberculosis.

The first State clinic for crippled children was held at Saint Luke's Hospital in Pittsfield on September, 1936. There are now ten monthly clinics held as follows:

<table>
<thead>
<tr>
<th>Clinic</th>
<th>Day and Hour</th>
<th>Hospital</th>
<th>Clinic Consultant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salem</td>
<td>3P.M. 1st Mon.</td>
<td>Salem</td>
<td>Dr. Harold C. Bean</td>
</tr>
<tr>
<td>Haverill</td>
<td>10A.M. 1st Wed.</td>
<td>Hale</td>
<td>Dr. Wm. T. Green</td>
</tr>
<tr>
<td>Lowell</td>
<td>2P.M. 1st Fri.</td>
<td>St. John</td>
<td>Dr. Albert Brewster</td>
</tr>
<tr>
<td>Gardner</td>
<td>1P.M. 2nd Tue.</td>
<td>Keywood Memorial</td>
<td>Dr. Mark Rogers</td>
</tr>
<tr>
<td>Brocton</td>
<td>2P.M. 2nd Thu.</td>
<td>Brocton General</td>
<td>Dr. Geo. Van Gorder</td>
</tr>
<tr>
<td>Pittsfield</td>
<td>10:30 A.M.</td>
<td>St. Luke's</td>
<td>Dr. Francis Slowick</td>
</tr>
<tr>
<td></td>
<td>3rd Mon.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinic</td>
<td>Day and Hour</td>
<td>Hospital</td>
<td>Clinic Consultant</td>
</tr>
<tr>
<td>------------</td>
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<td>----------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Northampton</td>
<td>2 P.M. 3rd Wed.</td>
<td>Cooley</td>
<td>Dr. G. de N. Dickenson Hough, Jr.</td>
</tr>
<tr>
<td>Worcester</td>
<td>1 P.M. 3rd Fri.</td>
<td>City</td>
<td>Dr. John O'Meara</td>
</tr>
<tr>
<td>Fall River</td>
<td>10:30 A.M. 4th Mon.</td>
<td>Union</td>
<td>Dr. John McCarthy</td>
</tr>
<tr>
<td>Hyannis</td>
<td>11 A.M. 4th Tue. Cape Cod</td>
<td>Dr. Paul Norton</td>
<td></td>
</tr>
</tbody>
</table>

In the first three years of this clinic service to the needy crippled children in the Commonwealth, 337 clinics were held, and 1409 children were admitted to full care. These 1409 patients, besides receiving many home visits, were given necessary appliances, etc. needed to aid their recovery.

The Massachusetts register contains the names of over 6,000 crippled children. This register is compiled from doctor's reports, from hospitals and clinics, and from parents and teachers, who send in information and apply for aid of some sort. It is believed that there are at least again as many children needing this care, who have not been reached. It is urged that all these children be reported by teachers, social workers, and doctors, or citizens. The Orthopedic Unit of the department has been able to take prompt care of all children presenting themselves. There are ample facilities for

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1 Appendix, p. 78
all these children. Some of the institutions in Massachusetts follow:

The Berkshire School for Crippled Children
The Hospital Cottage for Children, Baldwinsville
The Industrial School for Crippled and Deformed Children, Boston
The Lakeville State Sanatorium in Middleborough
The Massachusetts Hospital School in Canton
The New England Peabody Home for Crippled Children in Newton
The Shriner's Hospital for Crippled Children in Springfield
The Sol-e-Mar Hospital in South Dartmouth

Many crippled children who are also feeble-minded are cared for at the Walter E. Fernald School at Waverly, the Wrentham State School, and the Belchertown School.

There are of course many private agencies which give special attention to crippled children, and the following hospitals give special attention and follow-up social service:

Beth Israel
Boston City
Boston Dispensary
Carney Hospital
Children's Hospital
Massachusetts General
Massachusetts Memorial
St. Elizabeth's
Cambridge Hospital
St. Anne's, Truesdale, and Union hospitals in Fall River
Brubank hospital, Fitchburg
Henry Heywood Memorial, Gardner
Holyoke Day Nursery, Inc.
Holyoke Hospital
Lawrence General hospital
Leominster hospital Association
Lowell General hospital
St. John's Hospital, Lowell
Lynn hospital
Milford Hospital
St. Luke's hospital, New Bedford
Ann Jacques hospital, Newburyport
Newton hospital
Cooley Dickenson, Northampton
House of Mercy hospital, Pittsfield
Jordan hospital, Plymouth
Salem Hospital
Springfield Hospital
Worcester City and Memorial
The Harvard Infantile Paralysis Commission has established after-care clinics providing physiotherapeutic treatment for those suffering from infantile paralysis. The central clinic is maintained at the Children’s Hospital, 300 Longwood Avenue, Boston, and other clinics have also been established by the Commission and are held in the following places:

Arlington
Beverly
Cambridge
Dedham
East Boston
Haverhill
Lawrence
Lowell
Lynn
Malden
North Adams
Quincy
Somerville
Waltham

There are also opportunities for the care of a limited number of crippled children during the
summer months at the Children's Island Sanitarium, Lowell Island, Marblehead Harbor, and at the Children's Sunlight Hospital, Egypt, Massachusetts.

The Children's Mission to Children has done and is doing fine work in aiding the handicapped child with proper care and treatment, and in Boston it is famous for its success with cardiac patients.
Dr. Charles S. Berry in his report on "Special Classes" at the 1930 White House Conference found that there was a surprising number of handicapped children of every type in every state who needed special education and a comparatively small number who were receiving it. Those who were receiving it were usually the children in the larger cities, while little was done for the rural child who was physically handicapped. Dr. Berry also found from his study that the less seriously handicapped were more numerous and more neglected than those who are more seriously handicapped. This seems most inconsistent from an economic angle as the less seriously handicapped are more liable to become self-supporting, if given the proper training. He also noted that little was being done at the time in special classes to remove or reduce the handicap or to discover and develop special aptitudes.

The above mentioned condition still exists in all states today and I am sure Massachusetts is no exception with its lack of educational provisions for the handicapped child. It is true that this

1 Dr. Charles S. Berry, White House Conference, 1930
state, as do the other states, avails itself of the funds offered by the Federal Government for rehabilitation services, but since this is only offered for the use of children over sixteen, there is very little done educationally for younger children in need of education who have as much right to education from taxes as do the well children.

In Massachusetts there are some facilities for the education of children in institutions and there are about fifty-seven cities and towns offering instruction to crippled children in their homes, under the provisions of Chapter 71, Section 46A, of the General Laws.

Chapter 368 of the Acts of 1830 was the first attempt on the part of legislators to provide instruction for certain crippled children who could not attend public schools. This law required school committees to have an annual census taken of all crippled children and to arrange for instruction of such children at home or elsewhere, provided they were not able to attend school.

1 Appendix, p. 78
In accordance with the provisions of the Act of 1930 the Boston School Committee authorized the employment of so-called temporary teachers for the teaching of crippled children in their homes, and the Superintendent assigned five teachers to begin service January 5, 1931.

When this home instruction had been under way for one month, the Boston School Committee, realizing that many children who were not crippled were nevertheless confined to their homes because of some physical handicap, authorized on February 16, 1931, home instruction for all children who were physically handicapped to the extent that they could not attend school. By far the greatest number of children confined to their homes are victims of infantile paralysis, heart ailments, or epileptic seizures. Children who are physically handicapped and who also have some mental impairment are not given home instruction in Boston. No child who cannot show a mental age of at least five years is allowed the services of a teacher.

It is interesting to note that two years
after its passage, the Legislature, following the lead of the Boston School Committee, amended the original act authorizing home instruction for all children who are physically handicapped.

The operation of the law for instruction of physically handicapped children is under the direction of the State Department of Education and the Department of Public Welfare, and under the regulations of these departments, teachers who are employed must have been graduated from a normal school or a college offering four years of instruction, and must have had at least three years of regular teaching experience. A form 1 is filled out for each new pupil for statistical purposes.

The salary of these teachers is established at three dollars a day per session of two hours, not to exceed two sessions a day.

In the period between January 9, 1931 and June, 1931 forty-six children received home instruction under the direction of seven teachers.

At the present time (May 1941) there are approximately five hundred and fifty pupils receiving home instruction under the direction of seventy-seven teachers.

1 Appendix, p. 78
In June, 1939, nine pupils who had received home instruction were graduated with high school diplomas; thirty-eight were graduated from intermediate schools, and six were graduated from eighth-grade schools.

The maximum hours of teaching being four per teacher, each child receives three hours instruction every week with the exception of one pupil who is given only two hours, thus making the twenty hours per week of teaching as required. The seven pupils that each teacher is thus able to instruct are given instruction in whatever grade they attended when they were last in school. Some of these handicapped children have never been able to attend school so they, of course, are started with the work of the first grade and pass into each successive grade exactly as a child attending school would. Some pupils will have the same teacher for several years at a time and the private instruction thus given is the child's only means of expression and growth.

Every teacher is required to follow the Course of Study required by the Boston School Department so that a child receiving home instruction
is given as far as is practical the same work his erstwhile classmates are having. In this way, if a child returns to school in the middle of the term, as often happens, he will not suffer from his absence any more than is necessary and is able to take his place in the work of his grade.

Books and other school supplies are furnished by the neighborhood school and are brought back to the school when the child returns or at the end of each school year.

When a teacher receives the name of a new pupil she first makes a primary investigation to discover 1) that the doctor or hospital is willing that the child should have home instruction; 2) the nature of the illness so that she can determine hygienic procedures for herself and protection for others; 3) the school work already done by the child and the place he now belongs in the school to which he is attached by virtue of his location in the city; 4) plans and discussions are made and had with the principal of the school and usually with each of the pupil's teachers in the school, so that every attention may be paid to individual needs and special difficulties. Often the teacher at the school will plan
a program exactly as she will proceed in the classroom and this is closely followed by the home teacher.

When the pupil is discharged and is able to return to school, or if he should move and become connected with another school a complete report is made out by the home teacher of the pupil's progress and the work he has covered with grades (i.e. marks) for same. These are placed on file in the school just as they are for normal children attending school, for future reference or in case of a change in teachers the following year.

In many instances the social service workers from the various hospitals or the doctor on the case will talk with the home teacher in regard to special needs or plans for the pupil and in the hope of integrating as much as possible the work of the three departments, medical, social service, and educational. It seems to be the general belief among the doctors, nurses, and social workers I have contacted in my work as a teacher of physically handicapped children in Boston for the past four years, that there is a direct and often surprising correlation between the improved physical condition and the
event of starting home instruction.

My experience shows that Boston leads all other cities in its provision for home instruction for the physically handicapped child. Other cities have in some instances appointed one or two teachers to do this work but the number of teachers is so inadequate that not nearly all the pupils needing and having the right to this form of education are receiving it. Even in Boston, in spite of its seventy-seven teachers, there are times when there is a long waiting list of pupils, many of whom may not be reached for many months or even longer.

The law in this instance is not lived up to in most cities. It seems to be a question of finances on the part of some communities and ignorance on the part of parents and others that such a service must and will be provided, if requested.

A monthly meeting is held at the School Committee headquarters, 15 Beacon Street, Boston, for the purpose of reports, discussion of individual problems, and new instructions.
"The school is an important social agency, and the teacher a social worker with a responsibility for understanding the 'whole child.'" A statement such as this deserves much consideration and would certainly call forth much heated debating from the teacher, the social worker, and the social and educational agencies! After several years of teaching and social work and after being taught in my social work classes at Boston University that good social work has as its underlying philosophy the individualization of the client and the hope of helping him become as well integrated and self-sufficient as is possible with the physical, mental, and social resources at his command, it would not be possible for me to consider a teacher in any other light but as a social worker and a group worker, who must use the skills and knowledge of professional social work if she is to help her pupils toward self-development. Certainly those should be the aims of every thoughtful and intelligent teacher rather than the stuffing of facts into a child regardless of his needs and resources,

1 Baylor & Monachesi, Opus cit., p. 48
emotionally and physically.

The problem of teaching a well child through the years of his adolescence, social, economic, and emotional deprivations, broken homes, and a tense, modern civilization is no small task and no small responsibility. The teaching of a child who is physically handicapped is an even greater responsibility and is fraught with difficulties. Most children will form some sort of identification with any adult with whom contacts and the physically handicapped child is no exception. In this relationship the pupil is inclined to take over and consider as his own any attitude the teacher expresses. Thus it is very important for the teacher as well as the social worker to maintain an objective attitude and to keep foremost in her mind the necessity of understanding what is appropriate for the pupil.

When a physically handicapped child is first visited with the thought in mind of arranging for some sort of home lessons, I am usually struck with the pathetic eagerness of the child and the relief of the parents. The child is often apathetic at first and discouraged because his illness has
made him an outsider with his classmates and friends. Often, especially in cardiac cases, the child does not feel ill and finds it difficult to be patient and quiet just because he has been told he is ill by doctors. Sometimes the child has become very much spoiled by the attention of parents, doctors, and nurses during the more acute stages of his illness and he is now inclined to cling to that attention and also to the illness. The "secondary gains" he receives somehow make up to some extent for his inability to play and attend school and keep up with his class.

My observation with several hundred physically handicapped children, as well as with well children, has been that all children are inclined to enter into things with a great deal of enthusiasm and the physically handicapped child is inclined to enter into despair with the same intensity that a well child might in some new plan or project. Often the child is more worried about his condition than appears on the surface. When he is assigned a theme to write it is interesting to note how often he chooses to write about some theme having to do with illness, doctors, hospitals, and even death. When he is asked to give a sentence explaining some
point of grammar he is almost sure to give several which contain references to his illness. Examples of this type could be given ad infinitum.

Children who have been ill often seem pitifully old for their years and wise beyond their ages. There is seldom a disciplinary problem of any sort unless being "too tired" to do assigned lessons may be called one!

I believe that it is the home teacher's job to understand all these above mentioned characteristics and to plan for the child and his rehabilitation and readjustment in his home, neighborhood, and school with just as much thought as she plans for his school work. What profit to the child to be carried along in his school work if he is unable to make the necessary adjustment to his handicap when he returns to school and society?

Dr. James S. Plant says, "Some of our most stubbornly delinquent problems are the boys with sufficiently serious heart lesions so that they cannot play actively. When such a boy appears to be in good health but constantly has to announce that "Mother won't let me play this or that" he opens himself to the severest of social disapproval and the

1. Plant, Dr. James S.: Essentials of Mental Health, p. 364
consequent necessity of finding some other way of establishing leadership."

In a world which places physical fitness above almost everything else we sometimes overlook the importance of the mental development of those who might lack much in the way of physical fitness but have all the mental capacity needed for the fullest development. No one can tell which of the little physically handicapped children of today will be the Helen Keller, the Stevenson, the Milton, or the President Franklin Delano Roosevelt of tomorrow. Even without this possibility, it is the birthright of every child to have all the benefits offered by society for his development. This should be one of the compensations for being born a "Child in a Democracy."

"The world remembers Demosthenes as a great orator and not as a stammerer; Pasteur as a great physician and not as a paralytic; Steinmetz as a great electrician and not as a hunchback; Milton as a great poet and not as a blind man; Beethoven as a great composer and not as a deaf man. Throughout the world today thousands of physically handicapped persons through developed abilities, are
taking their places in society and in employment in competition with their normal fellows.\(^1\)

One of the most efficient and effective means of attacking the problem of the physically handicapped child is prevention. It is gratifying to learn that much is being and more will be accomplished for early diagnoses, early treatment and avoidance of after-effects of certain diseases which cause physical handicaps.

Private as well as public enterprise shows a gradually increasing understanding of the needs of the thousands who have not had the advantage of a Miss Sullivan (the life-long teacher of Helen Keller) nor the financial resources for special training and care. Clinics and laboratories as well as hospitals and doctors are working on prevention. Under the auspices of the Rockefeller Foundation at the cost of $25,000. per year the Otological Research Laboratory at Johns Hopkins Hospital is evolving a method of testing children and treating them for the prevention on deafness in later life - a very serious handicap.

In New York City at the Manhattan Ear, Nose

\(^1\) Ninth Biennial Report on Vocational Rehabilitation Mississippi Department of Education
and Throat Clinic, and at the Presbyterian Medical Center; in Minneapolis at the University of Minnesota Medical School; in Boston at the Children's Hospital; and at the University of Rochester in New York State we find serious research in the problem of deafness and its causes, treatment, and cure.

When Alexander Graham Bell opened his School of Vocal Physiology at 18 Beacon Street, Boston, to give instruction in lip reading he had vision and great enthusiasm, but it is doubtful if even he realized that the time would come when 40% of the 24,000,000 school children in the United States would be estimated by Johns Hopkins to have a high tone hearing loss. Today approximately only 40,000 children in America are being taught lip-reading as a preventive measure against complete dependence in the event of total loss of hearing but there are over 3,000,000 children having some degree of deafness so there is still room for a great many more lip reading classes.

When twenty thousand requests came to the Baltimore Board of Health from school doctors for removal of tonsils and adenoids and when by using every facility 2500 alone were operated on and nothing

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1 Barbara Rex: A New Hope for the Deaf, Atlantic Monthly, July, 1941, p. 83
whatever done for the remaining 17,500 we can see that the problem of preventing infections and deafness in school children is still a serious one.¹

Radium treatment to keep back lymphoid tissue would tide a child over the time when adenoids recur as they seem to do in thousands of cases. Since this condition is often a cause of deafness and radium reaches it at once it would seem urgent to provide for these treatments as a preventive measure.

Proper care and rest can often prevent after effects of poliomyelitis and the proper rest and care after an acute attack of rheumatic fever may prevent a lifetime of dependency.

Since rheumatic fever often causes serious heart impairment and since there are "over nine hundred new cases yearly in Boston alone,"² it is gratifying to mention the experimental work being done by the Children's Mission to Children and the Massachusetts General Hospital. As a prognostication it would seem that Boston at least is well on the way to preventing the fever from becoming so severe that the damage to the heart is unavoidable.

¹ Barbara Rex: Opus cit.
² New England Journal of Medicine, April, 1941 - Dr. Paul D. White 224. 627-638
The new Sharon Sanatorium at Sharon, Massachusetts, is conducting an experiment in hospitalization based on an attempt to determine whether a rheumatic child in a carefully controlled open-air environment can be kept free of respiratory infections which so often precipitate serious relapses and whether the rheumatic infection responds favorably to a rigorous open-air environment. There are over 4,000 beds available in Massachusetts for tuberculosis but only 177 for those with rheumatic fever so it seems justifiable to use the Sharon beds for this experiment instead of for tuberculosis as was previously done.

During the first two years of this experiment nearly fifty children have been cared for with excellent results. There was increase in weight and freedom from respiratory and recurrent rheumatic infections.

Based on the above experiment a proposed model hospital has been designed to carry on the work more extensively, caring for twenty-four children at a time and giving them the maximum sunlight, fresh air, and proper care.

The estimated approximate cost for construction of this Children's Pavilion is $64,098. and the
estimated cost of equipping is $5,631, making a total cost per bed of $2,905. The pavilion embodies all the desirable features disclosed to date by the study of rheumatic fever and marks a milestone in the successful treatment of the disease. The Board of Directors of the Sharon Sanitarium says, "It is hoped that in the years to come to render rheumatic fever as innocuous as diphtheria, the old scourge of childhood."

It is because similar work is being done all over the United States and because it is a scientific and important step in the prevention of the physically handicapped child that it seems worthy of detailed mention in a prognostic section of this thesis.

We are able to conclude that emotional factors are not being neglected. In a talk given at Stamford, Connecticut, on November 15, 1940, Miss Edith M. Terry representing the Children's Cardiac Clinic at Massachusetts General said, "The educational and recreational problems of any handicapped child require constant consideration."

The cardiac child in the majority of instances feels well after his acute episode of rheumatic
fever has ended, but he must remain in bed for months and needs a carefully thought-out program if later he is to make a readjustment with his classmates. Failure to keep up with one's friends in school creates a situation the average child is unable to face. For the adolescent many times it means the cutting short of an education so necessary where a means of livelihood must be limited to sedentary employment. One girl, who returned to school at the end of a long period of convalescence, said, "I can't go on with school. How can you expect me to? The girls in my class are all little kids in panty dresses and my skirts reach my ankles!!" While the proverbial short skirts of this day may prevent such an outcry, the fact remains that the wide difference in outlook between the ten year old child and the one of fourteen creates a situation that makes impossible any mutually satisfactory adjustment. The home teachers furnished by the public school system of Massachusetts has done away with much maladjustment. These teachers not only keep the children secure educationally, but, in addition, aid in the recovery plan by their insistence on study hours and prepared work.
One of the greatest dangers that any chronic illness presents is a sluggish mental attitude and the feeling, "what's the use? I'm ill. Why should I try?"

About seven hundred children made over eighteen hundred visits to the Massachusetts General Hospital Cardiac Clinic last year. These are cared for by the doctors in charge, visiting doctors to the homes, two case workers, a secretary, an occupational therapist, and volunteers from colleges, Junior League, and Federal Art Project.

We see that society has come a long way from the days when the Greeks placed such a high premium on physical perfection that they had little sympathy for crippled children. When the ancient city-state of Sparta passed a law which provided for the destruction of crippled children by exposure they were attempting to live up to the teachings of the Greek philosophers who said, "Let it be a law that nothing deformed be permitted to live."¹ It is true that the Romans gave some attention to crippled children but not on a very scientific basis. Caesar was an epileptic and the preservation of his life gave Rome a man such as Sparta.

never produced. In England during the Feudal system the disabled were considered necessary evils and it was only the church which extended any sympathy to the crippled.

"Physically handicapped persons were destroyed two thousand years ago - one thousand years ago it was felt that the physical handicap was the result of a visitation of Divine Providence. Five hundred years ago the crippled and disabled were ostracised, one hundred years ago they were tolerated but neglected. Today, thanks to an improved social attitude on the part of the people and the lawmakers we see that provision is made whereby the opportunity is offered the handicapped to prepare for making a living and to enter the business of making a living."

1 Ninth Biennial Report on Vocational Rehabilitation by the Mississippi State Board, Jackson, Miss.
INTRODUCTION TO CASE STUDIES

The three methods used in the preparation of this thesis were the historical, which included readings and inquiries; the statistical, which included material from the files of the Boston School Department and from letters and personal interviews; and the case work, which was obtained from the actual cases in my everyday work as a teacher of the physically handicapped child in the Boston School Department. In the consideration of the following cases I made a selection with the thought in mind of including those cases which were most representative of the entire group. A hundred cases were especially reviewed and a final sample of the following cases selected so as to include 1) children who have had a teacher for at least a year and who have been able to return to school; 2) children who have had a teacher continuously for a year or more and who will probably be unable to return to school or do any work outside their own homes; and 3) children who have been home ill without a teacher for a period of at least six months before having a home teacher assigned. By this type of selection I was
able to exclude many short term contacts, part time contacts, and a number in which the age limit of sixteen permitted the child or family to discontinue home instruction in the middle of the school term.

By this selection of cases for study I was also able to draw conclusions which I hope will be valuable in showing the advantages to the child and to the teachers of the first group in the greater adjustibility in school rehabilitation because of the home teaching, and in financial saving to the School Department because the child is not forced to repeat the grade as he would have done without the home instruction. The child's attitudes about school and illness will also be seen from the following cases. The cases selected for group two will show, I hope, the need for this group of children to carry on as nearly like normal as possible even though they may never recover. The emotional factors will be presented with the effects on other children in the household, and the parents as well as the child.

I was limited in my sample as it consisted of the cases I, myself, have had and only children from Boston proper during the past four years.
Another limitation was that the sample was not the Universe of all children in Boston who have had home teachers, nor was it the Universe of all children of this type that I, myself, have had. There were various other factors of limitations such as age, sex, nationality differences, economic differences, pupils from various schools, material and grades gathered from various teachers, whose ideas of success and failure may differ and whose prejudices will, no doubt, affect their opinions. In spite of these limitations, however, I believe that the study of the sample chosen shows enough of a cross section to show certain needs, trends, and the importance of the work being done by Boston. I shall not attempt to draw many irrevocable conclusions from such qualitative material, as the emotional reactions of parents, siblings, and pupil. The following cases show best the type of cases and the results obtained in the majority of contacts. Each case represents about twenty-five almost identical cases as to grade, sex, age, nationality, and mental ability and handicap.
CASE I.

P. T. was an eighteen year old Italian girl living in a congested North End district at the time of contact with the department of home instruction. She was the only girl in a small family consisting of mother and father and two brothers, one two years older and the other two years younger than herself. The client had spent most of her life in one hospital or another and had just returned home from a two year period at a tuberculosis sanitarium, and was now considered to be an arrested case but still far from well and unable to attend school.

The client had had various teachers at the hospitals and sanataria and was rated as a second year high school student at the time of contact. She was a very ambitious girl and wished to be a social worker when she was stronger. The teacher was asked by the doctor and social worker at the clinic to help the client accept the fact that she would probably always be in delicate health and must conserve her energy as much as possible. She was greatly depressed and felt that she was a failure as she had had to leave various part-time jobs she had attempted and because she had not yet completed
high school. She also seemed to feel that she had failed in her duty to her parents as "they had always done so much for me and I have never been anything but a burden to them."

It seemed necessary to the teacher to help this girl accept her limitations and face reality if she were to help her in her school work and in her personal adjustments with other school children in the neighborhood.

Beginning with her interest in reading and English it was possible to interest the client in reading about other people who had accepted the handicap of ill health and still carried on cheerfully and with the maximum of efficiency. History and mathematics were gradually added to the course of study and at the end of two years of home instruction the client had completed her high school work and was graduated. During the three hours of weekly instruction the idea of trying part-time work was presented by the social worker at the clinic and a position was found in a neighborhood bakery. Here the work was clean, light, and within the limits of success for the client. The small salary helped her to a feeling of greater independence and help to her
parents for the first time. Since she had reached the age limit for having a home teacher (twenty-one) she was no longer able to study under supervision but was planning to continue her reading and study for self-interest and had apparently given up the idea of attending college or being a social worker. Her I.Q. was low, her ability to concentrate poor, her health very poor, so it seemed best to doctors, social worker, parents, and teacher that she accept her limitations and this she has seemed to have done. She was more cheerful, interested in making friends of her own age, and having as much interest in and enjoyment out of life as was possible.

It seemed to all concerned that the home instruction and personal interest of the home teacher had helped carry this client through a difficult emotional and physical readjustment period, perhaps saving herself and her family from a lifetime of maladjustment and depression.
CASE II.

E.M. was seven years old at the time of contact and had never attended school and had no rating for any school work done during the years she had spent in a hospital, a victim of heart involvement due to rheumatic fever when she was three years old. There were eight other children and the family of eleven were living in a crowded tenement of three rooms in East Boston.

Home instruction was begun at the time of contact, which was in January, and by June the child had completed the work of the first grade. The following year home instruction was continued from September until January when the child was permitted to attend school for half days. Home instruction was continued three afternoons a week and again in June promotion was earned and E. M. was now in the third grade. Thus in one and a half years of home instruction and personal tutoring a badly handicapped child was helped to reach a place in school where she might continue without being too far behind her classmates. Much of the strain of school work was removed and she received the personal help that no teacher in school, having classes of thirty
or more would have been able to give her.

I have presented this case as an example of an ill child who never having attended school or had instruction of any sort is helped to reach a certain grade before being returned to school and thus avoiding what to a child would have been a serious and possibly unbearable situation, that of being in the first grade with five year old children when chronologically she should have been in the third. The emotional importance of inferiority and of not belonging might easily leave lifelong marks on the personality of a child made to face such a situation in school.

It will be seen from this sort of case that home instruction had doubled and sometimes trebled benefits. It bridges the gap of hospital and school making a gradual return to normalcy rather than an abrupt one, which might overtax the newly regained health and strength; it helps bring the student to his proper place in school and thus prevents possible failure; and it is economically sound as the expense of home instruction has been shown to be very little more than the expense of a failure in school and carrying the child through the same grade twice. The emotional and physical
effects are obvious and cannot be counted in dollars but in sounder personalities, with greater confidence in their own ability and success on the part of the client and a sure realization on the part of parents, doctors, school authorities, and social workers that it is one more step in the modern scheme of social work when underprivileged and handicapped children are being helped in every way possible to maintain themselves and become independent in spite of their handicaps. It is a far cry from the inhuman and degrading practices of years ago when a weak body meant either being accepted as a dependent or discarded by society as a physical misfit who could be of no value to himself or society. The law of the survival of the fittest may be still in practice but we have yet to be told whether or not by that we mean the survival of the physically, mentally, or spiritually fittest. Perhaps a combination of all these qualities make up the truly fit, who are strong in character as well as body and in brain as well as brawn.
Another example of the type of cases served by the teachers of the physically handicapped in their own homes shows the less constructive and less optimistic side of this service but gives one a fresh realization that emotional factors and humane implications are not forgotten even in a system as large as Boston. Cases of this type are all too numerous and pathetic in their frequency. These are cases where the only practical claim to the public expense of a home teacher rests on the possibility that science will discover that long sought-for elixir or cureall that can mend badly damaged hearts or replace new ones for old. I refer to the "hopeless" cases who cannot be expected to live for more than a few months or a year or two at most; - cases which have been sometimes returned home from the hospitals and convalescent homes to make way for children whose prognosis is more favorable - children who themselves often feel ambitious and eager to continue their school work so that they will "pass" into the proper grade at the end of the school year - children whose strength and mental powers seem to be gradually lessening and whom only a miracle could make well enough to return to school.
Should these children be denied the comfort of carrying on as long and as normally as possible because of the little expense involved? Have we become so financially cautious that we cannot condone an expenditure of money that will bring no more practical return than a thankful family and the peaceful complacency of a dying child? I think not.
CASE III.

M. S. was a sixteen year old student at Boston Girl's High School when she first applied for home instruction after being ordered to bed by her physician because of a recurrence of trouble from a damaged rheumatic heart. This was no new event for M. S. as her life had been a series of these interruptions to her school work and normal activities ever since she had first been a victim of rheumatic fever at the age of nine. The client was in her third year at high school and most anxious to continue her school work at home so that she would be given credit for third year work and be able to return to school a senior the following September. This she did with efficiency, intelligence, and interest. Her physician was still hopeful at this time that with care she might be able to lead a fairly normal life for some years to come. He realized too "her keen interest in her school work and her great depression when she was forced to discontinue it. I have weighed both factors for M. and feel that if she is to recover her maximum strength she must be made to feel that her school work can continue at least at home."
her cheerfulness returned, the rest in bed once more rallied her strength, and the following fall she was able to return to school as a senior. Within a few months she had another recurrence and hope was given up by her own doctor and specialists but her school work was continued. She was presented with a high school diploma in June and during the following summer died.
CASE IV.

P. de P. is a fourteen year old Italian girl living in the North End of Boston. She was referred to us by the doctors at the Long Island Hospital as having recovered sufficiently from a sudden acute attack of multiple scleroses to be returned home and have home instruction. Before her illness she was a bright, alert girl, according to her teachers at the Michael Angelo School, and had finished the work of the sixth grade. She had been hospitalized for a year and although recovered sufficiently to be returned home still had such an unsteady gait and emotional instability that it would have been unwise for her to be returned to school.

Home lessons for the sixth grade were started and it was soon apparent to the home teacher that her alert mentality had somehow been affected by her illness as she had little ability to concentrate and a very poor memory. She was especially nervous and for several months it was necessary to have a great deal of patience and understanding. Gradually she resumed her ability to concentrate and study and she was promoted to the
eighth grade at the end of the school year. According to her medical report it is extremely doubtful if she will ever be able to attend school again so she will probably continue to have home instruction as long as her health permits. With the disease from which she suffers there is a strong possibility of recurrence and often gradual deterioration. In spite of her dubious prognosis it is important to keep her occupied and feeling that she is carrying on with her daily work. Both the family and herself as well as society are benefited from this procedure. There is no other plan that would carry her through a very difficult time. At home she is being supported by her parents and is happier and healthier than she would probably be elsewhere. She is not a mental case so would not be eligible for special mental teachers yet her emotional instability would make it unwise for her to attend school even during the period between recurrences if her physical health were to permit a return to school. She is unfortunately one of life's misfits and society has no special place for an inbetween case such as hers. The present arrangement of home instruction carrying on her lessons when she is
able helps keep her as alert as is possible without undue strain and stress and competition with normal children.
Although most of the pupils receiving home instructions are at home for the greater part of one year at least and often longer I should like to present the cases L. Q., M. M., and J. de G. as examples of another kind of service done for the physically handicapped. These cases are all alike in that they were ninth grade pupils who had planned to be graduated in June, but who met with physical disaster of three different kinds a few months before graduation and would have been unable to complete their work without home instruction. One broke his leg playing football in the school yard; another developed a curvature of the spine which necessitated such a tight, heavy brace that she was unable to sit in school for long enough periods to attend school but who was perfectly able to have home instruction; and the third child was ordered home by the school doctors for rest in bed as she had been a previous rheumatic patient and was running a slight temperature which might signify a recurrence unless great care was taken.

It was my privilege to see each of these children receive his diploma this June and to see their faces when they realized that they were not to be made to repeat the entire ninth grade because they
had met physical disaster a few months before graduation. It seems to be important to a child's sense of values that he keep up with his friends and classmates and while it would be a simple matter to present diplomas to these children even though they had missed three months' school and had not had the services of a home teacher, I believe that the psychological effect would be entirely different for the clients, the other pupils, and the parents. Diplomas and promotions are something to be earned and not to be given out unless they have been earned. Something for nothing seems to be the desire of many individuals and it is not a help but a disservice to foster this idea in the minds of our children or parents. Respect for the school system and for promotions might suffer. Aside from this latter rather esoteric consideration the actual school work done at home forms a good basis for beginning school the following fall and the merit of the home instruction on this basis alone is obvious.

Thus it will be seen that the cases receiving home instruction are varied and require individual and special thought in each case. Whether the child had a broken leg, a damaged heart, chorea,
infantile, or an incurable disease it seems important to that child and to the parents to feel that he is carrying on as near like normal children as possible so that in the event that he does return to school the work of taking up life as before the illness will not be too strenuous and demanding physically or emotionally. In the event that the child fails to recover there is great satisfaction in knowing that as long as possible he was treated like his chums and classmates who had a purpose and plan in life but who might also any day enter into the ranks of the physically handicapped.
CONCLUSION

This study shows that there has been a gradual but decided trend on the part of society to a greater awareness of the special needs, deprivations, and special planning necessary for the physically handicapped child. Society has also reached a point where it realizes that from an economic as well as emotional and sentimental reasons prevention is less expensive than cure and care and that training of the handicapped is far more economical in the end than charges to the state for maintenance in the various categorical forms of relief for dependent handicapped individuals. My study has shown that from an educational standpoint the child who has home instruction and continues to develop mentally and intellectually is a greater asset to society and less expense to the educational department than one who is permitted to indulge in an educational slump and requires an entire year to gain what has been lost by absences.

The study also presents facts which show that doctors and educators are gradually realizing that a cooperative program in health and education cannot stop with care, education, placement, and follow-up of the handicapped. It must include what
is still more important than all these things: prevention.¹

"Parents must be instructed how to guard children against accidents and disease. Children must be taught how to avoid accidents. Better obstetric care for mothers will reduce birth injuries and crippling due to syphilis. Codliver oil and adequate exposure to sunlight will largely prevent rickets. The complete use of pasteurized milk from cows free from tuberculosis and the protection of children against exposure to active cases are factors in preventing bone and joint tuberculosis. Periodic medical supervision of children, especially in the pre-school period, will reveal injuries when treatment can be most effective.

"With the Federal funds now available it is possible for agencies, following epidemics of infantile paralysis, encephalitis, or meningitis, to provide immediate diagnosis and treatment so as to prevent and reduce the physical handicap which may follow the disease.

"Cooperation between private and public groups is of the greatest importance and the interest and understanding of private groups is frequently

¹ Children in a Democracy - White House Conference, 1940
responsible for the improvement in public and private facilities used for the care of crippled children."¹

With the Federal funds provided and with the requirement of registering crippled and handicapped children I have shown that more and more resources are being and will be offered by society to the child who is physically handicapped with the hope of rehabilitation and prevention. As the various states are becoming better acquainted with the problem and how to meet it and as social agencies are becoming more and more willing for self-evaluation of their own failings we see a decided increase in insight and understanding. My material and my experience both have shown me that the procedures and preparations for meeting the problem of the handicapped are becoming more efficient, more comprehensive, and more far-reaching.

My research has shown me that one of the greatest present needs is reaching rural children. Providing care for those who live in the cities is now being rather well done but those who live in rural communities seem to be somewhat neglected still.

I have learned from this study and from my experience with the handicapped child that organizations must work not only with the handicapped
directly but must lead in fighting disease, ignorance, poverty, and fear, since the handicap is usually the result of one of these.

The emotional problem must also be considered since the traumatic results of illness and the inferior feelings of the cripple often continue long after the individual has been cured or has apparently accepted his handicap on a reality basis facing his limitations with what seems to be tolerance and acceptance on the surface but maintaining a smoldering frustration and despair within his conscious or unconscious mind. My own personal experience with cardiac cases had led me to believe that it is the rare individual (especially child) who can accept the fact of ill health and deformity with the equanimity and placidity he often shows his friends and family.

My experience has also shown that the problem of the handicapped child's education must be handled far better than it is at the present time in any state. Resources have been only tapped and it is the minority of handicapped children who are receiving as good an education as their more fortunate contemporaries. Even Boston, which ranks highest of
all cities studied in the provision for home instruction, permits only three hours a week for each child. I have found in many cases this is insufficient for children of high school grades. I have also found considerable lack of cooperation on the part of some principals and teachers in the schools, who are so concerned with the well children and covering a certain amount of work per year per pupil and who are also concerned and rather resentful that the class standing in attendance is being lowered by the sick child that they are inclined to forget their responsibility to the child who is deprived of a normal school life.

My study of this problem has made me even more interested than previously in this phase of social work and I hope it shows that in the very near future there will be no child who is physically and mentally handicapped who is so deprived and neglected in his handicap that he must look at life with the despair of the Braille-less Milton and cry as he did:

"When I consider how my light is spent
Ere half my days in this dark world and wide,
And that one talent which is death to hide
Lodged with me useless..."  

1 Milton's Sonnet on his Blindness
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A BILL OF RIGHTS FOR THE HANDICAPPED CHILD

The handicapped child has a right:

1. To as vigorous a body as human skill can give him.
2. To an education so adapted to his handicap that he can be economically independent and have the chance for the fullest life of which he is capable.
3. To be brought up by those who understand the nature of the burden he has to bear and who consider it a privilege it help him bear it.
4. To grow up in a world that does not set him apart, which looks at him, not with scorn or pity or ridicule - but which welcomes him, exactly as it welcomes every child, which offers him identical privileges and identical responsibilities.
5. To a life on which his handicap casts no shadow, but which is full day by day with those things which made it worthwhile, with comradeship, love, work, play, laughter, and tears - a life in which these things bring continually increasing growth, richness, release of energies, joy in achievement.

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<thead>
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<th>Date..........</th>
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<tbody>
<tr>
<td>Name........</td>
<td>Sex.... Date of Birth....</td>
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<td>Residence...</td>
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<tr>
<td>Father's name...</td>
<td>Occupation........</td>
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<td>Mother's name...</td>
<td>Occupation........</td>
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<td>Child's disability...</td>
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<td>Additional defects...</td>
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<td>TREATMENT (To be filled out for all cases reported)</td>
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<td>Family physician...</td>
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<td>If not receiving, why not?...</td>
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<td>When last examined...</td>
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<tr>
<td>Recommendations...</td>
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<tr>
<td>EDUCATION (To be filled out for minors of school age and over)</td>
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<td>Grade and school last attended...</td>
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<td>Physically able to attend school?...</td>
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<td>Mentally able to do school work?...</td>
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<td>Remarks...</td>
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<tr>
<td>(Minors beyond school age) Nature &amp; length of employment, if any.....</td>
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<tr>
<td>If unemployed: Employable?...</td>
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<td>...what training given?...</td>
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Return to Supervisor of Special Schools and Classes, State Department of Education.

1 Copy of form to be filled out by every teacher of physically handicapped child before beginning home or hospital instruction.
SHORT RESUME OF VOCATIONAL REHABILITATION SERVICE

Funds for establishing the Vocational Rehabilitation Service were appropriated by the Legislature of 1937. These funds are administered by the State Board of Education through the Department of Education and are matched dollar for dollar by Federal funds allocated to the various states under the Vocational Rehabilitation Act of 1920. At the present Vermont is spending $10,000 a year for this work, which matched with Federal funds, makes a total of $20,000 being spent in the State for the administration of this service.

The purpose of a vocational rehabilitation program is to fit, through training or re-training, physically handicapped people for regular remunerative employment. To be eligible for this service one must be a resident of the State of Vermont at least one year before making application, sixteen years of age or over, and both physically and vocationally handicapped. The four major groups served are the orthopedic, whose disabilities to their arms and legs have been brought about because of industrial or public accidents, disease and congenital malformations; the hard of hearing and totally deaf; the defective vision of totally blind; and the pulmonary tuberculous and cardiac.
The money for this service can be used to pay for the actual cost of training in a vocation leading to a specific job objective. Under the course of training can be included the actual tuition, cost of books and supplies and the transportation of the individual to and from the training agency. Artificial limbs and orthopedic braces can be purchased if their use is a definite factor in the individual's return to immediate employment or if such appliances are needed in order that the handicapped person might more readily be trained in a vocation.

The scope of training can and usually does include anything from shoe repairing, barbering, watch and clock repairing and many of the less technical trades, to some few professions and very highly skilled trades, for which university training is necessary and desirable. However the latter vocations are the exceptions to the rule and generally speaking the vocational rehabilitation program can best serve the disabled group by training them for the less technical sedentary types of work.

In order to determine what treatment is required for the vocational rehabilitation of a particular individual, a thorough diagnosis must be made of his physical, mental, social and economic condition,
as well as of the training and employment opportunities in his community. When these facts are secured, arrangements are made for the person to be given the services he requires.

State rehabilitation departments do not maintain workshops, institutions, and other facilities. All necessary services are secured through purchase or cooperative arrangement with existing public and private schools, commercial and industrial establishments, hospitals, social organizations, and any other agencies in a position to assist.

The entire program is based on the fact that physically handicapped people, whose disabilities prohibit them from returning to a former occupation or from entering industry perhaps for the first time, can be trained in specific vocations which will allow them to be employed on a regular job and thus take a financially independent place in their community which is rightfully theirs.
THE CHILDREN'S CHARTER

President Hoover's White House Conference on Child Health and Protection, Recognizing the Rights of the Child as the First Rights of Citizenship, Pledges itself to These Aims for the Children of America.

I. For every child spiritual and moral training to help him stand firm under the pressure of life.

II. For every child understanding and the guarding of his personality as his most precious right.

III. For every child a home and that love and security which a home provides; and for that child who must receive foster care, the nearest substitute for his own home.

IV. For every child full preparation for his birth, his mother receiving prenatal, natal and postnatal care; and the establishment of such protective measures as will make child-bearing safer.

V. For every child health protection from birth through adolescence, including: periodical health examinations and, where needed, care of specialists and hospital treatment; regular dental examinations and care of the teeth; protective and preventive measures against communicable diseases; the insuring of pure food, pure milk, and pure water.

VI. For every child from birth through adolescence, promotion of health, including health instruction
and a health program, wholesome physical and mental recreation, with teachers and leaders adequately trained.

VII. For every child a dwelling-place safe, sanitary, and wholesome, with reasonable provisions for privacy; free from conditions which tend to thwart his development; and a home environment harmonious and enriching.

VIII. For every child a school which is safe from hazards, sanitary, properly equipped, lighted, and ventilated. For younger children nursery schools and kindergartens to supplement home care.

IX. For every child a community which recognizes and plans for his needs, protects him against physical dangers, moral hazards, and disease; provides him with safe and wholesome places for play and recreation; and makes provision for his cultural and social needs.

X. For every child an education which, through the discovery and development of his individual abilities, prepares him for life; and through training and vocational guidance prepares him for a living which will yield him the maximum of satisfaction.

XI. For every child such teaching and training as will prepare him for successful parenthood, home-making,
and the rights of citizenship; and, for parents, supplementary training to fit them to deal wisely with the problems of parenthood.

XII. For every child education for safety and protection against accidents to which modern conditions subject him - those to which he is directly exposed and those to which through loss or maiming of his parents, affect him indirectly.

XIII. For every child who is blind, deaf, crippled, or otherwise physically handicapped, and for the child who is mentally handicapped, such measures as will early discover and diagnose his handicap, provide care and treatment, and so train him that he may become an asset to society rather than a liability. Expenses of these services should be borne publicly where they cannot be privately met.

XIV. For every child who is in conflict with society the right to be dealt with intelligently as society's charge, not society's outcast; with the home, the church, the school, the court and the institution when needed, shaped to return him whenever possible to the normal stream of life.

XV. For every child the right to grow up in a family with an adequate standard of living and the security of a stable income as the surest safeguard against
social handicaps.

XVI. For every child protection against labor that stunts growth, either physical or mental, that limits education, that deprives children of the right of comradeship, of play, and of joy.

XVII. For every rural child as satisfactory schooling and health services as for the city child, and an extension to rural families of social, recreational, and cultural facilities.

XVIII. To supplement the home and the school in the training of youth, and to return to them those interests of which modern life tends to cheat children, every stimulation and encouragement should be given to the extension and development of the voluntary youth organizations.

XIX. To make everywhere available these minimum protections of the health and welfare of children, there should be a district, county, or community organization for health, education, and welfare, with full-time officials, co-ordinating with a state-wide program which will be responsive to a nation-wide service of general information, statistics, and scientific research. This should include:
(a) Trained, full-time public health officials, with public health nurses, sanitary inspection, and laboratory workers.

(b) Available hospital beds.

(c) Full-time public welfare service for the relief, aid, and guidance of children in special need due to poverty, misfortune, or behavior difficulties, and for the protection of children from abuse, neglect, exploitation, or moral hazard.

FOR EVERY CHILD THESE RIGHTS, REGARDLESS OF RACE, OR COLOR, OR SITUATION, WHEREVER HE MAY LIVE UNDER THE PROTECTION OF THE AMERICAN FLAG.