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A follow-up investigation of children who have been studied in the Special Education Clinic for the school year 1953-54

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A FOLLOW-UP INVESTIGATION OF CHILDREN WHO HAVE BEEN STUDIED IN THE SPECIAL EDUCATION CLINIC FOR THE SCHOOL YEAR 1953-54

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CHAPTER I

THE PROBLEM AND A DESCRIPTION OF THE SPECIAL EDUCATION CLINIC

It is gratifying to see education keeping pace with industrialization, mechanization, natural science and many other areas. The familiar old adage, "They don't teach school like they did when I was a child", is becoming encouragingly true. The average person, however, realizes that there has been a change but may not realize that this change has meant progress. The development of special education is only one rung of the ladder of educational progress, but without it many children would not have the opportunity for a normal and happy life.

I. THE PROBLEM

Statement of the problem. It was the purpose of this study to make a follow-up investigation of the children who have been studied in the Special Education Clinic. This investigation involves the children who were referred, interviewed and examined in the clinic from September 1953 until July 1954. It should determine (1) the general nature of the problems and facts concerning the children seen in that year, (2) the progress they have made and the benefits received as a result of the clinic, (3) the effectiveness of

the clinical procedures, (4) the over-all attitude of the parents of the children who visited the clinic, and (5) the suggestions offered to improve the clinical program.

The importance of the investigation. Many times a clinician will follow therapeutic techniques and diagnostic procedures, gaining positive results and a feeling that the program was successful. The clinician then discharges the child and in most cases a follow-up investigation is never made. What happens to the children who were studied? An answer to this question can and should help to determine the effectiveness of the clinic and perhaps provide criteria for modification and improvement of the clinical procedures.

II. A DESCRIPTION OF THE SPECIAL EDUCATION CLINIC

The history of the clinic. The Special Education Clinic has been a part of Indiana State Teachers College since the school year of 1938-39. Plans for the clinic were drawn up and construction was started in 1939-40 school year. After careful consideration it was decided to locate the clinic in the Laboratory School in order that the facilities would be available to the children of that school.

Dr. D. W. Morris, now president of Southern Illinois University, was the first director of the Special Education Clinic. He began his work in 1939, holding the combined

titles of Associate Professor in English and Director of Speech Correction. In the beginning the Clinic placed much emphasis upon speech correction. Every few years a new phase of special education was added until now the program includes speech correction, hearing conservation, problems of the mentally retarded and physically handicapped, and psychological services.

In 1941 the Special Education Clinic was still a part of the Speech Department, which included radio, forensics and theater; however, by this time the Clinic staff had grown from one to three members. Dr. Morris was the chairman and Mable-Louise Arey and Margaret Pankaskie made up the rest of the staff. This being the year that the law concerning the hard of hearing had come into effect, the instructional program was altered to include training for hearing testing and hearing therapy. The areas of re-education and sight saving and remedial reading were made possible by adding a new member to the staff. Lip reading instruction was also added to the re-education program. The Clinic cooperated with the County Welfare Department and the Vocational Rehabilitation Department.

The 1942-43 school year found the staff multiplied to include a field hearing tester, a supervisor of hearing therapy and an assistant in routine intelligence testing. During this year "out-patient day" began which included

examination, diagnosis and a consultation period. One day each week was set aside as "out-patient day", so as to free each staff member from his routine duties for that day.

In 1943-44 the Special Education Clinic was still a part of the Speech Department. The testing and follow-up program of the Laboratory School was continued as in previous years. The off-campus services again included the state hearing testing program and the out-patient services.

Early in 1945 it became apparent that a Department of Special Education should be considered, and plans were made for the proposed department; however, the clinic continued its operation under supervision of the Department of Speech.

In the years that followed the clinic continued on much the same bases as previous years, increasing its staff membership and its range of special education areas. In 1948 Dr. Rutherford B. Porter replaced Dr. Morris as head of special education. The clinic became a part of the Education Department in 1947. In 1951, the report to the Dean of Instruction stated that "Special Education, a Division of the Department of Education, has operated this year independently from its mother department but within policies and regulations of that department. At all times the Head of the Education Department has been informed of the activities

which he felt to be advisable."[1]

Description of the present situation. To describe the present Special Education Division and its clinic, there must be a knowledge of the aims of this Division. The following is a list of the aims:

> (1) To train teachers, (2) to provide re-education for college students in the areas of speech correction, hearing conservation, psycho-therapy, remedial reading and vocational counseling, (3) to provide clinical services for Vigo County and Terre Haute, and (4) to conduct special classes for the mentally retarded and crippled children.[2]

These clinical services which probably orginated in the teacher-training program are now essentially professional even though some of the routine tasks are still a part of the teacher-training program.

The clinical services primarily have to do with college students, out-patients, laboratory children and those who are referred from the Welfare Department and Vigo County Rehabilitation Center.

The present staff, headed by Dr. Rutherford B. Porter, includes a supervisor in hearing, an instructor of a special

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[1]Rutherford B. Porter, Division of Special Education, Annual Report for Year Ended June 1951, Indiana State Teachers' College, Terre Haute, Indiana, 1951.

[2]Ibid., 1954.

class for the physically handicapped, a clinic supervisor in reading, an instructor for mentally retarded children, a supervisor in speech correction, a part time physical therapist, a staff secretary, a part time clinical assistant, and a graduate, clinical assistant.

The philosophy of the Special Education Clinic is based on the recognition of the existence of wide deviations from person to person as to their abilities and skills. It is realized that the free public schools of the country do not necessarily mean that each child has an equal opportunity for education. It is the purpose of the Division and Clinic to help each child obtain more equal opportunity for education.

III. HISTORICAL FACTS

The Division of Special Education has grown since its beginning in 1938 from a staff of one to a staff of nine. It has not only grown in staff members but also in the number of areas of special education it offers. Expansion can also be noted in the various types of groups to which the Division offers its services.

CHAPTER II

INVESTIGATING PROCEDURES AND RESULTS

In this chapter the investigating procedures will be explained and the results interpreted. It must be remembered that the findings in no way represent a total evaluation of the services rendered at the Special Education Clinic over a period of years, but present a picture of clinical services for the school year of 1953-54.

I. SELECTION OF THE SAMPLE

The number. This study is one sample group of sixty-six children who had visited the Clinic in the 1953-54 school year. The data about them is from the files of the Special Education Division, Indiana State Teachers College.

An unselected group. Age, sex, or reason for referral did not serve as a basis for selection. The children in the Laboratory School and those who were referred to the Clinic as speech problems are omitted from this study.[3] The method of selection, with the above exceptions in mind, included every child who visited the clinic for the purpose of receiv-

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[3]The speech cases are excluded because they are not considered out-patients due to the fact that they are usually seen more than one time. The same is true for the Laboratory School children.

ing its services from September, 1953, to July, 1954. In no way was the number limited, and with the exception of Laboratory School pupils and speech cases, the sixty-six children represent the total number of children for the year on a one visit out-patient diagnostic basis.

II. THE QUESTIONNAIRE

The construction. Data for this follow-up investigation were obtained through a questionnaire[4] in which the questions were both simple and meaningful. Preceeding the questions were four lines of instructions which explained specifically what was to be done. There were nineteen questions and in all but two instances the questions were answered by merely encircling either the "Yes" or the "No" at the end of the sentence. In these two instances the person responding was to put a check in front of the desired answer. Approximately 55 per cent of the questions were worded so that the answers had a direct reference to the clinic or showed specific clinical results. The other 45 per cent were merely descriptive of the clinic and of the parental attitudes toward the clinic. Table I presents the two types of questions and designates into which type each question falls.

The actual questionnaire, which was lithographed on

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[4]See Appendix A.

TABLE I

QUESTIONNAIRE EVALUATION--
AS TO THE NATURE OF QUESTIONS

Specific results shown	Descriptive results shown
Question number	Question number
1	3
2	7
4	10
5	11
6	12
8	14
9	15
13	18
16	19
17	

one page and was sent first class mail with a self-addressed, stamped envelope. An explanatory-type letter[5] signed by the Director of the Special Education Division accompanied it.

To whom sent. The questionnaire and letter were sent to the parents of each child, and in the Terre Haute city schools, to the child's teacher at the time of the visit to the clinic. If the school principal was the one who was involved, the questionnaire was mailed to that person.

The geographical distribution of those children seen in the 1953-54 school year and who received questionnaires included twenty-seven cities and two states, Indiana and Illinois. Terre Haute was the city which sent the largest number of children to the clinic. A list of other cities can be found in Table II.

The parents were given approximately one month to return the questionnaires before written reminders were sent to them. Reminders were not sent to the teachers. The sample was then treated as two groups. One group consisted of those who returned the questionnaire before the mailing date of the reminder and the other of those who returned it after receiving the reminder.

The questionnaire response. Of the sixty-six question-

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[5]See Appendix B.

TABLE II

GEOGRAPHICAL DISTRIBUTION AND NUMBER OF CHILDREN IN VARIOUS INDIANA AND ILLINOIS CITIES, IN THE SCHOOL YEAR OF 1953-54

City	State	Number
Bloomingdale	Indiana	1
Brazil	Indiana	3
Clinton	Indiana	1
Converse	Indiana	1
Covington	Indiana	1
Danville	Indiana	2
Dugger	Indiana	1
Francisco	Indiana	1
Gabrill	Indiana	1
Hillsboro	Indiana	1
Humbolt	Illinois	1
Ladoga	Indiana	1
Lawerenceville	Indiana	2
Linton	Indiana	2
Marshall	Illinois	1
Martinsville	Indiana	1
Matoon	Illinois	2
Newport	Indiana	1
Okland City	Illinois	1
Paris	Illinois	2
Rockville	Indiana	2
Rosedale	Indiana	2
Sullivan	Indiana	2
Terre Haute	Indiana	27
Vincennes	Indiana	4
Williamsport	Indiana	1
Worthington	Indiana	1
Total		66

naires which were sent to parents, 66 per cent returned them before the reminders were sent to them. The teachers, which numbered fourteen, returned 70 per cent of their questionnaires. This makes a total of 80 questionnaires that were sent with a return of 68 per cent. See Table III for a comparison of the percentages for this first group.

The written reminder[6] was sent to twenty-two parents, with a 40 per cent return. Approximately 20 per cent of the teachers, although they were not sent a reminder, returned their questionnaires at this time. In all, 38 per cent or ten out of twenty-six people, returned their questionnaires after the mailing of the reminders. Whether this response was due to the reminders it is not known, but it is assumed that at least the returns from the parents were a result of the reminders. Table IV presents this data.

A total of sixty-six questionnaires were sent to the parents and fourteen were sent to the teachers. The total response for the parents is 80 per cent and for the teachers it is 79 per cent, giving a total response for both teachers and parents of 79 per cent. Table V presents a more complete comparison of the responses.

It is important at this point to explain that while a high percentage of the questionnaires sent to the teachers

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[6]See Appendix C.

TABLE III

NUMBER AND PERCENTAGE OF RESPONSE OBTAINED FROM PARENTS AND TEACHERS BEFORE THE REMINDER WAS SENT

Group	Number sent	Number returned	Number remaining	Percentage returned
Parents	66	44	22	66
Teachers*	14	10	4	70
Total	80	54	26	68

*A written reminder was not sent to the teachers.

TABLE IV

NUMBER AND PERCENTAGE OF RESPONSE OBTAINED FROM PARENTS AND TEACHERS AFTER THE REMINDER WAS SENT

Group	Number sent	Number returned	Number remaining	Percentage returned
Parents	22	9	13	40
Teachers*	4	1	3	20
Total	26	10	16	38

*A written reminder was not sent to the teachers and the figures shown in this table merely represent those questionnaires that were returned after the mailing date of the reminder.

TABLE V

THE TOTAL NUMBER AND PERCENTAGE OF RESPONSES OBTAINED FROM PARENTS AND TEACHERS

Group	Number sent	Number returned	Number remaining	Percentage returned
Parents	66	53	13	80
Teachers	14	11	3	79
Totals*	80	64	16	79

*The total percentage of questionnaires that were returned shall be considered on the basis of the parental response alone, since the teacher's group has been dropped from this study.

was returned, it became necessary from a practical standpoint to base the results of the study on the parents' group. The actual number of questions answered by teachers was too few to arrive at a valid conclusion. The reasons for this incompleteness of answers cannot definitely be determined, but it appears to be due to (1) questions pertaining primarily to the parents, (2) directions insufficent for the teacher, (3) assumptions that those involved would use intuitiveness in interpreting the questions, and (4) assumptions that the teacher or principal had adequate information concerning the childs visit to the clinic. Of all the questions that were to be answered, the teachers left 46 per cent blank. Questions four, eight, thirteen, and fifteen were left blank most frequently, while questions seventeen, eighteen and nineteen were answered most frequently. Table VI illustrates the percentage of blanks for each of the nineteen questions.

The letter. An explanatory letter was sent along with the questionnaire which explained its purpose and pointed out that the effectiveness of the clinic was dependent upon the responses received. It was emphasized that the information would enable the clinic services, both past and present, to be evaluated and plans to be made for any changes which might be necessary for the future.

Written comments. The letter also urged the parents

TABLE VI

PERCENTAGE AND NUMBER OF QUESTIONS LEFT BLANK BY SCHOOL PERSONNEL

Number of question	Number left blank	Percentage left blank
1	4	36
2	5	45
3	4	36
4	7	63
5	6	54
6	5	45
7	3	27
8	7	63
9	8	72
10	2	18
11	5	45
12	4	36
13	7	63
14	4	36
15	7	63
16	3	27
17	1	9
18	0	0
19	0	0

and the teachers to write any further suggestions which they might have on the back of the questionnaire. The fifty-three questionnaires that were returned contained twenty-three separate discussions written as directed. Their contents included constructive suggestions, additional questions, further explanations of questions, expressions of gratitude, expressions of concern for their child, and direct critisms.

Approximately 39 per cent of the written discussions contained information that further explained the questions. Expressions of gratitude made up 30 per cent, and 17 per cent was devoted to additional questions. The remainder of the written discussions was composed of expressions of concern for the child, 5 per cent; direct criticisms, 5 per cent; and constructive suggestions, 5 per cent.

The two types of comments which are of most concern to the clinic are those pertaining to direct criticisms and those giving constructive suggestions. The only significant comment, and the only one that shall be mentioned here, is the one that has to do with clinical fees.[7] The comment was received from a mother who stated "I am willing to pay, for as a free service I personally hesitate to bother the staff with questions that later occur." This seems to be the opinion of about one-half of the parents questioned, if not

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[7] A fee schedule was established in November 1954, but was not in effect for this group of parents.

specifically then in general. A comparison of the comments can be seen more readily in Figure 1, which also presents the percentage distribution of this data.

The written reminder. The parents and teachers, as previously stated, were given about a month to return their questionnaires. Written reminders were then sent to parents who had not returned their questionnaires. It had been decided by this time that the teachers would be dropped from the study since their over-all percentage of unanswered questions was so high. The written reminders were sent on two-cent post cards. The follow-up post cards were mailed, twenty-six of them, and within two weeks 40 per cent of the unreturned questionnaires had been returned. It is therefore concluded that the reminder was a success and proved to be most helpful to this investigation.

III. TABULATION

Question number one. "Did you have difficulty in finding the clinic?" The fifty-three parents who returned questionnaires stated, 100 per cent, that they had no difficulty in finding the clinic. One person stated that she could not answer the question because she was ill at the time and was unable to accompany the child to the clinic.

This seems to indicate that, although there are no

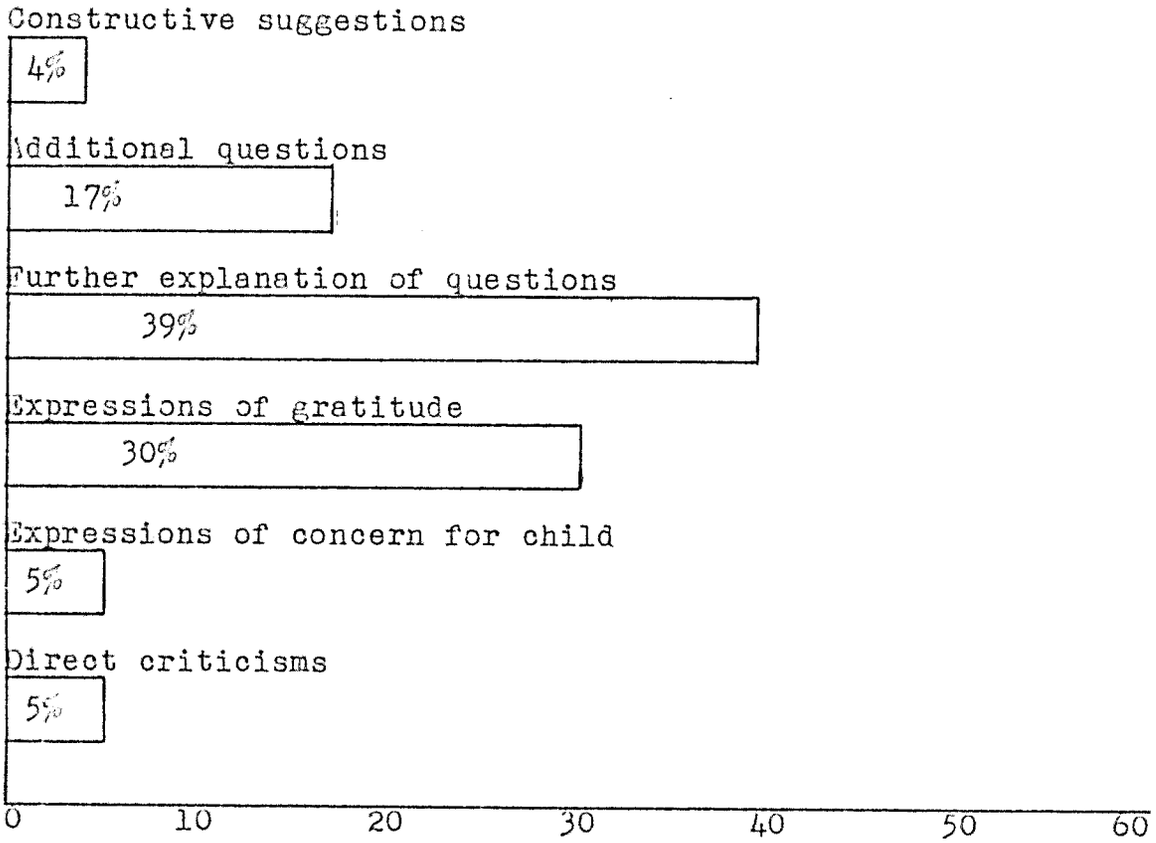

FIGURE 1

THE DIFFERENT TYPES OF DISCUSSIONS FOUND IN THE WRITTEN RESPONSES

signs pointing the way to the clinic for its visitors and although the clinic is not conveniently on a first floor, few or none had difficulty in locating it.

Question number two. "Were you welcomed upon your arrival?" This question received a 92 per cent affirmative response, while only 4 per cent stated that they had not been welcomed and another 4 per cent left the question unanswered. This appears that the vast majority of the people in this study who entered the doors of the clinic were welcomed upon arrival.

Question number three. "Did you know what the problem was before coming to the clinic?" Of the fifty-three parents, 75 per cent replied that they did know what the problem was before coming to the clinic. Only 19 per cent said they had no knowledge of the problem at all, while 6 per cent stated that they had some knowledge of the problem prior to their clinical visit.

It is difficult to determine what percentage of the 75 per cent had adequate and valid information to substantiate their convictions. According to these data, it appears that the majority of people come to the clinic with some knowledge of their problem.

Question number four. "Did the visit give you a better

understanding of the problem?" The results of this indicate that the services and information obtained at the clinic provided 81 per cent of the parents with a better understanding of the problem, while 9 per cent stated that they had not received a better understanding and 4 per cent said they had only partially obtained this service. The question was left unanswered by 6 per cent. The 81 per cent, who received a better understanding of their problem, seems to indicate that the clinic is doing its job in enlighting the parents as to their specific problems.

Question number five. "Do you feel you obtained any real help?" This question received a 77 per cent affirmative response, a 17 per cent negative response and a 6 per cent of no response at all.

The 17 per cent who replied negatively show some interesting facts when examined closer. It was discovered that 44 per cent of the group contained children of the trainable type and 55 per cent of the children have below average mental ability. It must be remembered that to parents, help may mean many things. To one, help may mean that which is curative but to another parent it may mean that which is either diagnostic or analytic. It is difficult to determine what a discouraged parent of a child severely handicapped would term as helpful. Thus the negative answers although they are only

a small percentage of the total, can be explained and for the most part understood.

Question number six. "Did you follow many of the suggestions?" According to the questionnaire response, 79 per cent of the parents followed the suggestions given to them by the clinic, 4 per cent did not, 8 per cent left the question unanswered and 6 per cent replied (by comments which were written on the back of the answer sheet) that no suggestions were given. An examination of the latter group disclosed the following facts:

(1) all of the I.Q.'s were between 40 and 60,

(2) all subjects had multiple handicaps,

(3) a review of each subject's psychological report reveals that all had been given constructive and specific advice. Some of the suggestions included advice to investigate the state school for the blind, recommended therapy and recommended re-test for the following year.

It appears to be conclusive that the majority of the parents did follow many of the suggestions which were given. It also seems that those who stated that they had not received suggestions, had received them and for some reason had failed to recognize them.

Question number seven. "Does the same problem still

exist?" Fifty-seven per cent of the parents were of the opinion that their problem still exists; 26 per cent stated that the problem does not exist any more; and 13 per cent said that it only partially exists. When considering the group that stated that their problem still exists, the possibility that some are seriously and permanently handicapped must be remembered. Intelligence is only part of the total problem, but it cannot be overlooked as important. If the problem were low intelligence or deafness, it would probably still be in existence. This point is offered as a possible solution as to why many of those problems still exist. There, of course, is no way to measure the parents' ability to judge whether the problem still exists.

Question number eight. "Did you receive a verbal report before you left the clinic?" The parents reported, through their answers, that 94 per cent of them received a verbal report, while only 4 per cent stated that they had not received one. The verbal report to the parent, which usually follows the examination, is considered a most important part of the clinical visit. It is during this time that the clinician summarizes, as best he can, what has been done and what information has been found and discusses the possible alternatives.

Question number nine. "If so, did the report help you

to understand the problem?" In the group of those who signified that they had received a verbal report, three reported that the report did not help them understand the problem and two stated that they only partially understood the problem; however, 83 per cent did receive a better understanding of their problem as a result of the verbal report. These data have been based on the 94 per cent who said they received verbal reports.

Question number ten. "Did you receive a written report?" The questionnaire results showed that 74 per cent of the parents received a written report and that 24 per cent had not received one. Of those who did not receive a written report, 14 per cent had seen it through school authorities. This was concluded through an analysis of questions ten and twelve. It was assumed that, if the respondee stated in question ten that she had not received a written report and then replied in question twelve that the report was worded so she could understand it, she had seen the report. According to these findings, 86 per cent of the parents who did not receive a report did not see the report. This infers that for some reason the school personnel did not discuss, to the fullest extent, the contents of the written report with the parent. It also infers that possibly adequate use was not made of the report.

The scheduling of a child for a clinical visit is made possible by filling out and mailing a referral sheet to the clinic. After the visit a psychological report is sent to the person who made the initial referral. This may be the parent, or school authorities, or a social worker. In the case of the 24 per cent who had not received a written report, the initial referral was most probably made by someone other than the parents and the report sent to that person.

Question number eleven. "If so, do you still have the report?" Naturally those who did not receive a report, left the question blank or answered it with a "no". Of those who received a report, 87 per cent reported that they still had it.

Question number twelve. "Was the report worded so you could understand it?" According to the response of the thirty-nine parents who received written reports, the reports were worded so they could understand them. There were no negative responses to this question. This is a most important finding concerning the psychological reports, for too often specialists use technical wording such that a layman is unable to comprehend it.

Question number thirteen. "Did you feel the child did his best at the clinic?" An analysis of question thirteen,

shows that 62 per cent of the parents felt that their children did their best at the clinic, 22 per cent felt that they did not and 15 per cent did not answer the question at all.

It is only human nature for parents to think that their child, due to unnatural surroundings, did not do as well as he could have done. Several of the parents stated that, for some reason or other, they were unable to accompany the child to the clinic. This possibility is offered as an explanation for the 15 per cent who left the question blank.

Question number fourteen. "Did you come to the clinic expecting to pay for the service?" Response to question fourteen indicates that 28 per cent of the parents came to the clinic expecting to pay for the service. Since the fall of 1954, it has become necessary to charge a minimum fee for the clinical services.

Question number fifteen. "Would you have preferred to pay something for the service?" In line with question fourteen, 47 per cent of the parents reported that they would have preferred to pay something for the service, 28 per cent stated that they would not have preferred to pay, and 25 per cent chose to leave the question unanswered.

This response, which concerns the minimum charge now effective at the clinic, is most encouraging for it seems to indicate that almost one-half of the parents of this study

would voluntarily pay a clinical fee. It is assumed that a much larger percentage would respond favorably if they were asked to do so.

Question number sixteen. "Would you come to the clinic again if you had a similar problem?" The answers to this question indicate that 89 per cent of the parents would come to the clinic again if they had a similar problem and only 5 per cent would not.

Question number seventeen. "If a friend had a problem would you refer him to the clinic?" To this question, 94 per cent replied that they would and only 4 per cent said they would not. Two per cent left the question unanswered.

Question number eighteen. "Check how you heard about the clinic." According to the parents' response, about 62 per cent heard of the clinic through the school. Other sources were friends, physicians, P.T.A. meetings and welfare boards. The school, which was the most significant referral source, appears to be aware of the clinics services and is doing its job, in most cases, by referring people to the clinic. For a comparison of these data see Figure 2.

Question number nineteen. "Check your relationship to the child." It was determined who filled out the questionnaires by asking the person to check his or her relation-

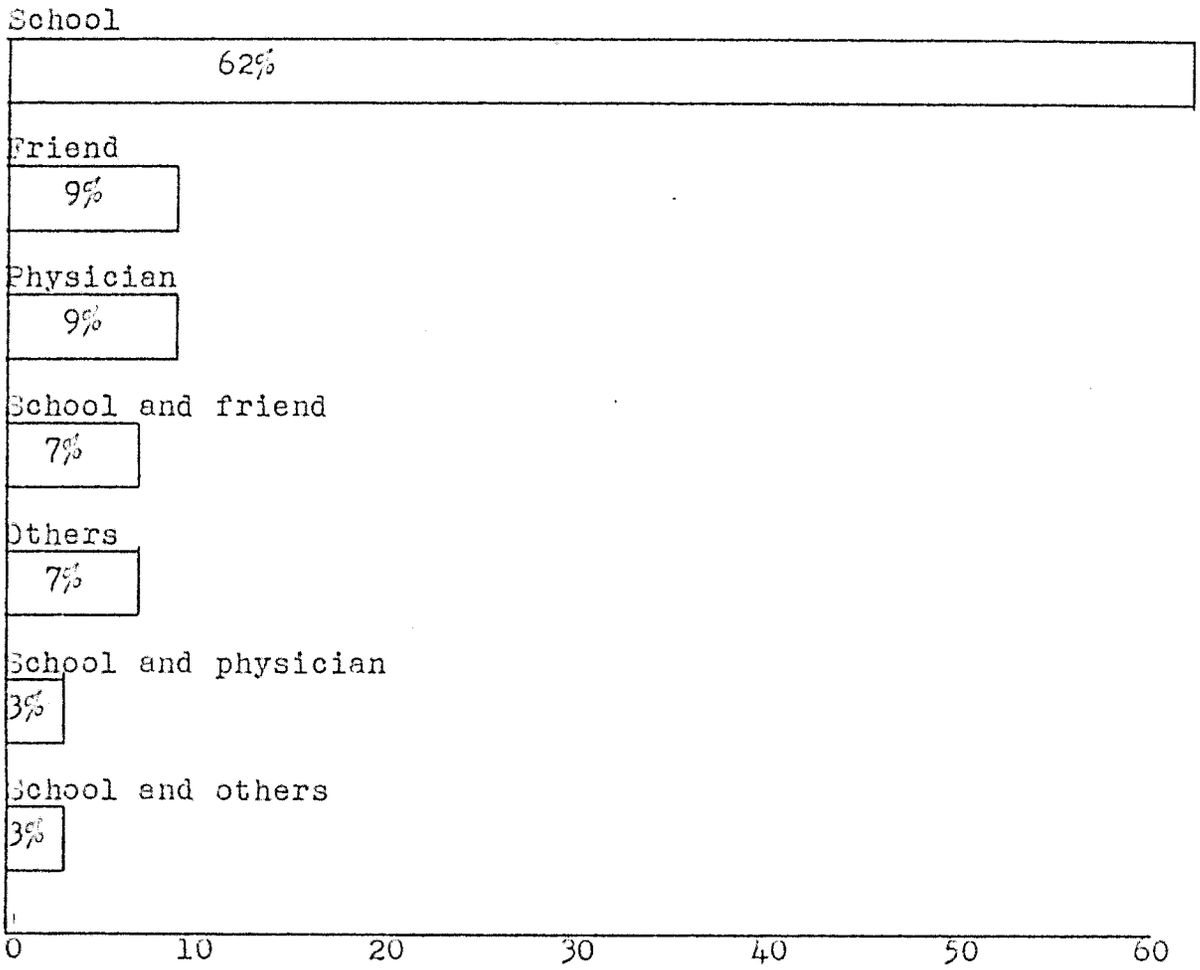

FIGURE 2

SOURCES THROUGH WHICH PARENTS LEARNED
ABOUT THE CLINIC

ship to the child. In the first group, the mothers in 74 per cent of the cases answered the questionnaires. A second group of 13 per cent was made up of both mothers and fathers, and a third group called others which included grandparents and foster parents totaled 6 per cent.

From the large percentage of those who filled out the questionnaire, one can assume one of the following: (1) that the questionnaires were filled out when the fathers were not at home, (2) that the fathers have little part or take little part in coping with the child's problem, (3) that the fathers just did not check their relationship, or (4) that they did not accompany the child to the clinic and therefore were not qualified to answer the questions.

IV. CASE ANALYSIS RESULTS

An analysis of the children was made by reviewing their clinical folders which contains case histories, actual tests which were given, notes from interviews and telephone calls and psychological reports. The information obtained includes the following items: reasons for initial referral, sex distribution, age distribution, grade placement, mental level, and conclusions which were obtained. These data were gathered for the purpose of better describing the clinical procedure of 1953-54 through a knowledge of the children and the problems they brought to the Special Education Clinic.

Reasons for referral. The reasons for referral were found to relate to mental ability, emotional adjustment, behavior, hearing, speech, vision, physical handicaps, school achievement and readiness for entrance to school. It was found that 77 per cent of the children had multiple causes for referral and only 23 per cent were referred for single causes. Table VII shows the frequency with which the above reasons for referral were found.

Sex distribution. It was found that 68 per cent of the cases of this study were of the male sex and 32 per cent were of the female sex. Since the clinic does not choose their cases by their sex, it may be that problems occur in this proportion.

Age distribution. The age of the child at his last birthday was used to figure the age distribution, and again the age was not the criteria used to select the cases. See Table VIII for the ages of the children and the frequency with which they occur.

Grade placement. The actual grade placement of the children at the time of their visit to the clinic was obtained through a review of the case histories and the psychological reports. The mean average was found to be fourth grade, the median grade level was also four as was the mode. The over-

TABLE VII

THE PERCENTAGE AND NUMBER OF VARIOUS HANDICAPS FOUND IN REASONS FOR THE INITIAL REFERRAL FOR A CHILD FOR 1953-54

Handicaps	Number	Percentage
Mental ability	34	64
Behavior	17	6
Emotional	3	32
Hearing	6	11
Speech	10	19
Vision	4	8
Physical handicap	4	8
School achievement	24	45
Readiness for school	4	8

TABLE VIII

THE DISTRIBUTION OF THE AGES AT WHICH THE CHILD CAME TO THE CLINIC

Life Age	Frequency
4	1
5	5
6	8
7	7
8	7
9	8
10	5
11	5
12	2
13	3
15	1
16	1
Total	53
Mean	8
Median	8
Mode	9

all grade levels ranged from pre-school and kindergarten to the eleventh grade. Those children in special instances were classified into homebound, ungraded and not-in-school areas. These data are presented in Table IX.

Data obtained. The conclusions, which were derived from data gathered through psychometrics, observations, interviews and case histories, were obtained from the psychological reports. The conclusions, for the most part, were based on the following areas: mental ability, emotion, behavior, hearing, speech, vision, physical handicaps and school achievement.

Mental ability will be discussed as the rate of mental growth. This is usually expressed by an intelligence quotient. The intelligence quotients were obtained through individual psychological examinations at the Special Education Clinic, Indiana State Teachers College. The tests which were used most frequently to obtain this estimate of mental ability were the Binet Intelligence Scale, Wechsler Intelligence Scale for Children and Wechsler-Bellvue Intelligence Scale. These tests were administered as part of the procedure in examining the whole child and even though most children received only one test of mental ability it is believed that, in most cases, safe conclusions can be based on this information for the following reasons:

TABLE IX

ACTUAL GRADE PLACEMENT AT THE TIME OF THE CLINICAL VISIT

Grade placement	Frequency
Pre-school	5
Kindergarten	3
1	6
2	7
3	3
4	11
5	4
6	3
7	1
8	1
11	1
Homebound	3
Ungraded class	1
Not in school	4
Total	53
Mean	4
Median	4
Mode	4

(1) tests in areas other than mental ability were administered and interpreted with mental ability in mind,

(2) observations during the testing period were recorded and interpreted by the examiner,

(3) previous tests both group and individual were taken into consideration,

(4) all information obtained was integrated into the final conclusions.

Results of this study show that of the children with problems who visited the clinic, slightly more than half have average or above average mental ability (I.Q. of 90 or above). These findings disprove the belief that a clinic of this type deals primarily with children with extremely low mental ability. Teble X reveals the distribution of intelligence quotients as they were reported.

The area of emotional adjustments is difficult to report. Most of the children who were reported as having problems which seemed to be emotional were reported because it was felt that this problem would be interfering with school achievement. Some of the emotional problems were merely mentioned and although they were not causing undue difficulties at the present they might in the future. The emotional problems were discovered through tests, observation (many times in the form of play therapy) and information obtained from

TABLE X

DISTRIBUTION, PERCENTAGE AND CLASSIFICATION OF THE RATE OF MENTAL GROWTH OF CHILDREN WHO VISITED THE CLINIC IN THE 1953-54 SCHOOL YEAR

Classification	I.Q.	Percentage
Average and above	90 and above	51
Slightly below average	89-70	10
Mentally retarded	69-50	13
Trainable	50 and below	26

the case history. According to the psychological reports 25 per cent of all children seemed to have problems which were emotional in nature. The majority of these children had multiple handicaps.

Those problems which were observed and reported as behavior problems made up about 15 per cent of the children in this study. These problems were more specifically described as a result of poor school achievement, social immaturity, parental conflicts with the child and adjustment problems in general. It seems that it can be concluded that 85 per cent were not behavior problems or at least their behavior was in keeping with their mental level.

It was also found that 10 per cent of the children had enough hearing loss that it seemed advisable to have lip reading, examination by an otologist or an hearing aid or all three. These loses were detected through an individual test of hearing with a pure-tone audiometer, and were administered by a person trained in audiometry.

Speech defects of various types and degrees were found in about 20 per cent of the children. This number does not include those who have defective speech that is in line with their mental level. It must be kept in mind that these children were not referred to the clinic primarily for speech evaluation, and that the many cases which are exclusively speech cases (evaluated and given speech therapy in the clinic's

speech correction division) were not included in this study; therefore, this 20 per cent must not be interpreted as the entire number of speech defectives seen in this year.

A complete visual examination and evaluation was not done, but a screening-type examination was frequently administered to detect undesirable tendencies. This examination was the Keystone Visual Survey. The main purpose of this examination was to determine whether the child needed a more complete examination by a specialist. According to the data obtained from the Keystone record blank, which is kept in the clinical folder, and the psychological report, 26 per cent needed a more complete visual examination.

Physical handicaps like any physical problem can not be diagnosed in the Special Education Clinic, only the tendencies and the symptoms can be recognized and pointed out. Results of the psychological reports show that 19 per cent needed a thorough examination by a physician and of that number, one-third or 6 per cent came to the clinic already diagnosed as physically handicapped.

A review of the conclusions of the psychological reports disclosed that approximately 25 per cent of the children seemed to have problems in school achievement. This figure does not include those with low mental ability whose achievement is below what would be expected for their age level but still in line with their mental level. The 25 per

cent, however, includes the children who were reported as having average or above average mental ability with poor school achievement or those whose achievement is considerably under what might be expected for their mental level. Table XI describes the various problem areas as to their number and percentage.

TABLE XI

NUMBER AND PERCENTAGE OF THE VARIOUS PROBLEM AREAS FOUND IN THOSE CHILDREN WHO VISITED THE CLINIC IN 1953-54*

Problem area	Number	Percentage
Emotional	13	25
Behavior	8	15
Hearing	14	26
Speech	11	20
Vision	14	26
Physical handicap	10	19
School achievement	13	25

*The area of mental ability was not included in this table since it was considered important enough to be discussed individually in Table X. Because of multiple problems this table does not total 100%.

CHAPTER III

SUMMARY AND CONCLUSION

It was the purpose of this study to make a follow-up investigation of the children who have been studied in the Special Education Clinic. This investigation involves the children who were referred, interviewed, and examined in the clinic from September 1953, until June 1954, and attempts to determine the effectiveness of the clinic's program and to provide a criteria for modification and improvement of the clinical procedures.

The data for the follow-up investigation were obtained through questionnaires and a review of the case histories, and for the most part the conclusions are based on these facts. The suggestions which will be given at the end of this chapter are also an outgrowth of the data derived from this study.

The Special Education Division got its start in 1948, under the direction of Dr. D. W. Morris, as a part of the Speech Department. The school year of 1950-51 found the special education functions being carried on, apart from the Speech Department, under the title of the Division of Special Education. In 1938 Dr. Rutherford B. Porter became the director. Since the beginning of this division, when its primary concern was that of speech correction, it has been evident that the division was a growing one and that one of its goals

was to offer training in as many areas of special education as feasible.

The main functions of the Special Education Division, at the present time, are to train teachers, provide re-education for college students (this is done in almost all of the areas of special education), extend clinical services for Vigo County and Terre Haute, and conduct special classes for the mentally retarded and crippled children.

The purpose of the Division of Special Education which lies behind all of its functions, is to help provide an opportunity for every child to profit to the greatest extent of his abilities. In a broader sense this is also the main purpose of modern education and its educators.

I. THE FACTS CONCERNING THE CHILDREN IN THE STUDY

The age. The average age for the sixty-six children who visited the clinic was eight years. The ages ranged from four years to sixteen years, and the mode or the age most frequently found was nine years.

The sex. The children who visited the clinic during this year were predominately of the male sex.

The grade placement. The grade placement for these children ranged from pre-school to the eleventh grade. The average grade level was four.

Reasons for referral. In the majority of cases the children were referred to the clinic with more than one porblem, and in at least one-half of these cases mental ability was a reason for referral.

Conclusions obtained. According to the information gathered from the clinical folders, about one-half of the children who visited the clinic in this year had average or above average mental ability.

II. WHAT PROGRESS AS A RESULT OF THE CLINIC?

The help and understanding obtained. It was found through this study that the majority of the parents assumed that they knew what the problem was before coming to the clinic; however, after the clinic visitation, 81 per cent reported that they had obtained a better understanding of the problem. The negative response is not significant enough to warrant mentioning.

In general, the services obtained at the clinic seemed to give the parents the feeling that they had received real help. Results show that 77 per cent felt that they had obtained real help, while 83 per cent were inclined to believe that the verbal report helped them to understand the problem better.

The problem at the present. Approximately one-half

of the parents reported that the problem was still in existence. There is evidence, however, which seems to infer that low or below average mental ability is a deciding factor in this existence. As it has been stated before, mental ability is only one phase of the child's development, but since about one-half of the children were referred on the basis of mental ability, it seems fitting to single it out for discussion. It was revealed that 49 per cent of the children seen in the clinic had below average mental ability, with some classified as mentally retarded or trainable. These data are offered as a possible explanation of why the problems, in some cases, still exist, for if low mental ability is the primary problem there is little chance for that to change.

The extent to which suggestions were followed. The majority of parents followed the suggestions which were given to them by the clinic reports. A few stated that they had received no suggestions, but a further check revealed that they had received suggestions but that they were of the type that were unacceptable to the parents such as, institutionalization.

III. HOW EFFECTIVE HAVE CLINICAL PROCEDURES BEEN CARRIED OUT?

The arrival of the parent and child. The arrival of

the parent and the child and the manner in which it is carried out is very important. It is important not only for the child's own mental health but also for a good first impression for the parents. It must be kept in mind that some people are prone to judge quickly on first impressions. Along this line is the matter of ease with which a visitor is able to find his way to the clinic. If he is sent on fruitless paths, choosing blindly and not knowing which one leads to the clinic, he may reach his destination in a state of utter confusion and with a prematurely acquired bad impression of the clinic.

The response to this study shows that this does not seem to be a problem at the clinic, at least for this school year, for as far as can be determined by this investigation none of the parents had difficulty in finding the clinic. It was also found that 92 per cent stated that they had been welcomed upon their arrival.

The verbal and written reports. It is the aim of the clinic to give each child, and the person or persons who accompanies him, a verbal report. The parents in this study reported that 94 per cent of them did receive a verbal report.

The written psychological report was received by 74 per cent of the parents, of course a report was written for every child but in some cases the report was sent to school

personnel or welfare authorities.

Another fact concerning the written report has to do with the number who received the reports and who kept them. It was found that 87 per cent reported that they still had the report. It would seem that this information emphasizes the value and importance that parents place on these reports.

Probably the most important phase of the written psychological report is whether or not it is understandable by the laymen. All too often psychological terms which are unfamiliar to the parent are used. This study revealed, however, that all of the parents who received reports claimed they were able to understand them. This is a point on which too often psychological clinics fall down, and a point on which this clinic, according to the questionnaire results, is able to feel a sense of accomplishment.

IV. THE OVER-ALL ATTITUDE OF THE PARENTS OF THE CHILDREN WHO VISITED THE CLINIC

Response concerning payment for the services. The response of the parents concerning the payment of the services was sought mainly because the clinic found it necessary to require a minimum fee beginning this year, 1954-55. The response showed that there are those who expected to pay the clinic for its services. Approximately one-half of the parents stated that they would prefer to pay something for the

service.

Response concerning the childs performance. As it has been said, it is only human nature for the parent to think that the child did not do his best at the clinic especially if the findings are unacceptable, however, 62 per cent of the parents stated that they felt that the child had done his best while at the clinic.

Response concerning any return visit to the clinic. Finally the majority of the parents stated that they would return to the clinic if they had a similar problem and practically everyone stated that they would refer a friend to the clinic.

Response of a negative nature. It is interesting to note that a negative response of approximately 4-6 per cent appears throughout the study. It has been found, through careful study of the questionnaires, that a group consisting of about 8 per cent of the parents responded negatively to the questionnaire in general. The entire response was considered negative when seven or eight questions, which are directly related to clinical procedures, were marked "no". It is significant at this point to note that the problems of this group were of a serious nature, with an average intelligence quotient of approximately 47.

V. VARIOUS WAYS INFORMATION WAS OBTAINED CONCERNING THE CLINIC

The source. The various sources and combination of sources from which the parents heard about the clinic are the following:

(1) School
(2) Friend
(3) Physician
(4) P.T.A. meetings
(5) Welfare Boards
(6) School and friend
(7) School and physician
(8) School and others

Needless to say that the majority of parents heard about the clinic through the school. It, therefore, seems logical to conclude that some schools are doing their job in referring parents with problems to the clinic.

VI. WHO FILLED OUT THE QUESTIONNAIRE?

Reletionship to the child. The majority of those who filled out the questionnaires were the mothers. Unfortunately, for the child, the parents were unable to consider it together and we can only hope that this is not indicitive of the attention he gets at home.

VII. SUGGESTIONS OFFERED TO IMPROVE THE CLINICAL PROCEDURES

Suggestions offered by the parents. The actual constructive suggestions which were written on the back of the questionnaire by the parents were so few in number that conclusive suggestions can not be drawn from them alone. Probably the only suggestion which is important to the clinic procedure is the one which has to do with payment for the clinical services. It was suggested that a small fee be charged so that the parents will feel free to call upon the clinic for follow-up questions and additional service from time to time. This is probably one of the most important points, at this time, for the clinic to consider since they have so recently elected to place a minimum fee upon these services. The written comments which explain further the nature of the parents' answers, showed that of the people who opposed a payment of a small fee, practically all were of the opinion that the clinical services would be unavailable if they were unable to pay for them. It then appears that if the parents were to be enlightened as to these procedures, many more would be willing to pay for the clinical services.[8]

Suggestions drawn from the questionnaire. Since the findings of this study are decidedly in favor of the present

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[8]Payment for the clinical fee may be arranged through agencies such as the school and Welfare Department.

clinical procedures, few if any suggestions can be drawn from the questionnaire analysis. Probably the most important outgrowth of this study concerns the continuance of a follow-up study such as this one.

During the compiling and gathering of the data and reading the many comments from interested parents, it became increasingly evident that an annual follow-up project of this type could be helpful not only to the parents but to the clinic as well.

A follow-up study which would be carried on annually would not necessarily be as an extensive a study as this one. Such a study would probably have the same purpose and gather data by use of the questionnaire. As it has been said before, an annual investigation of this type would do two things: (1) it would offer to the parents a follow-up program and give them a chance to express themselves and (2) it would enable the clinic to continue an evaluation program. If the study is carried on over a period of years an even more extensive study than the present one may be conducted, revealing valuable facts about the clinic.

VIII. GENERAL CONCLUSIONS

To conclude a study such as this it is necessary to think back to the initial purpose for conducting the study. It was set up to reveal the following things concerning the

clinic:

(1) to analyze data concerning the children in the study,

(2) to investigate the progress they have made and how they have benefitted from the clinic services,

(3) to determine how effective the present clinic procedures are carried out,

(4) to obtain an over-all attitude of the parents toward the clinic visit,

(5) to gather suggestions to improve the clinich program.

An investigation of the avove areas seems to indicate that through the clinic there has been operated a helpful and beneficial program for all types of exceptional children. This is illustrated even more by the positive attitude most of the parents have toward the clinic and the fact that the clinical procedures were executed so effectively.

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APPENDIX

APPENDIX A

DIVISION OF SPECIAL EDUCATION

Please read the following questions. Mark the answers and return them in the enclosed envelope. Your assistance will make it possible to evaluate the work of the clinic.

_____ came to the Special Education Clinic on _____.

(Please encircle either "Yes" or "No" to answer the following questions.)

1. Did you have difficulty in finding the clinic? YES NO
2. Were you welcomed upon your arrival? YES NO
3. Did you know what the problem was before coming to the clinic? YES NO
4. Did the visit give you a better understanding of the problem? YES NO
5. Do you feel you obtained any real help? YES NO
6. Did you follow many of the suggestions? YES NO
7. Does the same problem still exist? YES NO
8. Did you receive a verbal report before you left the Clinic? YES NO
9. If so, did the report help you to understand the problem? YES NO
10. Did you receive a written report? YES NO
11. If so, do you still have the report? YES NO
12. Was the report worded so you could understand it? YES NO
13. Did you feel the child did his best at the clinic? YES NO
14. Did you come to the clinic expecting to pay for the service? YES NO
15. Would you have preferred to pay something for the service? YES NO
16. Would you come to the clinic again if you had a similar problem? YES NO
17. If a friend had a problem would you refer him to the clinic? YES NO
18. Check how you heard about the clinic.
    ( ) a friend ( ) the school ( ) a physician ( ) others _____ (specify)
19. Check your relationship to the child.
    ( ) mother ( ) father ( ) others _____ (specify)

INDIANA STATE TEACHERS COLLEGE

TERRE HAUTE, INDIANA

THE SPECIAL EDUCATION CLINIC

APPENDIX B

The Special Education Clinic is making a study of the last year's visitors, and needs your cooperation. Many times we have wondered just how much help we have been to you and how beneficial our suggestions were. Enclosed are some questions designed to measure the effectiveness of the clinic, and it is only through your favorable and unfavorable answers that we can plan for a change.

Please mark your answers and mail them in the enclosed envelope at your earliest convenience. If you have any further suggestions please write them on the back of the answer sheet.

Sincerely yours,

Rutherford B. Porter
Director

APPENDIX C

Date, 1955

Dear Parent,

This is to remind you that the questionnaire sent to you from the Special Education Division, Indiana State Teachers College has not been returned. We need your help, for your cooperation may aid us in evaluating the clinical services. If you desire another copy of the questionnaire one will be mailed to you with a stamped return envelope if you write:

Special Education Division,
Indiana State Teachers College
Terre Haute, Indiana

Sincerely,

Dr. Rutherford Porter,

Director of Special
Education Division

(This is a copy of the written reminder sent to the parents.)