failure to progress in school, which cannot otherwise be accounted for.

IN CONCLUSION
I would emphasize that:
1) Vision is a complex process involving two eyes and the mind.
2) Visual acuity improves with maturity and may be normal in spite of a significant refractive error.
3) Recurring and continuing discomfort may suggest a significant refractive error or a latent strabismus.
4) Learning difficulties rarely have the eyes as a primary cause, though at times they may be a contributory factor.

OFFICE EVALUATION OF INTELLIGENCE OF CHILDREN
By Ruth M. Bakwin, M.D.
Departments of Pediatrics, New York University and New York Infirmary

AN ESTIMATION of intelligence in office practice is possible within the broad classification of average, defective and superior. I will first discuss the diagnosis of mental retardation in the young child.

DIAGNOSIS OF MENTAL RETARDATION IN INFANCY

When the infant, less than 2 years of age, comes for intelligence testing, mental retardation has usually been suspected. It is very difficult, at so-early an age, to differentiate simple feeblemindedness from organic retardation. What the parent wishes to know is, is the child mentally defective and if so what can be done about it?

Severe Mental Retardation

The diagnosis of severe retardation offers little difficulty. The behavior of the infant in the office and the developmental history will establish the diagnosis. The imbecile and idiot (I.Q. below 50) are unable to do what the average child half their age can do. It takes them 2, 3, 4, or more years to learn what the normal infant learns in 1 year. Motor development is retarded and efforts at speech (babbling) are few and feeble. Inability to support the head, to sit up, to stand, to smile, to hold and handle objects at the proper time are valuable indices of mental defect.

It is rarely necessary to give an intelligence test to these severely defective children, as the level of retardation makes little difference in management and the prognosis for their mental development is already known to be poor.

The most severe cases of mental deficiency are easily recognized clinically. Usually the child is apathetic, lying quietly in the mother's arms but never looking at her or showing any awareness when she speaks. When picked up the child does not adjust to change in position, as does the normal infant, but remains quite still and relaxed.

Less often the child is extremely irritable, moving the jaws, rolling the eyes and crying constantly.

Severely defective children often show associated anomalies which can be recognized during the examination. Mongolism and cretinism need no discussion. Microcephaly and hydrocephaly are readily recognized, but one must be cautious in children with hydrocephalus as they are not always mentally retarded. Even moderate degrees are compatible with normal or superior mental functioning. Some deviations such as gargoylism, ocular hypertelorism,
tuberose sclerosis and the various types of premature cranial synostosis are less obvious. Examination of the optic fundi is essential in making the diagnosis of amaurotic familial idiocy and toxoplasmosis.

Severely defective children often have strabismus, high arched palates, irregular teeth, open mouth with protruding tongue, and vacant look. They rarely look you in the eye with the signs of recognition that the normal infant of even 9 months will have. Mentally defective children of low intelligence who are abnormally inert and placid, rarely smile.

Cranial deformities, anomalies of the eyes, deformities of the ears, web-fingers and polydactylism occur with some frequency but are not necessarily diagnostic of mental deficiency.

**Lesser Degrees of Retardation**

Diagnosis becomes much more difficult as the intelligence of the infant approaches the average. It is necessary to take a detailed history, observe the infant, do a physical examination, including funduscopic, and sometimes to give a psychometric test.

The reason for referral is important and may give the clue to organic and endocrine conditions. A comprehensive history is essential. Most parents are eager to pour out their troubles and they should be allowed to talk.

If there is a question of retardation, most mothers have already suspected that something is wrong with the child. It is surprising how often the mother will say “I have felt for months that he is not developing normally but the doctor says he’s all right”—or “there is something wrong, something strange about him, he doesn’t act like other children.” Much less often is the father aware of any difference, usually he finds the mother too apprehensive.

The usual questions about the birth and neonatal history should be asked and, if possible, information obtained about cyanosis, convulsions and the use of oxygen during the neonatal period.

A developmental history is most important but unfortunately many parents are vague about the ages of sitting, walking, talking, etc. Also our own criteria are confused. Does age of sitting mean sitting with support, sitting without support, being able to sit himself up? Does talking mean saying words, saying words with meaning, phrases, sentences or carrying on a conversation? More information is gained by inquiring whether these phenomena took place at the usual time, early or late, or by comparing this child’s development with that of the siblings.

The defective child is retarded in development all along the line. This is not as easy to elicit as one would think, because of the wide variation in normal development. Sitting without support, crawling, walking, talking, bowel and bladder control, holding the bottle, drinking from a cup and feeding himself are usually accomplished at significantly older ages than in the normal child. The mother’s memory need not be relied on in all instances as many of these actions can be observed in the office.

A history of illnesses (their severity and complications) may suggest the possibility of encephalitis. A change in behavior after an illness is highly significant. Diseases of the central nervous system may be followed by mental retardation. The parent should be questioned about head injuries and convulsive seizures, as cerebral damage may occur with or without mental deterioration. History of mental defect in other members of the family will help in differentiating hereditary feeblemindedness from other types. If galactosemia or phenylpyruvic oligophrenia has been known to occur in any member of the family, the urine and blood should be tested frequently, especially during the early weeks of life. Analyses for phenylalanine in the blood should be made as the urine is not always positive in the beginning. Where the diagnosis is made early, the prognosis is not so grave.

A diagnosis of mental deficiency should be made with caution when a neurologic defect is present. Since much of the intelligence of infants is measured by the motor
development, a careful physical examination with particular attention to muscle weakness or spasticity is often indicated. Myotonia which interferes with motor performance are sometimes seen. Children with cerebral palsy (either spastic diplegia or basilar ganglion lesion) are delayed in motor development but may have normal intelligence. Special tests must be used for these children.

In the retarded infant one should look carefully for signs of cretinism, as the prognosis for mental development depends upon how early treatment is commenced. Laboratory aids (tests for protein-bound or butynol-extractable iodine, radioactive iodine uptake) and roentgenograms of the centers of ossification should be used as necessary.

In making a diagnosis of mental retardation it is necessary to exclude sensory handicaps, such as impairment of hearing or poor vision.

Although observation of the infant together with the medical and developmental history are usually sufficient for a diagnosis of mental retardation, it is sometimes useful to have a more accurate estimate of the child's level of intelligence, as a basis for prognosis and for advice about management.

<table>
<thead>
<tr>
<th>Material Needed</th>
<th>Age and Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pencil</td>
<td>3 Months</td>
</tr>
<tr>
<td></td>
<td>Holds head erect on shoulders</td>
</tr>
<tr>
<td></td>
<td>Smiles to social approach</td>
</tr>
<tr>
<td></td>
<td>Eyes follow pencil</td>
</tr>
<tr>
<td></td>
<td>Opens mouth expectantly for feeding</td>
</tr>
<tr>
<td>Ring</td>
<td>4 Months</td>
</tr>
<tr>
<td></td>
<td>Lifts head and shoulders in dorsal position in effort to sit</td>
</tr>
<tr>
<td></td>
<td>Laughs aloud</td>
</tr>
<tr>
<td></td>
<td>Uses both hands to grasp ring</td>
</tr>
<tr>
<td></td>
<td>Inspects own hands in play</td>
</tr>
<tr>
<td>Bell Toy</td>
<td>5 Months</td>
</tr>
<tr>
<td></td>
<td>Rolls from back to stomach</td>
</tr>
<tr>
<td></td>
<td>Turns head to voice or bell</td>
</tr>
<tr>
<td></td>
<td>In dorsal position, recovers fallen toy within reach</td>
</tr>
<tr>
<td></td>
<td>Looks at toy in hand as he plays</td>
</tr>
<tr>
<td>Two cubes</td>
<td>6 Months</td>
</tr>
<tr>
<td>Spoon</td>
<td>Can hold cube in each hand</td>
</tr>
<tr>
<td></td>
<td>Crows and coos actively</td>
</tr>
</tbody>
</table>

* Modification from Gesell Developmental Inventories and Stanford Binet Test.
<table>
<thead>
<tr>
<th>Toy</th>
<th>8 Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cup with handle</td>
<td>Sits momentarily without support</td>
</tr>
<tr>
<td>Bottle</td>
<td>Vocal expression to recognition</td>
</tr>
<tr>
<td>Mirror</td>
<td>Looks for fallen toy (definite)</td>
</tr>
<tr>
<td></td>
<td>Uses handle in lifting cup</td>
</tr>
<tr>
<td></td>
<td>Restores bottle to mouth</td>
</tr>
<tr>
<td></td>
<td>Smiles at image in mirror</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pellet</th>
<th>10 Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Three cubes</td>
<td>Pulls self to standing position</td>
</tr>
<tr>
<td>Cup with handle</td>
<td>Picks up pellet with pincer prehension</td>
</tr>
<tr>
<td>Ring on string</td>
<td>Makes adjustment to certain words</td>
</tr>
<tr>
<td></td>
<td>Accepts third cube and retains two</td>
</tr>
<tr>
<td></td>
<td>Lifts cup by handle and secures hidden cube</td>
</tr>
<tr>
<td></td>
<td>Dangles ring by string in play</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Crayon</th>
<th>12 Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cube</td>
<td>Stands with support</td>
</tr>
<tr>
<td>Cup</td>
<td>Scribbles imitatively with crayon</td>
</tr>
<tr>
<td>Rod and hole</td>
<td>Can wave bye bye</td>
</tr>
<tr>
<td>(peg board)</td>
<td>Places a cube in cup on command</td>
</tr>
<tr>
<td></td>
<td>Puts rod in a ¾-inch hole</td>
</tr>
<tr>
<td></td>
<td>Holds cup to drink</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ball</th>
<th>18 Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Box</td>
<td>Walks alone</td>
</tr>
<tr>
<td>Four cubes</td>
<td>Throws ball in box</td>
</tr>
<tr>
<td></td>
<td>Points to nose, eyes, hair</td>
</tr>
<tr>
<td></td>
<td>Says hello or thank you</td>
</tr>
<tr>
<td></td>
<td>Accepts fourth cube, retains three</td>
</tr>
<tr>
<td></td>
<td>Builds block tower imitatively</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pencil</th>
<th>24 Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key, penny, watch</td>
<td>Draws a circle with help</td>
</tr>
<tr>
<td>Picture book</td>
<td>Uses simple phrases or sentences</td>
</tr>
<tr>
<td>Six cubes</td>
<td>Names key, penny, watch</td>
</tr>
<tr>
<td>Scissors</td>
<td>Points to 7 of 10 pictures</td>
</tr>
<tr>
<td>Wrapped candy</td>
<td>Distinguishes in and under</td>
</tr>
<tr>
<td></td>
<td>Repeats two digits</td>
</tr>
<tr>
<td></td>
<td>Builds block tower of three or more</td>
</tr>
<tr>
<td></td>
<td>Cuts with scissors</td>
</tr>
<tr>
<td></td>
<td>Removes wrapping from candy</td>
</tr>
<tr>
<td></td>
<td>Asks for things at table by name</td>
</tr>
<tr>
<td></td>
<td>Bladder control established</td>
</tr>
<tr>
<td></td>
<td>Can clap hands, put palms on head—on command</td>
</tr>
</tbody>
</table>

It is relatively simple to see if the infant can respond and what level of performance he reaches. If he is 18 months of age, and can accomplish only some of the things that the normal child of 12 months can do, he is functioning below the 12-month level.

**DIAGNOSIS OF MENTAL RETARDATION IN CHILDHOOD**

The diagnosis of retardation in the older child is easier. First, one must see if the child is functioning mentally at a level below normal, then approximately how retarded he is. In addition, the parent wishes to know if he will always be defective. Therefore the effort should be made to differentiate true feeblemindedness and pseudofeeblemindedness secondary to sensory defects (vision, hearing, etc.), developmental delay in speech, cerebral damage, or schizophrenia. In the case of true feeblemindedness, the prognosis is always unpromising for making up the deficiency, al-
though the child will usually continue to
develop at his own slower rate. When the
deficiency is due to a condition such as hy-
pothyroidism or impaired hearing, which
may be corrected, the child will develop as
a normal child. With cerebral damage or
schizophrenia there may be co-existent
mental retardation or the child may have
normal intelligence, in which case the em-
phasis must be on the child's learning how
to exercise his intellectual faculties in a
useful manner.

At school age, the added problem of
reading disability enters the differential di-
agnosis.

Severely defective children are easy to
diagnose from appearance, history of de-
velopment and disease, physical examina-
tion and their behavior in the office.

Many mildly defective children (those
with I.Q. between 50 and 70) can also be
diagnosed clinically. The facial expression
is often revealing. There is a vacant, fool-
ish look and sometimes facial grimaces.
Even morons can sometimes be recognized
in this way. The retarded child is often
awkward, the posture poor and the child
unusually placid and docile or unusually
restless and irritable.

Sometimes a child with a severe speech
defect will be mistakenly considered re-
tarded on first acquaintance.

A good history is of great importance
and may actually make the diagnosis. In
some instances the symptoms are more or
less specific. Thus, the combination of hy-
peractivity, distractibility, shifts of mood
and variable memory strongly suggest cere-
bral damage. Slow development from the
early months, delay in speech development
and immature behavior suggest mental re-
tardation.

Delay of speech to 2½ or 3 years of age
is occasionally seen in children who are
mentally normal. It may be familial. When
speech has not occurred by 3½ years or
more, symptoms of infantile autism should
be looked for.

Information about the daily routine and
case or difficulty in training may be of
value in estimating to what extent the child
is self-reliant and responsible. Is he able
and willing to do for himself the things
which may be expected at his age? And
does his parent permit him to do them?
Does he understand as well as other chil-
dren of his age and can he carry out direc-
tions with equal ease?

A great deal of information can be gained
from the knowledge of the play interests of
the child, and the age and sex of his play-
mates. Play interests roughly correspond
with mental age. The retarded child likes
to play the games and with the toys of
younger children, Most schizophrenic chil-
dren do not know how to play or to use
toys. In general, retarded children prefer
younger children or very much older chil-
dren, while bright children prefer to play
with older children, but there are excep-
tions.

The retarded child may lack skill in the
handling of materials and in actions. He is
rarely as clumsy in small or in large muscle
movements as the brain-damaged child.
Aptitude in sports is a good indication of
motor co-ordination. Most brain-injured
children hate anti-gravity play. By con-
trast, emotionally disturbed children love
swings, merry-go-round and rhythmic
movement.

A general idea of the child's intelligence
is gained by observing how he conducts
himself in the physician's office. When
blocks, drawing materials, puzzles and
books are available, the child's choice of in-
terest throws considerable light on his in-
telligence. The mentally defective child
usually prefers activities more suitable for a
younger child, Tests for estimating social
maturity are available but are rarely nece-
sary for finding the retarded child.

Observation of the period of concentra-
tion helps in the differential diagnosis of
the retarded from the pseudodefective child
with organic brain disease. It seems impos-
sible for the latter child to stick to anything
for long. He is easily distracted. Even when
interested, he displays hyperactivity and
leaves what he is doing to investigate every-
thing in the room, afterwards returning to
his original task, then shortly leaving it
again. The retarded child may have a short
attention span also, but he is not so dis-
tractable and usually, when he gives up a game or a task, he has lost interest in what he was doing, and does not return to it.

The behavior of emotionally disturbed children is most variable and cannot be predicted from child to child or even from day to day in the same child. If he likes what he is doing, he may continue the same activity for long periods of time. If nothing interests him he will indulge in unbelievably repetitious activity such as whirling, swinging and turning lights on and off. By contrast the brain-damaged child’s over-activity is purposeful.

The defective child is usually not facile in speech. In the brain-damaged child the normal smooth co-ordination between the act of talking and respiration may be disturbed. The absence of appropriate facial expressions and the presence of dissociated gestures during speaking may be evident.

A physical examination is indicated with special attention given to motor development, handicaps of any type and neurologic abnormalities. In many cases of cerebral damage the neurologic examination is negative, but changes in postural tests and motility can sometimes be elicited; inability to hold the extended hands still while concentrating on another task (e.g., counting), drifting of the hands to one side, inability to make the eyes converge on a near object, and inability to discriminate two points on the skin touched at the same time (two-point perception). In the differential diagnosis of simple feeblemindedness and pseudofeeblemindedness of organic brain disease, these tests are useful.

### Psychometric Tests

Comparison with the mental development of the normal child at various ages is easily carried out in the office with simple materials:

<table>
<thead>
<tr>
<th>Material Needed</th>
<th>Age and Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pencil</td>
<td>Draws a circle from copy</td>
</tr>
<tr>
<td>Picture book</td>
<td>Uses pronouns, past and plural</td>
</tr>
<tr>
<td>Six cubes</td>
<td>Names three objects in a picture</td>
</tr>
<tr>
<td>Buttons and button holes</td>
<td>Repeats six syllables</td>
</tr>
<tr>
<td></td>
<td>I have a little dog.</td>
</tr>
<tr>
<td></td>
<td>In summer the sun is hot.</td>
</tr>
<tr>
<td></td>
<td>Repeats three digits in correct order (1 in 3 trials)</td>
</tr>
<tr>
<td></td>
<td>6-4-1 3-5-2 8-3-7</td>
</tr>
<tr>
<td></td>
<td>Builds bridge imitatively</td>
</tr>
<tr>
<td></td>
<td>Builds tower of 4 or more blocks</td>
</tr>
<tr>
<td></td>
<td>Gives sex</td>
</tr>
<tr>
<td></td>
<td>Are you a boy or a girl? (own sex first)</td>
</tr>
<tr>
<td></td>
<td>Gives last name</td>
</tr>
<tr>
<td></td>
<td>What is your name?</td>
</tr>
<tr>
<td></td>
<td>Can do two buttons (less than 3 minutes)</td>
</tr>
<tr>
<td>Action agent</td>
<td>(4 of 9 correct; any appropriate answer)</td>
</tr>
<tr>
<td></td>
<td>What runs</td>
</tr>
<tr>
<td></td>
<td>What scratches</td>
</tr>
<tr>
<td></td>
<td>What swims</td>
</tr>
<tr>
<td></td>
<td>What blows</td>
</tr>
<tr>
<td></td>
<td>What sails</td>
</tr>
<tr>
<td></td>
<td>Can put on shoes</td>
</tr>
</tbody>
</table>

| Card with two lines of unequal length | Draws square from copy |
| Pencil | Counts 4 pennies |
| Four pennies | Uses descriptive words of pictures |
| Two-piece puzzle | Buttons clothes |
| Three-piece puzzle | Comprehension: (any appropriate answer) |

* Modification from Gesell Developmental Inventories and Stanford Binet Test.
Picture book
What must you do if you are sleepy?
What must you do if you are hungry?
What must you do if you are cold?
Two-piece puzzle in 4 seconds or less
Repeats 10 words (1 of 3 absolutely correct)
We will have a good time at the big picnic.
When the train passes you will hear the whistle blow.
Compares lines—which is longer? (3 times correct)
Draws cross from copy
Repeats 4 digits in correct order
4-7-3-9 2-8-5-4 7-2-6-1
Three-piece puzzle (in 45 seconds or less)

Pencil
Draws triangle from copy
Performs three commissions:
Put the pencil on the chair.
Close the door.
Bring me the box.
Laces shoes
Knows age. How old are you?
Names four colors (no errors)
Definitions use or better (4 of 5)
fork horse table pencil doll chair

Box

Four colors

13 pennies
Right hand, left ear, right eye (no errors)
Counts 13 pennies (2 trials) (no errors)

Nickle
Knows coins: nickel, penny, quarter, dime (3 of 4)

Dime
Is it morning or afternoon (correct one first)

Quarter

7 years
How many fingers on one hand, on other hand, on both hands
(no error)
Ties bow knot (less than 1 minute)
Copies diamond
Names days of week
3 digits backwards (1 of 3 correct)
2-8-3 4-2-7 9-5-8

Pen

8 years
Counts 20 to 0 (less than 40 seconds only 1 error)
Definition superior to use (2 of 4)
balloon tiger football soldier
What’s the thing for you to do (any appropriate answer)
If you’ve broken something that belongs to someone else?
If a playmate hits you without meaning to do so?
When you are on your way to school and notice you are in danger
of being late.
Writes with a pen (must be easily legible—1 minute only)
“See the little boy.”

9 years
Date (allow a 3-day error only)
Repeats 4 digits backward (1 of 3)
6-5-2-8 4-9-3-7 8-6-2-9
Names months (15 seconds, 1 error)
Makes a sentence with these three words in it: (2 of 3)
work — — — money — — — men
boy — — — river — — — ball
desert — — — rivers — — — lakes
Another means of estimating the intelligence is the drawing of forms. The child is asked to copy the drawing you make:

- a circle at 3 years
- a square at 4 years
- a cross at 5 years
- a triangle at 6 years
- a diamond at 7 years

The average child can copy:

- a circle at 3 years
- a square at 4 years
- a cross at 5 years
- a triangle at 6 years
- a diamond at 7 years

The retarded child is usually retarded in his ability to do this and the superior child usually can pass the items beyond his chronologic age, while the brain-damage child scores well below his intelligence level.

**GOODENOUGH DRAW-A-PERSON TEST:** In general the Goodenough Draw-A-Person Test correlates well with the Stanford Binet Test, is simple to give and not difficult to score. The child is asked to draw a person—any person he wishes. If necessary, he is urged to do as well as he can. This test may be used from 3 to 11 years of age, but in the upper range it is not so accurate. If the child draws a circle he is given a score of 3 years, and for each four details added, he is given 1 more year of credit. Fifty-one different details are possible.

The following outline adapted from Goodenough shows the simplicity of the scoring:

- Head present
- Legs present
- Arms present
- Trunk present
- Length of trunk greater than breadth
- Shoulders indicated
- Both arms and legs attached to trunk
- Legs attached to trunk; arms attached to trunk at correct point
- Neck present
- Neck outline continuous with head, trunk or both
- Eyes present
- Nose present
- Mouth present
- Nose and mouth in two dimensions; two lips shown
- Nostrils indicated
- Hair shown
- Hair nontransparent, over more than circumference
- Clothing present
- Two articles of clothing nontransparent
- No transparencies, both sleeves and trousers shown
- Four or more articles of clothing definitely indicated
- Costume complete, without incongruities
- Fingers shown
- Correct number of fingers shown
- Fingers in two dimensions, length greater than breadth, angle less than 180 degrees
- Opposition of thumb shown
- Hand shown distinct from fingers or arms
- Arm joint shown, elbow, shoulder or both
- Leg joint shown, knee, hip or both
- Head in proportion
- Arms in proportion
- Legs in proportion
- Feet in proportion
- Both arms and legs in two dimensions
- Heel shown
- Firm lines without overlapping at junctions
- Firm lines with correct joining
- Head outline more than circle
- Trunk outline more than circle
- Outline of arms and legs without narrowing at junction with body
- Features symmetrical and in correct position
- Ears present
- Ears in correct position and proportion
- Eyebrow or lashes
- Eye pupil
- Eye longer than high
- Eye glance directed to front in profile
- Both chin and forehead shown
- Projection of chin shown
- Profile with not more than one error
- Correct profile

If the child draws seven details, his drawing age will be 3 years plus 1½ years or 3½ years. If he draws 16 details, his drawing age will be 3 years plus 4½ years or 4 years. This can be compared to his chronologic age and a fair idea obtained as to whether he is average, retarded or superior in intelligence.

The drawings of brain-damaged children and of schizophrenic children are the exceptions to the close correspondence between the Draw-A-Person Test and the Binet. In brain-damaged children the drawings may score 2 or more years below the
Binet. In schizophrenia they may be advanced. In addition, the drawings of brain-damaged children often show a disorganized figure or the figure is large and empty. In schizophrenia the figure is bizarre, confused and often full of detail. These findings are helpful in the differential diagnosis.

**Other Tests:** School retardation of 3 years or more is suggestive of mental deficiency with I.Q. below 70. There are educational achievement tests which are easy to give in the office, and which are of some assistance in estimating how retarded the defective child is. They are especially valuable in differentiating reading disability.

If it is necessary to know more accurately at what level of intelligence the defective child is functioning, he may be sent to a psychologist for testing. The Stanford-Binet or the Wechsler Intelligence Test Scale for Children (WISC) are the tests usually used. The former is mostly verbal. The Wechsler has the advantage of differentiating the verbal and performance tests.

**Summary**

For office diagnosis of intelligence, one’s clinical judgment, based on the developmental history, medical history, observation of the child, and the child’s ability to carry out a few simple directions, is fairly accurate in determining if the child is functioning at a retarded, average or superior level. Whether the child is actually feebleminded or suffering from brain damage or schizophrenia or affected by a reading problem is sometimes much more difficult and time-consuming, although there are suggestive findings in the office examination. If necessary the level of intelligence can be confirmed by more exact measurements.

**Office Evaluation of Specific Reading Disability in Children**

By Leon Eisenberg, M.D.

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The purpose of this paper is to consider the child who hears well, whose vision is intact, whose general intelligence is good, but who, nonetheless, is unable to learn to read with normal proficiency. This, then, may suffice us as an operational definition of a specific reading disability.

It should not be necessary to expound at length on the importance of this problem. Not one of us, as physicians, would have been able to attain his present position without fluency in reading. Whatever hopes we may have for our own children presuppose the development of adequate reading skills; in a society in which the written word occupies such a position as it does in ours, illiteracy is an almost insuperable barrier to an adequate social adjustment. Reading disability, like mental deficiency of all but the most severe degree, is a disorder which is only discernible in literate society. Moreover, its diagnosed prevalence will depend upon the extent to which education is compulsory. The re-
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