1952

A survey of fifty-five cases examined by the Worcester Youth Guidance Center Traveling School Clinic in 1950-1951.

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Boston University
BOSTON UNIVERSITY
SCHOOL OF SOCIAL WORK

A SURVEY OF FIFTY-FIVE CASES EXAMINED BY
THE WORCESTER YOUTH GUIDANCE CENTER
TRAVELING SCHOOL CLINIC IN 1950-1951

A Thesis

Submitted by
Siegfried Michael Turner
(B. S. in J., Boston University, 1947)
In Partial Fulfillment of Requirements for
the Degree of Master of Science in Social Service
1952
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>CHAPTER</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Introduction, Statement of the Problem and Method of Procedure</td>
</tr>
<tr>
<td></td>
<td>Selection of Cases</td>
</tr>
<tr>
<td></td>
<td>Sources of Data</td>
</tr>
<tr>
<td>II</td>
<td>The Worcester Youth Guidance Center</td>
</tr>
<tr>
<td></td>
<td>Origin and History</td>
</tr>
<tr>
<td></td>
<td>Present Administration and Procedure</td>
</tr>
<tr>
<td></td>
<td>Diagnostic Studies</td>
</tr>
<tr>
<td></td>
<td>Consultation Service</td>
</tr>
<tr>
<td></td>
<td>Treatment</td>
</tr>
<tr>
<td>III</td>
<td>The Worcester Youth Guidance Center Traveling Psychiatric Clinic</td>
</tr>
<tr>
<td></td>
<td>Introduction</td>
</tr>
<tr>
<td></td>
<td>Description of the Clinic</td>
</tr>
<tr>
<td></td>
<td>Clinic Services and Procedure</td>
</tr>
<tr>
<td></td>
<td>The Role of the Social Worker</td>
</tr>
<tr>
<td></td>
<td>Attitudes toward Type of Problems Presented and Recommendations</td>
</tr>
<tr>
<td>IV</td>
<td>Examination of Clinic Reports to Schools</td>
</tr>
<tr>
<td></td>
<td>Distribution of Cases in School Systems</td>
</tr>
<tr>
<td></td>
<td>Distribution of Age Groups</td>
</tr>
<tr>
<td></td>
<td>Referring Complaints</td>
</tr>
<tr>
<td></td>
<td>Introduction on the Use of Terms in this Section</td>
</tr>
<tr>
<td></td>
<td>Distribution of Complaints</td>
</tr>
<tr>
<td></td>
<td>Clinical Examination Findings</td>
</tr>
<tr>
<td></td>
<td>Recommendations to the Schools</td>
</tr>
<tr>
<td>V</td>
<td>Examination of Follow-Up Study Findings</td>
</tr>
<tr>
<td></td>
<td>Introduction</td>
</tr>
<tr>
<td></td>
<td>Comparison of Children's Status in Regards to Presenting Symptoms</td>
</tr>
<tr>
<td></td>
<td>Academic Standing</td>
</tr>
<tr>
<td></td>
<td>Teachers' Understanding of Problem and Method of Dealing with It</td>
</tr>
</tbody>
</table>
# TABLE OF CONTENTS (cont'd)

<table>
<thead>
<tr>
<th>CHAPTER</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children's Adjustment</td>
<td>52</td>
</tr>
<tr>
<td>Additional Comments</td>
<td>54</td>
</tr>
<tr>
<td>VI</td>
<td></td>
</tr>
<tr>
<td>Summary and Conclusion</td>
<td>57</td>
</tr>
<tr>
<td>Summary</td>
<td>57</td>
</tr>
<tr>
<td>Conclusion</td>
<td>62</td>
</tr>
<tr>
<td>Bibliography</td>
<td>67</td>
</tr>
<tr>
<td>Appendix</td>
<td>68</td>
</tr>
<tr>
<td>Schedule A - Initial Survey</td>
<td>69</td>
</tr>
<tr>
<td>Schedule B - Follow-up Survey</td>
<td>71</td>
</tr>
</tbody>
</table>
# LIST OF TABLES

<table>
<thead>
<tr>
<th>TABLE NO.</th>
<th>Description</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Sex Distribution of Cases by School Systems at the Traveling School Clinic</td>
<td>23</td>
</tr>
<tr>
<td>II</td>
<td>Distribution by Ages of Cases Seen at the Clinic</td>
<td>24</td>
</tr>
<tr>
<td>III</td>
<td>Types of Problems Referred to the School Clinic</td>
<td>27</td>
</tr>
<tr>
<td>IV</td>
<td>Distribution of Descriptive Psychiatric Terms used in Reports of the School Clinic</td>
<td>31</td>
</tr>
<tr>
<td>V</td>
<td>Types of Psychological Tests Administered by the School Clinic</td>
<td>32</td>
</tr>
<tr>
<td>VI</td>
<td>Intelligence Ratings of Children Tested by the School Clinic</td>
<td>33</td>
</tr>
<tr>
<td>VII</td>
<td>Recommendations Made to Schools by the Clinic Team</td>
<td>35</td>
</tr>
<tr>
<td>VIII</td>
<td>Distribution of Returned Questionnaires</td>
<td>39</td>
</tr>
<tr>
<td>IX</td>
<td>Present Status of Students in Regard to Presenting Problems</td>
<td>42</td>
</tr>
<tr>
<td>X</td>
<td>Factors Contributing to the Present General School Adjustment of the Children</td>
<td>43</td>
</tr>
<tr>
<td>XI</td>
<td>Comparison of Academic Difficulties and Behavior Disturbances at Time of Referral and at Present</td>
<td>45</td>
</tr>
<tr>
<td>XII</td>
<td>Teachers' Evaluation of Clinic's Usefulness in Understanding and Helping the Children, and Estimate of Clinic's Effectiveness</td>
<td>49</td>
</tr>
</tbody>
</table>
CHAPTER I

INTRODUCTION, STATEMENT OF THE PROBLEM, AND METHOD OF PROCEDURE

Introduction

Without adequate provisions for diagnosis of the child and his potentialities and problems and the use of these findings in the guidance of children, the value of guidance efforts are very limited. Emphasis on the guidance of the individual child also requires flexible provisions within the school or school system for meeting his needs once they are ascertained. Diagnosis and guidance without the means for adjusting his educational program to meet his problems and needs would appear to be a rather futile procedure, and yet this still seems to be the situation in a number of the communities. The organization and process of guidance and counseling cannot be considered in isolation from other educational efforts to individualize the approach to each child and to help him to achieve a healthy, well-rounded development as an integrated personality.¹

This quotation summarizes the philosophy which in 1950 prompted the Director of the Worcester Youth Guidance Center² to accept the suggestion of the Worcester State Hospital to supervise a traveling diagnostic school clinic³ in cooperation with the Hospital, which up to then had been in sole charge of a traveling clinic servicing the school systems in the area under its jurisdiction.

The Center welcomed this opportunity, for here seemed

¹ Ernest Harms, editor, A Handbook of Child Guidance, pp. 439-440
² Hereafter referred to as the "Center"
³ Hereafter referred to as the "Clinic"
an excellent way of establishing closer relations with the schools, in which so many of its young patients' problems first manifested themselves. By offering its specialized skills in the children's field to the schools it was felt a sizable contribution to their better adjustment could be made. Furthermore, the Clinic consciously strove toward the "adjusting" of the educational program, not by means of radical and rightfully uncalled-for recommendations of the educators, but by interpreting and clarifying the needs of the children in the school. It was hoped that by involving the teachers, superintendents and other school personnel in the actual work of the Clinic, they could be enabled to gain a clearer view of the problems presented by individual students of which they otherwise might be unaware.

Problem to Be Investigated

The purpose of this study is to analyze the work of the Clinic as represented in a number of selected cases. This analysis will be attempted from the following two points of view: (a) to examine the aims, methods and procedures of the Clinic; and (b) through a follow-up study whose purpose will be to measure the extent to which the Clinic's aims were understood and realized. The relative amount of success of such an

4 The term "teachers" is used generally throughout this study, and includes all school personnel in question.
undertaking as the Clinic is difficult, if not impossible, to ascertain. Questions immediately arise as to the "yardstick" one can measure success with. Is it by the improvement of class grades - and if so, does this consider the emotionally restricted child with excellent grades? Is it by a child's emotional or behavioral adjustment - and if so, does this consider the behavior-problem child whose behavior improves but who does poorly in school work? What are the myriad environmental factors in school and at home which could contribute to the child's status? Obviously the criteria of grades, external and internal adjustment, and environmental factors all contribute to the making up of the "yardstick." Yet it would be beyond the scope of this study to undertake the minute follow-up procedure (including re-examination of all children already examined) required for such an evaluation. Since it has been shown in a recent study at the Center that the proportion of "untreated" children who tend to outgrow their problems is approximately the same as of those who were treated successfully, one wonders about the meaningfulness of evaluating the success of the Clinic in terms of the current status of the children examined.

Therefore this study is not intended as a critical ap-

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5 Jayne Keller, Outgrowing Childhood Problems: A Follow-up Study of Fifty Untreated Children, p. 53
praisal of the work of the Clinic as a whole, but as a report of the current status of fifty-five of the children examined, the emphasis being placed on the teachers' evaluation and comments. It is hoped that from this, certain conclusions may be drawn as to the teachers' understanding of the Clinic's purpose, for in that sense only will it be possible to evaluate the effectiveness of the undertaking.

Thus, a general question which this thesis will attempt to answer is "To what extent were the means of adjusting the educational system to a child's needs affected through the work of this Clinic?" (The "means of adjustment" being in this case primarily the teachers.)

In addition to the teachers' evaluation of Clinic effectiveness, it is felt that certain facts as to the bases of their evaluation must be established so that their criteria for relative degrees of success or failure in the children's adjustment may become clearer.

For this purpose the study is initially concerned with a summary of the fifty-five cases presented as to (a) types of presenting problems; (b) extent of clinical examinations, interviews and findings; (c) family patterns as related to children's problems; and (d) recommendations.

The follow-up investigation is concerned with the setting up of scales against which the above factors may be measured from the current viewpoint. While such factors as symptom-
atology, academic standing, parental patterns and environmental situations lend themselves well to such a direct comparison, it was felt that the major factor—gauging the response of teachers to the Clinic—could be measured only in a more indirect manner.

Therefore, the follow-up questionnaire included questions designed to elicit information relating to (a) the factors in a child's general school adjustment determining the teacher's evaluation of the present status of problems; (b) comments on the children's academic standing; (c) statements by teachers to show how the children's referral to the Clinic had affected their understanding of their problems and methods of dealing with them; (d) teachers' estimates and comments on the Clinic's effectiveness for each child studied and presented here; (e) teachers' estimates and comments on parental relationships, if known. In addition, comments on the overall work of the Clinic were asked for.

Selection of Cases

Fifty-five cases were selected out of a total of ninety-seven seen by the Clinic from October, 1950 to May, 1951. These represent all the cases in which at least one social work interview was conducted with one or both parents of each child. The reason for the selection of cases on this basis is immediately apparent, as in order to study the possibilities of the Clinic it would appear necessary to select cases
in which its full capabilities were realized. Furthermore, as social workers mainly saw parents of children not suspected of intellectual retardation, the emphasis of this thesis, like that of the Clinic, will be on the emotional adjustment of children in their present school setting.

Sources of Data

The Clinic reports to the school superintendents were used as the basis from which material for the initial summaries of the Clinic examination was obtained. This procedure was used in preference to a study of actual case material because it was felt that the focus of the study being on the child's school adjustment, the comparison should logically be based on material with which the school is familiar. Ideally, the material presented at staff conferences (in which teachers participated) should be included, but as no records of these were made, this is impossible.

The follow-up questionnaires were submitted to school superintendents who, in turn, passed them on to the teachers concerned with each individual child. Contact was maintained through personal visits, telephone calls and letters. In addition each school system received a copy of the thesis outline as a reference aid, supplementing verbal explanation of the project. Clinic reports and questionnaires were abstracted and projected on a work-sheet to facilitate handling of the material. Because of its voluminousness, the chart unfortu-
nately cannot be presented in this study, although the con-
tent is presented herein in summarized form.

Thus, the first part of the study is concerned with an
examination of Clinic procedure and findings, while the
latter part contains an examination of the questionnaire.6
A comparison of findings will yield certain conclusions as
to the work of the Clinic.

6 Complete schedule form and follow-up questionnaire
may be found in the Appendix, pp. 69, 70, 71, 72
CHAPTER II

THE WORCESTER YOUTH GUIDANCE CENTER

Origin and History

The school clinic system to examine retarded children in Massachusetts was devised and placed in operation by Dr. Walter E. Fernald in 1914 when he sent out the first traveling clinic team from the State School which now bears his name. Three years later a second clinic was sent by Dr. George L. Wallace from the Wrentham State School. Soon it became evident that these two clinics were not able to examine the vast number of children in all the public schools in Massachusetts. Dr. Fernald and Dr. George M. Kline placed the matter before the Commissioner of Mental Diseases, and in 1921 traveling psychiatric clinics were established at each of the institutions under the Department throughout the State. The Department was enabled to do this by a law passed in 1919 which made mandatory the testing of all children retarded three years in the public schools. At present the law also makes eligible for examination those children less than three years retarded, as well as children presenting various behavior problems which have been interfering with their school progress. In addition

1 Commonwealth of Massachusetts, Reprint of Annual Report of the Commissioner of Mental Health on the Division of Mental Deficiency, 1938, pp. 2,3

2 Mass., G. L., Ch. 71, sect. 46 (amended 1922, 1931)
to offering the diagnostic service required by law, some clinics began to offer treatment in cases where the parents of the child consented to it. Thus it may be seen that starting from their often routine examination of children, traveling clinics grew to offer diagnostic and treatment services to emotionally disturbed children as well, and thus in some instances assumed the character of child guidance clinics.3

Moreover, the early traveling clinics served to stimulate interest in child guidance, as more and more problems of an emotional nature were referred to them. By 1920 a number of out-patient mental hygiene clinics, attached to State hospitals, were well established in serving children as well as adults. In 1922 the Division of Mental Hygiene was established under the Department of Mental Health, and State funds were appropriated to it for research and the establishment of children's clinics. In the following year, a Habit Clinic for children was established at the Worcester State Hospital, offering for the main part consultation services. However, because of lack of public response to a clinic located in a State hospital, and fear of the association with mental illness, the clinic was discontinued in 1923. Soon after, the service was re-offered by the newly formed Mental Hygiene

3 Edgar C. Yerbury and Nancy Newell, The Development of the State Child Guidance Clinics in Massachusetts, pp. 2, 3
Clinic for adults and children at the Memorial Hospital, a general hospital which already held a high place in community opinion. The traveling school clinic, of course, continued its operation from the Worcester State Hospital.

In 1926 the Worcester Child Guidance Association was formed, and under its direction the Worcester Child Guidance Clinic (as the Center was then called) was developed as an independent unit of the Mental Hygiene Clinic. By 1929 the Center was able to offer full-time service, with some financial assistance from the community. Since Memorial Hospital afforded inadequate space for this offspring of its Mental Hygiene Clinic, the move to its own quarters was accomplished in this year. The Center thus became the joint enterprise of the community, the hospital and the state. Although it was still officially under the direction of the State Hospital, the Center's director was free to adapt its policies to the needs of the community as he saw them.4

Since then, treatment and community consciousness have been the theme of the Center, and the staff began an educational program to encourage parents rather than social agencies to initiate application for treatment. A small fee system was instituted as a further attempt to abolish the charity

4 Helen L. Witmer, Psychiatric Clinics for Children, pp. 149-155
aspects of the Center, and to encourage the clients' recognition of the value of treatment.

Present Administration and Procedure

The present sources of finance of the Center are the Community Chest, The State Department of Mental Health, and the United States Public Health Service, as well as through the fee system. Since 1947 it has been under the directorship of Dr. Joseph Weinreb. Its name was officially changed in 1948 to Worcester Youth Guidance Center. This change signified a further step in defining the role of the agency to the community in terms of preventive services, and represented an attempt to encourage the older youth to seek help with their problems.

The staff, at the time of this study, consists of the director, chief social worker, assistant psychiatrist, three psychiatric social workers, chief psychologist, assistant psychologist, psychometrist, social work training supervisor (who participates as a regular staff member collaterally with her training supervisory activities), two psychology internes and four social work students.

While in general functioning the various disciplines comprising the team follow the standard procedure, the Center allows some flexibility in the assignment of either a child or an adult client to any member of the therapy team.

Community educational programs are maintained by members
of the staff who are on call from various organizations for lectures on subjects related to the work of the Center. Other staff members conduct courses for student nurses at Worcester State Hospital. The Director has given several University Extension courses for school personnel and is on the faculty of Clark University Psychology Department. Association with Worcester State Hospital is maintained through the above-mentioned course for nurses. In addition, the Hospital furnishes free room, board and laundry to Center social work students and psychology interns. Monthly teaching staff meetings on child psychiatry are also held for Hospital staff members by the Center. The traveling school clinic which is the subject of this study, represents another facet of cooperation between the two institutions, as the psychiatrist for this project was paid by the Hospital and worked at the Center on a part-time basis. In return, the Center furnished additional personnel for the school clinic team.

Services rendered at the Center include:

**Diagnostic Studies**

This service is used mainly by social agencies, courts, physicians or parents interested in receiving an interpretation of a child's behavior and recommendations for treatment. It is also sometimes offered preliminary to treatment.

**Consultation Service**

Members of the staff are available on an advisory basis
to social agencies when they are dealing with children's problems. On an educational basis, a portion of the Center staff's time is available to community groups studying the behavior of children. Parents may also make use of consultation service on a short contact basis.

**Treatment**

Treatment is offered to all children, up to the age of seventeen, living in the area serviced by the Center, and is based on the diagnosis of the Clinic team. Treatment is the primary function of the Center and involves participation of the parent in relation to the parent-child situation. Parents' problems which appear to have a direct bearing on the child's difficulties are also dealt with. Separate therapists for both parent and child tend for a more favorable setting for a therapeutic relationship and minimize the opportunity for friction between parent and child during treatment. It was because the Center recognized that many emotionally disturbed children manifested their difficulties in inability to function at their normal intellectual level, that the Center offered its facilities to the Clinic in an attempt to create a more beneficial school environment for the individual child. It was hoped that by acquainting teachers with the types of personality problems involved, and the specific measures which could be taken to adjust the school environment to particular needs of children, a service
of more lasting value than mere diagnosis could be provided by the traveling Clinic.
CHAPTER III
THE WORCESTER YOUTH GUIDANCE CENTER
TRAVELING PSYCHIATRIC CLINIC

Introduction

From October, 1950 to May, 1951 the Center arranged to conduct the traveling Clinic, serving thirty-six towns in the area served by Worcester State Hospital. In all, nineteen school departments were contacted, some including several towns under their jurisdiction. The selection of these school systems was by virtue of their being outside the area of Worcester proper and therefore not regularly serviced except by traveling Clinics operated by the Worcester State Hospital.

While the cooperation between the Center and the hospital was an innovation, historically there has been a close relationship between the two, as we have seen. It is noteworthy, too, that as long ago as 1926 the trustees of the hospital anticipated the present Clinic's approach when they reported that in their traveling school Clinic

The attempt is made as far as possible to see the parents of the child... Talks have been given to teachers also in reference to the problems involved with the dealing with retarded children in school and a great deal of interest has been manifested in this way.1

1 Commonwealth of Massachusetts, Annual Report of Trustees of Worcester State Hospital, 1926, pp. 11, 12
Description of the Clinic

During the years of its early growth and development the Center did not consider a traveling school Clinic as properly a part of its service to the community. However, with the increase in personnel following the war such a project seemed feasible, when in 1950 the State Hospital assigned a psychiatrist who could devote part of his time to the Center as well as the Clinic. The Center, in turn, provided psychologists and social workers from members of its staff. Assistant psychiatrists from the Center also conducted occasional interviews, as did social work students.

The Clinic, unfortunately, could not be continued on this basis in 1951-1952 because of the recall of the psychiatrist into the Army and the difficulty of obtaining a replacement.

Clinic Services and Procedures

The Clinic's services consisted of psychological testing, psychiatric examination and social work interviews with parents. The Clinic was an experimental undertaking, varying somewhat from the work that had been done in this field in the past. While previous clinics of this kind had placed much emphasis on obtaining a great amount of history about the child and his family, the focus now was on the present status of the

2 The information contained in the remainder of this chapter is based on lectures given by the psychiatrist and social worker of the Clinic in March, 1951.
child and his problems.

The diagnostic service it offered was designed to be of value to the schools, and indeed the major emphasis was on the consultative aspects of this service. The social workers saw parents after examination of the children usually in the particular school building. As a rule the psychiatrist saw the child first and on the basis of his findings, appropriate psychological tests were administered, and if necessary the child's parents were asked to appear for an interview at a later date following the examination. The findings of the team were presented to school personnel (including the teacher who made the referral) at a diagnostic conference, following which the parents were seen an additional time by the social workers who interpreted the findings and recommendations discussed at the Conference.

Because of its experimental nature, modifications in Clinic procedure were made during its operation. Thus, the original plan to interview parents of all children examined was changed when it became evident that social workers would be unable to keep pace with the rest of the team as each parent was seen twice to the child's once. Also, in a few instances staff Conferences were not held because it was felt that adequate data were already in the school's possession.

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3 Hereafter referred to as the "Conference"
through previous examinations and contact with the family.

The major departure from routine clinical procedure, however, was the Conference in which team members and referring school personnel participated. Thus, in each case the school superintendent, teacher, school nurse or guidance director would share in discussing the findings of the team.

The procedure at Conferences was to allow the referring person to present the facts about the child as they were known to the school. At this point the team was able to offer consultation service based on the findings of the examinations. Additional staff Conferences were sometimes scheduled when it was felt that problems presented earlier had not been adequately covered. (The only exception to this policy was in the examination of high school students in Holden, where Conferences were held between the team psychiatrist and school guidance director alone.)

Following the Conferences, either the psychiatrist, psychologist or social worker wrote a report to the superintendent of schools for each case seen, listing (a) a description of the problem presented; (b) a summary of examination findings; and (c) specific recommendations.

These reports enabled schools to complete their records on each child and served as a tangible means of maintaining an atmosphere of better working relationship between Clinic and schools. For notwithstanding the great strides in popular
understanding of psychiatric clinics, some school personnel seemed quite apprehensive over the idea of psychiatric inter­views with children, or social work interviews with parents. One superintendent was reported not to have informed parents of the dates of their interviews for fear they would become too hostile.

The team recognized this factor and a standard procedure in interviewing parents was to approach the individual's feeling about coming to the Clinic, in an attempt to deal with the possible resistance present. In addition, the schools were encouraged to present the idea of self-referrals to parents who otherwise might feel pressured into coming to the Clinic.

The Role of the Social Worker

The purpose of having social work interviews in the Clinic may be described as (a) helping to round out the picture of the child for diagnostic purposes and suggesting suitable recommendations, as well as interpreting the problem; and (b) helping to improve, if possible, the relationship between the parents and the school.

In accordance with the general focus of the Clinic, parents' interviews were focussed on the child's presenting problems, starting with the reason for referral. Therefore, the initial interview differed somewhat from usual Center intake interviews, chiefly in that not so much attention was placed on details of early developmental history of the child. Rath-
er, the parents' feelings about themselves in relation to the children were explored, as were environmental circumstances.

Following this interview the social worker presented his findings at the Conference in an effort to relate the child's school and personality problem to his parental, and environmental situation.

The interviews with parents following the Conference were focussed on interpreting findings and recommendations of the team to them. The actual intelligence quotient was never revealed, phrases such as "average," "above average," or "below average" being substituted instead. In some cases, parents were referred to other social agencies or to seek medical attention.

In connection with the reports to schools following the examination, it is noteworthy to mention that there was no definite policy as to the amount of parental and environmental information which should be disclosed to the school, and this applied to the Conferences as well. This problem could not be satisfactorily dealt with through the creation of a standard policy as obviously no two cases presented similar circumstances. However, school personnel were cautioned about the confidentiality of all the information presented to them as a guard against indiscriminate divulgance of such information. Confidentiality was further insured by keeping all case records, including psychiatric, psychological and social work
Attitude towards Type of Problems Presented and Recommendations

While a variety of children's problems were represented, the factor basic to the majority was of an emotional nature. Because of the great number of children to be examined, it was impossible to interview parents of all children, and this service was therefore apparently limited to parents of children whose intelligence seemed high enough to exclude the diagnosis of defective mentality. It was felt that in concentrating on children whose emotional problems prevented their functioning at reasonable intellectual capacity, the Clinic would serve those most able to use all its facilities. While ideally, of course, all parents might have been interviewed, it was felt that in the cases excluded from this service because of low grade intelligence, the consultation with school personnel could suffice to provide for greater understanding and better management of the child's problem in school. If the Clinic team felt that placement in a State school or special class was indicated, however, the parents were sometimes seen also and recommendations interpreted to them.

Because the emphasis of the Clinic lay in affecting the children's improvement within the school setting, it was intended that relatively few recommendations for therapy at the Center be made. Although the percentage among those studied in this thesis appears high, this is not representative of the
entire group of children. Generally recommendations were aimed to assist teachers and others in direct contact with the children to aid them in their daily school activities.
CHAPTER IV
EXAMINATION OF CLINIC REPORTS TO SCHOOLS

Distribution of Cases in School Systems

Table I shows the distribution of cases in the five school systems included in the study. One of the cases referred by the Holden system was not in attendance there, but was seen for diagnostic purposes at the request of an adjacent town.

TABLE I
SEX DISTRIBUTION OF CASES BY SCHOOL SYSTEMS
AT THE TRAVELING SCHOOL CLINIC

<table>
<thead>
<tr>
<th>School system</th>
<th>No. of girls</th>
<th>No. of boys</th>
<th>Total</th>
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<tbody>
<tr>
<td>Auburn</td>
<td>1</td>
<td>7</td>
<td>8</td>
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<td>Holden</td>
<td>2</td>
<td>25</td>
<td>27</td>
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<tr>
<td>Shrewsbury</td>
<td>4</td>
<td>13</td>
<td>17</td>
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<tr>
<td>Sutton</td>
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<td>1</td>
<td>2</td>
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<tr>
<td>Warren</td>
<td>1</td>
<td>0</td>
<td>1</td>
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<tr>
<td><strong>Full totals</strong></td>
<td><strong>9</strong></td>
<td><strong>46</strong></td>
<td><strong>55</strong></td>
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Thus, boys outnumbered girls by a considerable margin in every system except Sutton and Warren, and represent eighty-four per cent of the total cases.

Distribution of Age Groups

Table II illustrates the distribution of age groupings among the fifty-five children studied in this thesis.
TABLE II

DISTRIBUTION BY AGES OF CASES SEEN AT THE CLINIC

<table>
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<tr>
<td>12</td>
<td>2</td>
</tr>
<tr>
<td>13</td>
<td>6</td>
</tr>
<tr>
<td>14</td>
<td>3</td>
</tr>
<tr>
<td>15</td>
<td>3</td>
</tr>
<tr>
<td>16</td>
<td>0</td>
</tr>
<tr>
<td>17</td>
<td>1</td>
</tr>
<tr>
<td>18</td>
<td>1</td>
</tr>
</tbody>
</table>

The preponderance of cases in the eight-year-old group (twenty-five per cent of the total number of cases) seems to indicate the existence of a greater number of disturbances at this age. This may be due to the introduction of more formalized academic procedures to which basically disturbed children may react more openly at this age. It must also be recognized that by the time children reach this age, they have usually had two years of schooling and by then the teachers may be in a position of judging whether the child is adjusting to school in a normal manner.

The ages of eight to thirteen appear to be the most generally represented. A possible explanation of this may be the difficulties of disturbed latency period and early adolescence.

The Referring Complaints

As the following material was obtained from the actual reports submitted to schools, it is necessary to explain that in many ways the reports do not give a "whole" picture of each child. The reports were necessarily brief, leaving out much of the qualifying data. However, it is felt that they do give sufficient details concerning essential facts to be presented.
as valid material.

Introduction on the Use of Terms in this Section

"Under our cultural conditions," writes Fenichel,¹ "aggressiveness is necessary for a healthy career." That this applies to the school situation is self-evident, and it is only necessary to point in this respect that under ideal circumstances learning is an aggressive act, which develops out of infantile curiosity, and in which the child through his own volition and out of the realization that he wants to mature, takes into himself the knowledge required in an adult world.

The number of children referred for clinical examination from our schools is sufficient evidence that in many cases the required aggressiveness has been thwarted (sometimes resulting in passivity, or in a "false, overcompensating and misdirected aggressiveness.")² Thus, when a child's aggressiveness is not allowed to flow into normal channels, it may become outwardly misdirected, resulting in aggressive misbehavior; in other cases it is inwardly misdirected, resulting in preoccupied, withdrawn or even self-punitive behavior.

For purposes of this study, these abnormalities have been simplified into two categories: withdrawn tendencies and aggressive tendencies of behavior. The former implies with-

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¹ Otto Fenichel, The Psychoanalytic Theory of Neurosis, p. 178
² Ibid., p. 58
drawal and the latter acting-out misbehavior. It may be argued that the complex reaction formations and counter-phobic defenses, which sometimes result in the adoption of opposite tendencies in an individual, will not yield a valid picture of the personality problems presented by the cases studied. In justification of this procedure, however, it is felt that since the classifications are employed only to categorize types of neurotic problems (apart from academic difficulties) it would be valid to single out the presenting aspect of the child's behavior problem as the teacher saw it, and regardless of whether there was a correlation of this to the later Clinic findings.

In the case of some children with markedly conflicting tendencies in the areas described above, it is felt that teachers were quite justified in emphasizing the acting-out part of a child's pattern because of its disturbing influence on the rest of the children in the classroom.

**Distribution of Complaints**

All children studied were referred for poor school adjustment of one kind or another. A study of the reports reveals that the referrals fell into two broad categories: (a) those due to a "learning disability," and (b) those due to misbehavior or preoccupation. The terms "academic difficulties" appear frequently for the former, and "disturbing behavior" for the latter in the referrals.
TABLE III
TYPES OF PROBLEMS REFERRED TO THE SCHOOL CLINIC

<table>
<thead>
<tr>
<th>No.</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>14</td>
<td>Academic difficulties alone</td>
</tr>
<tr>
<td>18</td>
<td>Academic difficulties and withdrawn behavior</td>
</tr>
<tr>
<td>15</td>
<td>Academic difficulties and aggressive behavior</td>
</tr>
<tr>
<td>2</td>
<td>Withdrawn behavior alone</td>
</tr>
<tr>
<td>3</td>
<td>Aggressive behavior alone</td>
</tr>
<tr>
<td>3</td>
<td>Conflicts between withdrawn and aggressive behavior, and academic difficulties</td>
</tr>
</tbody>
</table>

Tot. 55

In addition to the complaints listed in Table III, physical disturbances were noted in some of the referrals. However, these were often cited as minor evidences of the child's poor adjustment, and it is possible that teachers were aware of other somatic complaints which they did not report. There were no cases in which a physical complaint was the sole reason for referral.

Academic difficulties were noted in fifty of the referrals. Teachers called attention to such difficulties as "not able to do work," "retardation," "reading and spelling difficulty," "slowness," "marks dropping," "academic ineptness," "poor homework," etc. In two cases, mental deficiency was questioned as the reason for poor work, in another the complaint was mirror-writing.

In a total of forty-one cases evidences of disturbed behavior were noticed. Of these, seventeen mentioned such ag-

The remaining twenty-one cases referred to more withdrawn personalities in such terms as "immature," "self-conscious," "inability to work alone," "lacks concentration," "cries," "unsure," "daydreams," "holds in his feelings," "wanting to be protected," "not popular," "nervous," "distrustful," "unable to accept criticism," "inhibited," and "feelings of being picked on." One of the cases in this group mentioned over-eating at "odd hours" and another called attention to "unsavory sex habits" of a boy.

Three cases in which classification according to these categories seemed doubtful were those involving a boy who was "self-conscious" yet "shows off;" an adolescent who was a behavior problem because he was "afraid of being a sissy;" and a girl described as a "show-off, unliked and unreliable." In these cases, the internalized and externalized aggressiveness seemed difficult to differentiate.

Of the nine girls referred to the Clinic, only one presented an aggressive type of disturbance, the other eight being referred for shy and withdrawn behavior. All nine, however, presented problems in academic areas as well.

In eighteen of the cases mention was made of a bodily
malfunction or disfiguration. Five referred to enuresis, two mentioned deformities of the head, two noted disfiguration of the face. The remainder were described as "sick and weak," "sickly," "obese," "undernourished," "needing medical care," "speech defect," "breathing difficulty," "jerky movements," "uncleanness," and "facial tic."

Clinical Examination Findings

The entire Clinic team participated in examining every one of the cases presented, and at least two social work interviews were conducted with at least one present in all instances. In one case, that of a withdrawn adolescent girl, three psychiatric interviews were conducted. In another case the psychiatrist, rather than social worker, interviewed the father of a sickly six-year old girl whose parental relationship was rather poor. Both parents of two adolescent boys were interviewed in one school, but in the majority of cases only mothers were interviewed.

The following data are a summary of diagnostic material of the reports. The terms are for the greater part taken directly from the reports themselves. If a non-technical term was used, it was felt that for the sake of avoiding too many sub-groupings, such a term could be translated into technical terminology and be categorized more readily.

Since the reports were prepared by a number of individuals with differing professional backgrounds, it is not sur-
prising that there seems to be a lack of agreement as to the choice of the type of wording used in describing personality patterns. As it was assumed that teachers could not be expected to be familiar with technical terminology, it was felt that terms in popular usage would be used on the reports. Because of this, there was found a variety of descriptions, some referring to the intra-psychic aspects of the disturbances, others to the behavioral or presenting personality features. It is assumed, in this study, that the nature of the actual intra-psychic and presenting personality patterns was discussed at the staff conferences, and that the reports served to confirm the discussion.

In reviewing the types of basic personality disturbances referred, it was found that the group of boys with inadequate masculine identification was the largest. Frustrations due to mental defects, adolescent struggle for emancipation, affectional deprivations and over-discipline account for the remainder of the disturbances. It is important to note that elements of some of these problems were found to be present in a great number of these cases, and this may account for the frequent use of repetitious descriptive terms, as illustrated in Table IV.

Terms used in the table are those found in the reports, and are listed in the order of decreasing frequency with which they occurred in the fifty-five cases.
TABLE IV
DISTRIBUTION OF DESCRIPTIVE PSYCHIATRIC TERMS* USED IN REPORTS OF THE SCHOOL CLINIC

<table>
<thead>
<tr>
<th>No.</th>
<th>Description</th>
<th>No.</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>25</td>
<td>Anxious</td>
<td>3</td>
<td>Sensitive</td>
</tr>
<tr>
<td>16</td>
<td>Passive</td>
<td>3</td>
<td>Inhibited</td>
</tr>
<tr>
<td>11</td>
<td>Preoccupied</td>
<td>2</td>
<td>Not seriously disturbed</td>
</tr>
<tr>
<td>10</td>
<td>Lacks masc. identification</td>
<td>2</td>
<td>Adolescent struggle</td>
</tr>
<tr>
<td>6</td>
<td>Denies</td>
<td>2</td>
<td>Co-operative</td>
</tr>
<tr>
<td>6</td>
<td>Depressed</td>
<td>2</td>
<td>Obsequious</td>
</tr>
<tr>
<td>5</td>
<td>Childish</td>
<td>2</td>
<td>Frustrated due to low IQ</td>
</tr>
<tr>
<td>5</td>
<td>Over-aggressive</td>
<td>2</td>
<td>Lacks affect</td>
</tr>
<tr>
<td>5</td>
<td>Mentally retarded</td>
<td>2</td>
<td>Bizarre ideas</td>
</tr>
<tr>
<td>5</td>
<td>No apparent disturbance</td>
<td>2</td>
<td>Feminine identification</td>
</tr>
<tr>
<td>4</td>
<td>Shy</td>
<td>2</td>
<td>Hostile</td>
</tr>
<tr>
<td>4</td>
<td>Aggressive-passive conflict</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Other descriptive terms used in individual cases referred to daydreaming, castration anxiety, fear of relationships, fear of competition, self-satisfaction, perfectionism, lack of concentration and over-protection.

An almost universal tendency in the interviews was the presence of initial anxiety. In most cases, however, this was dispelled as the child grew accustomed to the surroundings and the Clinic personnel. Therefore, the references to anxiousness listed above are representative of those cases in which the anxiety was felt to be of sufficiently important clinical value to the understanding of the child.

The apparent discrepancy between findings in the psychiatric examination and the teachers' complaints may be explained by the fact that while teachers usually reported the classroom behavior pattern of a child, the clinical observation was
focussed on the intra-psychic and dynamic aspects of the child's personality. Thus while about half of the cases referred for behavior disturbances were described by teachers as having problems of an aggressive nature, the psychiatric findings reported only five basically "over-aggressive" children. It is therefore felt that a statistical comparison of the referrals and findings is invalid because they are based on different levels of observation.

TABLE V

<table>
<thead>
<tr>
<th>No.</th>
<th>Psychological Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>37</td>
<td>Stamford-Binet (forms L and M)</td>
</tr>
<tr>
<td>9</td>
<td>Goodenough Draw-A-Man</td>
</tr>
<tr>
<td>8</td>
<td>Rorschach Inkblot Test</td>
</tr>
<tr>
<td>5</td>
<td>Wechsler Intelligence Scale for Children</td>
</tr>
<tr>
<td>2</td>
<td>Children's Apperception Test</td>
</tr>
<tr>
<td>1</td>
<td>Szondi Test</td>
</tr>
<tr>
<td></td>
<td>Total 62</td>
</tr>
</tbody>
</table>

Table V shows the variety of tests noted on the reports. However, seven of the reports did not state which examination had been administered, although all but two contained an interpretation of the children's intellectual capacity.
TABLE VI
INTELLIGENCE RATINGS OF CHILDREN TESTED BY THE SCHOOL CLINIC

<table>
<thead>
<tr>
<th>No.</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>14</td>
<td>Above Average to Superior</td>
</tr>
<tr>
<td>16</td>
<td>Average (14) and Low Average (2)</td>
</tr>
<tr>
<td>17</td>
<td>Dull Normal (10) and Borderline (7)</td>
</tr>
<tr>
<td>6</td>
<td>Mentally Defective</td>
</tr>
</tbody>
</table>

Total 53

Psychologists often added qualifying statements when they felt the tests did not represent the child's true capabilities. Those marked as "minimal" representations of intellectual capacity included seven out of the ten classified as dull normal (an eighth possibility being represented by the notation on the report that a child in this category was not able to be tested fully because of his extreme anxiety.) Five in the average group were also qualified as "minimal" as were three in the borderline group, wherein the score of one child was declared "invalid" and another's "not representative" because of the severity of the emotional disturbances.

The unusually high number of children in the above average group leads to the speculation that perhaps among the total group of maladjusted children in school those with superior intellect show proportionally greater signs of their disturbance than those not so highly endowed. However it is important to remember that because of the smallness of the
sample the abnormality in this category may be due to chance.

No special study of the relationship between referral reasons and Clinic findings is attempted here because it is outside the area of this study. However, an informal comparison of the children classified as withdrawn or aggressive at time of referral with the Clinic's findings shows only a fair amount of relationship.

This disparity, again, may be due to the evaluation of presenting behavioral symptoms as against more basic personality patterns, and explains many cases in which the children had either over-compensated or adopted counter-phobic tendencies.

In forty-six of the fifty-five cases, an indication of the nature of family relationships was found. Of these, only two were found to be "warm and understanding" ones (one in the case of a physically handicapped girl and the other in the case of a boy of borderline mentality.) The remaining forty-four all showed evidences of disturbed relationships between parents and children, among siblings, or between husbands and wives. Teachers as a rule were not advised of the details of specific disturbances, this having been discussed at the staff conferences already. Instead, such remarks as "punitive and pressuring parents," "domineering mother," "overly severe parents," "sibling rivalry," and "overprotective home," were found in frequent use.
Recommendations to the Schools

An important aspect, especially for purposes of following up the cases presented here, is the consideration of recommendations made to the schools.

Table VII shows the groupings into which they fell, and the frequency of the reports in which they were noted.

**TABLE VII**

**RECOMMENDATIONS MADE TO SCHOOLS BY THE CLINIC TEAM**

<table>
<thead>
<tr>
<th>Number</th>
<th>Type of Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>43</td>
<td>Suggestions for attitudes of teachers</td>
</tr>
<tr>
<td>32</td>
<td>Psychotherapy</td>
</tr>
<tr>
<td>29</td>
<td>Adjusting present school program to ability</td>
</tr>
<tr>
<td>27</td>
<td>Placement in special schools or classes, or attention to other specific handicaps</td>
</tr>
<tr>
<td>14</td>
<td>Suggestions for aiding the child's general social adjustment</td>
</tr>
<tr>
<td>4</td>
<td>Attention directed to family and environmental problems</td>
</tr>
<tr>
<td>149</td>
<td>Total Number of Recommendations</td>
</tr>
</tbody>
</table>

A breakdown of the classifications reveals the following specific recommendations, using actual terminology in the reports:

In the group of recommendations dealing with suggestions for the attitudes of teachers, there were twenty references to encourage children; seven mentioned the teachers' providing satisfactory adult relationships with the children; seven mentioned helping the boys to assert their masculinity; five stated the need for the teachers' understanding and accept-
ance; and four mentioned giving praise.

The large number of recommendations for psychotherapy refers to treatment at the Center, with the exception of one adolescent for whom treatment at an outpatient clinic was suggested. The high proportion of this figure to the total number of cases studied indicates that a large percentage was felt to be seriously enough disturbed to warrant psychiatric help. It also indicates that despite the Clinic's intention to refer a minimum of cases to the Center due to its long waiting list, this opportunity could not be denied those who were felt to be in need of help. A possibility in speculating on the high ratio of this recommendation is the fact that the cases studied represent those hypothetically most capable of making a better adjustment through help with emotional problems. A study of the remaining forty-two cases not presented here would perhaps substantiate this speculation.

In the group of recommendations dealing with the adjusting of the present school program to the children's ability, nine suggestions were made to gear the school work to the child's ability; eight recommended easing school pressures; six mentioned giving the child special attention; and six suggested giving the child added responsibilities. While it is easy to understand the reasons for easing pressure for a child unable to function at his normal level, the reason for adding responsibility becomes clear when the high proportion of intellect-
usually superior children is considered. Such children are exemplified by an eleven-year-old boy with an I.Q. of 131 who was a behavior problem because he was so far ahead of the rest of his class. In his case, additional work was recommended.

Measures to be taken in regard to special school or class placement numbered nine. Of these there were six which recommended State schools for feeblemindedness, two private schools for gifted children, and one for a trade school in the public school system. There were eight recommendations for ungraded class placement, four recommendations for attention to medical conditions, three recommendations for remedial reading or speech classes, and three for tutoring.

Attention to the family situation was recommended by referrals to a family agency in three cases, and in one case a home investigation by the school was suggested.

Measures to aid in the children's general social adjustment included suggestions for group participation in six instances, social promotions were recommended in four, social guidance in three, and channelling of aggressive tendencies in one.

In two cases no recommendations were offered, the reason for one being that the child seemed to have adjusted well to a physical handicap, and the other being a pessimistic prognosis because of the seriousness of the emotional disturb-
ance, and a home environment unfavorable to treatment. In another case the teacher was asked to protect the child from his classmates who seemed to be taking advantage of his extreme submissiveness.

Summarizing the recommendations, it was seen that in keeping with the aims of the Clinic to try to modify the child's personality and social adjustment in school, most of the recommendations aimed specifically toward the school setting stressed the importance of understanding, by the teacher, of the child and his problems.
CHAPTER V
EXAMINATION OF FOLLOW-UP STUDY FINDINGS

Introduction

The problem in examining teachers' questionnaires was a somewhat more difficult one than that encountered in studying the reports. This was primarily due to the fact that many different individuals with varying academic and pedagogic backgrounds were involved in completing the questionnaires. Table VIII shows the distribution of school personnel involved in filling out the questionnaires.

TABLE VIII
DISTRIBUTION OF RETURNED QUESTIONNAIRES*

<table>
<thead>
<tr>
<th>No.</th>
<th>Returned by</th>
</tr>
</thead>
<tbody>
<tr>
<td>27</td>
<td>teachers</td>
</tr>
<tr>
<td>6</td>
<td>superintendents</td>
</tr>
<tr>
<td>6</td>
<td>guidance director</td>
</tr>
<tr>
<td>7</td>
<td>principals and assistant principals</td>
</tr>
<tr>
<td>1</td>
<td>school nurse</td>
</tr>
<tr>
<td>2</td>
<td>unsigned</td>
</tr>
</tbody>
</table>

Total 49

* A total of six questionnaires were not computed in these figures. Four of these had left the school system because they had moved to another town. Two questionnaires were not returned by one school system.

In devising the questionnaires, it was hoped that teachers would be familiar with the diagnostic findings, as well
as recommendations, as stated on the reports. In order to substantiate the hope that teachers had remembered the findings and applied the recommendations, which after all was the major aim in helping them to understand the child and on which basis we are measuring the effectiveness of the Clinic, a specific plan was devised to gauge the teachers' response to the Clinic's methods.

For this reason the questionnaire emphasized the presenting aspect of the child's symptoms, for it was felt that only in this way could teachers evaluate his present status. Since the Clinic contact with most schools was a limited one, it cannot be expected that the Clinic's diagnosis would necessarily mean as much to them as the observance of daily classroom behavior and performance, and justifiably so.

Therefore, besides containing the name, school and town of each child studied, the questionnaire also contained the presenting problems, if possible in the teacher's own words. In most cases, of course, the child was being taught by a different teacher than at the time of referral. Conferences between old and new teachers were not suggested (although this procedure was spontaneously adopted in several schools.) In this way, it was hoped to obtain a more accurate picture of how the present teacher saw the child in relation to his problems of last year. It would furthermore increase the possibility of learning how much of the information gained
through the Clinic's services was carried over from one teacher to another. Of the forty-seven returns on which an identification of the person filling in the questionnaire is given, thirty-four bear a name different from that making the original referral.

Questionnaires were presented to school superintendents to whom the study was explained, and copies of the thesis outline were left with them as reference aids. It is to be noted that all of the findings here presented are not clinical evidences of movement but are based on classroom observations. It is felt that only a follow-up clinical examination could reveal the exact nature of intra-psychic and behavioral changes. However, as this study does not attempt to deal with these factors from a psychiatric point of view, the present procedure is justified.

Comparison of Children's Status in Regard to Presenting Symptoms

The following findings are based on the first section of the questionnaire which followed the listing of the presenting problem as noted in this report. Table IX lists the frequency of responses to this section. The parenthesized explanation which follows beneath the individual category is in each case the same as was used in the questionnaire itself.
TABLE IX

PRESENT STATUS OF STUDENTS IN REGARD TO PRESENTING PROBLEMS

<table>
<thead>
<tr>
<th>No. Overall Status</th>
<th>No. Acad. Status</th>
<th>Present Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>3</td>
<td>Improved (problem eliminated; no new problems)</td>
</tr>
<tr>
<td>26</td>
<td>20</td>
<td>Somewhat improved (problem partly eliminated; no new problems)</td>
</tr>
<tr>
<td>18</td>
<td>17</td>
<td>Unimproved (problem not eliminated; no new problems)</td>
</tr>
<tr>
<td>3</td>
<td>6</td>
<td>Deteriorated (problem not eliminated; new problems in addition)</td>
</tr>
<tr>
<td>49</td>
<td>46*</td>
<td>Total</td>
</tr>
</tbody>
</table>

* Three questionnaires did not contain responses on academic status.

The table shows the vast majority of students in the somewhat improved and unimproved categories, while the number of improved or deteriorated children is small indeed. Interesting is the close relation between overall status and academic status. The figures on academic standing are in response to a separate question on the questionnaire and are brought in at this point for comparison. Academic standing is discussed in a later section of this chapter.

In order to ascertain by what standards teachers measured students' status they were asked to state what factors in the
students' general school adjustment determined their answer to the first question. In categorizing the responses to this question, the groupings shown in Table X were devised. In scoring them on this table it was found advantageous to describe them as "positive" or "negative," the former indicating a favorable and the latter an unfavorable change in the area described.

**TABLE X**

FACTORS CONTRIBUTING TO THE PRESENT GENERAL SCHOOL ADJUSTMENT OF THE CHILDREN

<table>
<thead>
<tr>
<th>Present Status</th>
<th>Academically</th>
<th>Behaviorally</th>
<th>Home cond.</th>
<th>Medical cond.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved</td>
<td>2 1</td>
<td>1 1</td>
<td>0 0</td>
<td>0 0</td>
</tr>
<tr>
<td>Somewhat improved</td>
<td>22 7</td>
<td>21 3</td>
<td>1 0</td>
<td>1 1</td>
</tr>
<tr>
<td>Unimproved</td>
<td>2 12</td>
<td>1 16</td>
<td>0 4</td>
<td>1 4</td>
</tr>
<tr>
<td>Deteriorated</td>
<td>0 4</td>
<td>2 2</td>
<td>0 0</td>
<td>0 0</td>
</tr>
<tr>
<td>Total</td>
<td>26 24</td>
<td>25 22</td>
<td>1 4</td>
<td>2 5</td>
</tr>
</tbody>
</table>

The inconsistency in the frequency of these responses is due to the fact that in some instances teachers referred to more than one positive or negative factor, and included more than one area, in appraising a child's adjustment, whereas in other replies the responses were more limited. Noteworthy in the various groups is the presence of a close relationship in the number of positive academic and behavior responses. This seems to indicate an awareness of the difficulty in drawing a
defining line between behavioral change without its con­
comitant, academic change.

Typical of the positive replies for the academic group­
ing are such remarks as "work improved," "span of concentra­
tion improved," "reading ability improved," "solved school
problem" and "desires to learn."

Negative replies in this category referred to the per­
sistence of various learning difficulties. Phrases such as
"no interest in learning," "low power of retention," "read­
ing difficulty persists," "doing poorly in class," and
"lacks concentration" are common in this group.

In the behavior grouping, positive responses included
remarks such as "more outside interests," "not so shy,
"tries to be like other boys," and "associations with other
children strengthened, not so withdrawn."

Negative responses listed phrases such as "snaps back
at teacher," "chums with maladjusted friend," "nervous,
"had to be eliminated from regular class," "daydreams," and
"timid and afraid to play with other children."

One teacher noted a "positive" influence of the home on
the child's adjustment because the girl now cooperated with
the housework, while her mother worked. The negative as­
pects of home environment were cited by others in terms such
as "home uncooperative," "has to baby-sit and deliver pa­
pers," and "parents filing for divorce."
In the group of medical needs, the positive references are "physical appearance improved due to cosmetic covering of birthmark," and "has received needed medical attention." Negative replies stated that some children were still "ill a great deal" and "had frequent accidents."

Comparison of present status with the classifications according to distribution of academic and behavioral difficulties at time of referral is shown in Table XI.

**TABLE XI**

COMPARISON OF ACADEMIC DIFFICULTIES AND BEHAVIOR DISTURBANCES AT TIME OF REFERRAL AND AT PRESENT

<table>
<thead>
<tr>
<th>Disturbance</th>
<th>No. at ref.</th>
<th>No. improved</th>
<th>No. somewhat improved</th>
<th>No. unimproved</th>
<th>No. deteriorated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Academic</td>
<td>14</td>
<td>1</td>
<td>9</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Academic withdrawn</td>
<td>18</td>
<td>1</td>
<td>7</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Academic aggressive</td>
<td>15</td>
<td>0</td>
<td>6</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Withdrawn</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Aggressive</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Withdrawn aggressive conflict</td>
<td>3</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>55</td>
<td>2</td>
<td>26</td>
<td>18</td>
<td>3</td>
</tr>
</tbody>
</table>

The two cases in the "improved group represent two children of superior intelligence and this may account for their showing academic improvement. The larger number of cases which appear in the "somewhat improved" and "unimproved" groups may be explained by the greater variety of
disturbances represented. Thus, while there may have been improvement in one aspect of a child's presenting problem, another part may not have improved and the child was placed in this category by the teacher. It may be of significance that in the unimproved cases disturbances of aggressiveness predominate. However, the cases in the classification "conflict over withdrawal and aggression" could presumably be shifted toward either direction so that this aggressive predominance would not be apparent.

The deteriorated cases represent those of a seriously emotionally disturbed boy whose withdrawal is progressively becoming worse; another boy previously described as withdrawn who, apparently as the result of being in psychotherapy, has been acting out his repressed hostility, to the school's disapproval; the third being a boy whose aggressive tendencies have increased. All three, however, are capable of superior intellectual ability.

Academic Standing

Since so large a number of children were referred for academic reasons, it was felt to be of value to include on the questionnaire an item referring to the child's present academic standing compared to that at the time of referral. Of the forty-nine replies three students were placed in the "improved" group; twenty in the "somewhat improved"; seventeen in the "unimproved" and six in the "deteriorated"

1 supra, p. 40, Table IX
Commenting on this section in the questionnaire, most teachers cited specific subjects which had troubled, were improved or continued to trouble the children, although some mentioned other factors they felt had contributed to the children's standing. One mentioned "clowning and very nervous" in this respect. "Social improvement rather than academic" was another. Physical complaints, desire to emulate classmates, the hope that psychotherapy would help, and "trying up to his ability" were some of the other comments on this question.

Teachers' Understanding of Problem and Method of Dealing With It.

The question "Would you please state how this student's attendance at the school clinic has affected your understanding of his problem and your method of dealing with it?" on the questionnaire was designed to reveal the diagnostic understanding the teacher had gained through Clinic conferences and reports, as well as the recommendations made. The question following it, "estimate of Clinic's effectiveness for this student" was designed to reveal the teacher's evaluation of the Clinic services in general. In actuality however, comments on both questions overlapped consistently, so that it was found more advantageous from the point of view of clarity to present them here under one heading. Of the forty-

nine questionnaires completed, thirty bore comments on the
teacher's understanding question, and thirty-seven bore com-
ments on the Clinic's effectiveness. There were twenty-four
estimates that the Clinic had been "beneficial," ten that it
had been "ineffective," and three that it had been "harmful."
It is interesting to note that in offering the "beneficial"
estimate, eight teachers did not add comments thereon, though
these were asked for.

Comments fell into three major groupings: evaluations of
the clinical diagnosis, evaluations of recommendations, and
concern with the students' adjustment. In the latter group-
ing it was felt appropriate to include comments made on the
final section of the questionnaire on evidences of any changes
in parental relationships. Table XII lists the frequency with
which these comments occurred and into what subgroupings they
fell, as well as the estimation of the Clinic's effectiveness.
TABLE XII

TEACHERS' EVALUATIONS OF CLINIC'S USEFULNESS IN UNDERSTANDING AND HELPING THE CHILDREN, AND ESTIMATE OF CLINIC'S EFFECTIVENESS

<table>
<thead>
<tr>
<th>Estimate</th>
<th>Beneficial</th>
<th>Ineffective</th>
<th>Harmful</th>
</tr>
</thead>
<tbody>
<tr>
<td>No.</td>
<td>24</td>
<td>10</td>
<td>3</td>
</tr>
</tbody>
</table>

Comments on Diagnosis

<table>
<thead>
<tr>
<th>Helpful</th>
<th>Confirmed School diag.</th>
<th>Not helpful</th>
<th>Misinterpr.</th>
</tr>
</thead>
<tbody>
<tr>
<td>No.</td>
<td>18</td>
<td>5</td>
<td>2</td>
</tr>
</tbody>
</table>

Comments on Recommendations

<table>
<thead>
<tr>
<th>Applied</th>
<th>Would like to apply</th>
<th>Added to Clinic Recommend.</th>
<th>Misinterpreted</th>
</tr>
</thead>
<tbody>
<tr>
<td>No.</td>
<td>18</td>
<td>5</td>
<td>5</td>
</tr>
</tbody>
</table>

Concern Over Students' Adjustment

<table>
<thead>
<tr>
<th>Emotional</th>
<th>Academic</th>
<th>Discipline</th>
<th>Medical</th>
<th>Home*</th>
</tr>
</thead>
<tbody>
<tr>
<td>No.</td>
<td>13</td>
<td>9</td>
<td>3</td>
<td>2</td>
</tr>
</tbody>
</table>

* This figure represents the answers to the last section of the questionnaire, dealing with teachers' awareness of home conditions.

In addition to these comments, there were five teachers who did not feel qualified to evaluate the Clinic's services or effectiveness, and three who revealed they had not seen the child's record and were unaware of his having been seen at the Clinic. Three comments stressed the need for follow-up examinations for children.
Comments of those who felt diagnostic services were helpful, stressed the fact that they were enabled to understand the child better. "The seriousness of the child's disturbance was revealed by the diagnosis, and helped me to deal patiently and sympathetically even when he didn't respond," wrote one teacher. "It showed me there was very little to expect from this child," wrote another, and added, "patience and kindness are needed." "I now understand his loneliness and not belonging," wrote still another teacher of a child, "and I can accept his social improvement now, and hope for academic improvement later."

The group who felt that the diagnosis in itself was not helpful as it merely confirmed what the school already believed, was represented by comments like "we had considerable investigation prior to the Clinic, and the Clinic confirmed the school's viewpoint."

The two unfavorable comments regarding the diagnostic service referred to one boy for whom it was felt "the Clinic may have actually created more anxiety" by facing him with his problems, and another boy "getting insight but a school not getting insight to deal with his problems." In these two cases no staff conference had been held, the psychiatrist conferring with the guidance director alone, instead.

In one case a teacher had apparently mistaken the Clinic recommendation for "speech class" for "special class" and
wrote that the diagnosis was not helpful because the child "does regular class work efficiently and is doing better than she was expected to," despite the fact that in the report the girl was described by the Clinic as being capable of above average work.

In the group of comments concerned with specific Clinic recommendations, the following are typical of these which had been applied by teachers: "As suggested, the child has not been forced academically;" "Clinic suggested tutoring - now the child has no competition and seems more certain of himself;" "Clinic may be credited with parents' consent for long-term therapy;" "physical appearance improved due to Clinic attendance;" and "more love and attention has been given this child."

Of the twenty-seven original recommendation for special school or class placement or attention to other specific handicaps, none of the recommendations for State schools was referred to directly in these responses, and only one mention was made of a special school placement for a gifted child (although this placement had not been practicable.) Although only one response indicated that placement in a special class had been carried out, this may be accounted for by the fact that few such facilities existed in the schools concerned.

In many instances there were indications (from responses to

---

2 supra, p. 33, Table VII
other questions) that recommendations regarding medical attention, remedial classes and tutoring were carried out more consistently. In the group of those who stated they would have liked to carry out certain recommendations, several teachers commented on the desirability of obtaining special class placement for which, however, facilities were lacking. Another two expressed the wish for psychotherapy for a child.

A misinterpretation of recommendations is evident in the remark by one teacher that "the information regarding a child's high I.Q. was helpful in encouraging teacher to expect more of the child."

Several comments indicated that teachers had provided additional means of stimulating some children's adjustment, even though they were not recommended for these particular children. These fall generally into the tutorial or small group coaching area, although one teacher stated she felt a boy could benefit by additional responsibilities and asked him to do small errands for her to which he responded well.

Children's Adjustment

Teachers were generally more concerned over a child's emotional than academic adjustment, although the problem of discipline mentioned in three cases seems to indicate a part of the difficulty in objective interpretation of children's emotional status in a disturbed classroom situation. As has been seen in previous examples, concern over the emotional
well-being stressed a child's behavioral aspects, while that over the academic standing stressed repeating of grades and failure in specific learning tasks. The disciplinary aspect was brought out by one teacher who stated that a child's presence in class "added the problem of discipline to the teacher." Concern over medical problems was shown by one teacher commenting on a child's long-standing need of glasses which she felt the Clinic had fulfilled, and another who commented on a boy's improved facial appearance.

In commenting on the children's home conditions and parental relationships thirty-two teachers noted that the relationships had not changed noticeably, six said that they were better, and one that it was worse. In the comments following this question, however, there were only twenty-six replies, several teachers indicating that they did not wish to comment on this part.

Typical remarks made for this entire section in which conditions had not changed were "no apparent change, mother was always interested in child's behavior and work and continues to be so;" "mother hasn't taken care of child's tonsils;" "child seems happy and proud of his parents. They seem genuinely interested in his happiness and welfare;" "never met Mrs. L and unable to tell from conversation with child;" "conversation with mother reveals that she admits she can't handle him;" and "parents looking for institution or
school for child, and accept the situation more realistically and try to give him enriching experiences in his daily life.

It seems unusual that relatively few references to psychotherapy at the Center were made by teachers in view of the fact that it was recommended in thirty-two of the cases studied. The term does not appear more than five times in all the replies. An explanation of this may be the fact that this aspect of the recommendations was dealt with more thoroughly in social work interviews with the parents, the Center practice being to avoid, if possible, taking referrals through intermediary sources and having the parents apply themselves. A survey of Center records indicates that a total of five cases seen at the Clinic were seen in treatment in the year since its operation. Of these, four had been recommended for treatment, one having applied voluntarily. Two cases were withdrawn after brief contact and the other three continue in active therapy.

Additional Comments

Several general comments on the work of the Clinic were received in response to the final section of the questionnaire. Most of these expanded on points relating to the child's adjustment, although two offered broader views on the Clinic procedure.

A school official who, though understanding the need for
follow-up examinations, bases his suggestions on a need for "answers" from the Clinic wrote as follows:

If the same workers could have followed-up the cases the Clinic would have been of great value. Testing and first interviews are just a start. I understood why this was not done.

The Clinic workers were very helpful in encouraging local teachers to study more thoroughly these special cases.

Such problems as:

1. How many times do we need to expose John to certain words before they are his?
2. What incentives does each child need to do his best?
3. What is his capacity for doing specific things?
4. How to get the highest cooperation from the home?

are waiting to be solved.

We need clinics for these research problems. Then teachers would be able to do much for these children.

When you have a staff large enough it will be again received in this union with opened arms.

A guidance director who saw her work with the Clinic in a somewhat different aspect wrote the following:

In spite of the legal limitations of the school clinic to diagnose and recommend being stressed to teachers, in working with these questionnaires there was revealed a definite reaction toward the work of clinics in general. This excuse provided the opportunity for teachers to free themselves of certain resentments toward the whole field of psychiatry.

Some of the helpful ideas that emerged which may color future school clinics were:

The need for high school staff conferences as conducted in grammar schools. High school teachers in general seem a little more receptive to this type
of work. Nearly every high school teacher has had more basic psychology more recently than most grammar school teachers. The high school has been the scene of a more organized guidance program than grades. Guidance program stressed individual case studies.

The need for some type of more extended teacher-clinic relationship. Some teachers do not recognize or do not want to recognize their part in pupils' problems.

This is a vital point because some teachers felt it was more harmful to stir up parents, teachers and child and not provide for continued guidance than to ignore the whole problem.

Teachers expressed some resentment toward secrecy and top-lofty attitude of some workers, not because of their attitude but because they were not a part of the school.

Teachers felt that the pressure of time on the Clinic teams resulted in a friendly, intimate relationship being established with no one but me. (I did the schedule planning, etc.)

Some expressed the idea that progress of the type we need will be impossible until we have a social worker and psychologist on our staff. Because of the barriers between the fields of psychiatry social work, etc., and education there must be direct communication not through an intermediary (guidance worker) only.

Some teachers felt in order to judge progress or lack of it on the part of pupils another scientific analysis by Clinic team would be needed.

This report was written after my initial delivery of the questionnaires. Now studying the returns I find that there are many favorable judgments by teachers on Clinic work - so, the initial reactions may now be modified by some teachers.
CHAPTER VI
SUMMARY AND CONCLUSION

The study attempted to answer the general question: "To what extent were the means of adjusting an educational system to a child's need be affected through the work of a traveling school clinic?" In order to do this, the origin, aims and method of procedure of the Traveling School Clinic supervised by the Worcester Youth Guidance Center in 1950-1951 was described, and a follow-up study of fifty-five cases selected on the basis of full-team participation was presented.

The major innovation, it was seen, was the use of staff conferences with team members and school personnel. Cases were discussed diagnostically and recommendations by the team suggested to the schools and parents, in an attempt to deal with the children's problems in a consultative rather than purely diagnostic manner.

The formal, written reports sent to schools following completion of the examination were used as a basis of the study of teachers' reasons for referrals, findings of psychological and psychiatric examinations, parental relationship patterns and recommendations.

Reasons for referral fell into various combinations of academic, and withdrawn or aggressive behavior disturbances. Academic reasons existed in nearly all cases studied, and the
division among predominantly withdrawn and aggressive tendencies in children was fairly even. Only a very small minority of cases were referred for behavior disturbances alone, and again the division between withdrawn and aggressive tendencies was balanced.

Examination findings disclosed a large number of children with potentially above average intellectual ability, and a correspondingly small minority of cases in the mental defective category. Many of those in the dull normal category were described as capable of working on a higher level. The predominance of children with above average intelligence would seem to substantiate the selection of this group of cases by the psychiatrist for full-team participation on the basis of initial evaluation of primary emotional difficulties rather than mental defectiveness.

Psychiatric interpretation of personality placed a vast majority of cases in the subgroupings of passive, withdrawn tendencies. That many of these displayed aggressive behavior on the surface may explain the disparity of psychiatric findings with the teachers' reasons for referral, with their emphasis on the more aggressive tendencies.

Family patterns, where indicated on the reports, were found to be disturbed in almost all instances. Most common were disturbed parent-child relationships, but a large number of cases showed disturbed sibling relationships as well.
Recommendations to schools fell into several groupings, the most predominant being suggestions for the attitudes of teachers toward children. Following in order were, psychotherapy at the Center, adjustment of present school program to child's ability, placement in special schools or classes, and attention to specific handicaps, suggestions for aiding the child's general social adjustment, and direction of attention to family problems.

The study of children's current status and of the teachers' understanding and evaluation of the Clinic's work was based on follow-up questionnaires. Information on the present status of forty-nine out of the fifty-five cases was obtained, two questionnaires not having been returned\(^1\) and a total of four children having left the school due to moving to another town or having been graduated.

Teachers were asked to evaluate the children's current status in regard to their presenting problems. A majority reported some improvement, but a fairly large number reported no improvement. An exceedingly small minority reported either elimination of problems or their deterioration.

In evaluating comments following this estimation, it was found that teachers accounted for the children's movement by

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1 These two questionnaires were later returned, although they arrived too late for inclusion in the main body of this study.
references to academic, behavioral, home and medical factors. An almost direct relationship between positive and negative responses in these categories was noted, as was the balanced emphasis between academic and behavioral factors and home and medical factors.

A comparison of the children in the various groupings of reasons for referral with the scale of movement used showed that children referred for academic and withdrawn behavior accounted solely for the cases in the improved category. These types again predominate in the somewhat improved group. Whereas in the unimproved and deteriorated groups the combinations of academic and aggressive disturbances predominated. This may confirm the impression that it is a more difficult and unrewarding task to deal with an aggressive child, especially in the class situation.

In estimating the children's academic standing it was found that teachers were inclined to correlate the students' general status with academic achievement, the only discrepancy being in the somewhat improved category wherein the general standing is higher than in the academic. This may be accounted for either by the fact that three questionnaires did not contain checkmarks on this question, or that some teachers considered that a student had made slight general improvement even though his marks did not show it.

Comments on the value of clinical diagnosis were found
to be favorable in the majority of cases, with only a very small minority reporting "harmful" effects. The number of comments mentioning specific recommendations which had been carried out was also very large compared to those commenting on recommendations which through necessity had not been carried out but which were felt to be valid. Several teachers added comments on measures they had spontaneously adopted to help children. Comments showing concern over the children's adjustment showed a preponderance stressing the emotional factors, although the separation of concern over academic and disciplinary factors may distort the picture somewhat in this respect. Misinterpretation and misapplication of diagnostic findings and recommendations were evident in a very small number of cases. The sparsity of comments relative to the recommendations for psychotherapy was noted, indicating the results of this not having been stressed with the schools, or an unawareness that this had been recommended, an attitude of discouragement because of the Center's waiting list, or indifference.

The sparsity of comments relative to recommendations for special school or class placement was also noted, although it was felt that this was due to lack of adequate school facilities in some instances. There were also indications that more of these recommendations had been carried out than were reported here.
It was found that teachers were generally aware of the child's home environment and recognized in a vast majority of cases that conditions had not changed, while the minor number of improvements outnumbered the ones commenting on deteriorated conditions.

Somewhat differing viewpoints were represented in the general comments on the Clinic's work. They agreed that the work of the Clinic had been helpful but that it should be continued on a regular basis for maximum benefits. The difference seemed to arise in the interpretation of the long-range goals of the Clinic, one expressing the belief that it could be most beneficial in a research aspect, to investigate problems of learning as well as to be instrumental in answering the question of realizing closer relationship between home and school. The other comment interpreted the role of the Clinic from the viewpoint of a guidance director who had worked closely with the Clinic. Specific suggestions as to improved Clinic procedures were offered, as were comments on the difficulties encountered due to indifference or even hostility toward the field of psychiatry on the part of some teachers, although it was recognized that on the whole, teachers regarded the Clinic favorably.

Conclusion

From the results of this study it may be seen that teachers were generally aware of the Clinic's aim, whether or not
they fully understood its objectives or carried out its suggestions. Considering that this was a somewhat different Clinic with an approach of an experimental nature, the results appear gratifying in general.

The days when mere clinical testing and recommendations were thought of as the answer to school problems are on the wane, and most school personnel exhibit an awareness of the environmental influences on a child's behavior and capacity to learn. The parent-teacher movement would seem an indication of this awareness. Yet much work is still to be accomplished in affecting a closer relationship between pedagogy and psychiatry, and it is this aspect which it is hoped will make dealing with poorly adjusted children in school more rewarding to all concerned.

It is only proper that teachers should have a part in recommending changes in the procedural aspects of the Clinic, since the success of any future venture of this kind would depend on their ability to make maximum use of its facilities.

It is for this reason that the writer agrees with the suggestions for improving Clinic procedure suggested in Chapter V,2 although of course Clinical facilities in the future may not become more adequate of necessity. In addition, however, several recommendations became apparent during the course of this study. Among the procedural recommendations

2 supra, pp. 52-53
it is felt that more social workers should be on the Clinic staff in order to enable parents of all children to be seen and relieve pressure in working with school personnel. It is felt that the lack of enough social workers on the staff may have been a somewhat unfair discrimination against a large number of children, and this also placed too much of a burden on the psychiatrist on whose decision the matter of seeing parents, depended. The greater number of social workers would also insure improved relationships with school personnel. Another procedural recommendation is the standardization of Clinic reports to insure greater objectivity in reporting findings and recommendations. The difficulty among disciplines in this respect is recognized, but it is felt that a common ground of agreement between members of the team as to how much and what kind of information is valuable to the school to be included in reports should be made. Another procedural recommendation is that staff conferences be scheduled on every child seen at the Clinic. The incidence of several cases in this study in which full conferences were not held is relatively light, but it was in these cases that most of the adverse criticism against the Clinic was seen.

It would appear that the most immediate problem which would have to be surmounted if work of this kind is to be continued would be the establishment of closer working relations with the school systems. The Center has made attempts in
this direction in recent years through courses for teachers and special lectures designed to acquaint them with the work of the agency and the principles of dynamic psychiatry.

Of primary importance, however, in the betterment of Clinic-school relationships is the continuance of the Clinic itself. There was no question that the Clinic would not continue in 1951-1952 and its unfortunate cessation was due solely to the departure of its psychiatrist. However, in view of the present lack of any type of testing service for the schools visited in 1950-1951, it is suggested that other means of continuing consultation service for teachers requesting it, be made available. In the face of the extreme case-load pressure at the Center at present it does not seem possible to carry this out, either.

Suggestions for further study would include a closer survey of existing school clinic facilities for this area, with a view to gaining increased knowledge of methods and procedures currently found most effective, and comparing these with the Center's Clinic; a study of the forty-two records not included in this thesis with a view to comparison with the findings in this study; an examination of the actual clinical records, social work interviews and psychiatric and psychological findings in order to obtain a more detailed dynamic picture of the types of difficulties encountered; and a comparative study of those children now in treatment as against those for whom
treatment was recommended but not carried out, the emphasis being on the parental attitudes as revealed in social work interviews.

Though the results of this study would indicate a good beginning in the Center's attempt to work with children in the school setting, it is nevertheless felt that it is only a beginning, and as such results cannot be considered conclusive. Further Clinic visits and subsequent re-examination of children and re-evaluations will have to be undertaken before a more definite verdict can be pronounced.

Approved:

Richard K. Conant
Dean
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APPENDIX
SCHEDULE A
Initial Schedule

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>M</th>
<th>F</th>
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</thead>
<tbody>
<tr>
<td>School</td>
<td>Town</td>
<td>Grade</td>
<td></td>
</tr>
</tbody>
</table>

Referred by Position

Academic difficulty __ type
Behavior difficulty __ type
Neurotic symptoms __ type
Physical symptoms __ type

Interviewed by: psychiatrist __ psychologist __ (parents) social worker __

Psychiatric evaluation: no apparent disturbance __ sensitive __ preoccupied __ shy __ inferiority feelings __ inhibited __ anxious __ childish __ lacks identification __ over-aggressive __ passive __ guilty __ denies __ unresolved oedipal __ adolescent struggle __ withdrawal __ sexual problems __ type other

Psychological testing: Mental Age
Rorschach __ Thematic Aperception __ Sentence Completion __
Stanford Binet __ M __ L __ Verbal IQ __ Performance IQ __
BA __ Draw-a-man __ Score __ IQ __ Other

Parents' attitude toward clinic referral
Indifference __ Acceptance __ Concern __ Anxiety __

Hostility __
## SCHEDULE A (cont'd)

<table>
<thead>
<tr>
<th>Parents' attitude toward symptoms</th>
<th>Indiff.</th>
<th>Denial</th>
<th>Recognition</th>
<th>Concern</th>
<th>Anxiety</th>
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<table>
<thead>
<tr>
<th>Child's attitude toward school problem</th>
<th>Indiff.</th>
<th>Denial</th>
<th>Recognition</th>
<th>Concern</th>
<th>Anxiety</th>
</tr>
</thead>
</table>

<table>
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<tr>
<th>Child's attitude toward personality problem</th>
<th>Indiff.</th>
<th>Denial</th>
<th>Recognition</th>
<th>Concern</th>
<th>Anxiety</th>
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<table>
<thead>
<tr>
<th>Parental pattern as related to child's symptoms</th>
<th>Disturbed relation</th>
<th>marital</th>
<th>par.-child</th>
<th>sibling</th>
<th>other</th>
</tr>
</thead>
</table>

**Recommendations:**
- Psychotherapy
- WYGC
- other remed. classes
- spec. school
- group activ.
- tutor.
- hetero-sexual relation
- adult identification
- M
- F
- praise
- encouragement in school
- ease press. in school
- gear schoolwork to ability
- added responsibilities
- other
SCHEDULE B
FOLLOW-UP QUESTIONNAIRE

(Note: No actual names of students will be used in the final report, and other confidential information will be disguised as well.)

Student__________________ school__________________ Town__________________
(if student is no longer at this school, please indicate name of new school and reason for change)

Student's major presenting problems:

Please indicate student's status at present in regards to above problems:

- Improved (problem eliminated; no new problems)
- Somewhat improved (problem only partially eliminated; no new problems)
- Unimproved (problem not eliminated; no new problems)
- Deteriorated (problem not eliminated; new problems in addition)

Please state what factors in student's general school adjustment determined above answer

Academic standing of student at present as compared to that at time of referral:

- improved
- somewhat improved
- same
- worse

Please comment:

Would you please state how this student's attendance at the school clinic has affected your understanding of his problem and your method of dealing with it?

Your estimate of clinic's effectiveness for this student:

- Beneficial
- Ineffective
- Harmful
SCHEDULE B (cont'd)

Please comment

Is there any evidence of change in parental relationship _ __
   ___ same ___ better ___ worse

Please comment:

Name of person filling this questionnaire

NOTE: If space is insufficient to answer any of the above questions, please use other side of this page.
General comments or suggestions on the Clinic and its procedure will be greatly appreciated.