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The social worker's function in a Child Guidance Clinic team in treating problems of poor school adjustment in children with average or high IQ's - A study of twenty representative cases

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THE SOCIAL WORKER'S FUNCTION IN A CHILD GUIDANCE CLINIC TEAM
IN TREATING PROBLEMS OF POOR SCHOOL ADJUSTMENT
IN CHILDREN WITH AVERAGE OR HIGH I. Q.'S

A Study of Twenty Representative Cases

A Thesis

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CHAPTER I
INTRODUCTION

A child guidance clinic team usually consists of a psychiatrist, psychologist, and psychiatric social worker with the psychiatrist in charge of the team. The usual division of responsibility in treatment is that the psychiatrist treats the child, who is considered the clinic's patient, and who is the focus of diagnosis and of treatment plans. The psychologist tests the child's mentality and determines his I. Q. and emotional and personality patterns. The social worker works in the area of the child's environment. This means that usually she works with the mother and whoever else may be important in the child's life.

There were two purposes in making this study. One was to determine what the specific functions and activities of a social worker are when the clinic team treats children with school problems. The second purpose was to determine, if possible, what effective contribution the worker makes to the treatment results.

As the term "child guidance team" implies, child guidance is a cooperative effort by the three members of the team, each making an essential contribution in his own field to the whole therapeutic effort of child guidance.
Any one member of the team without the other two, could not function effectively in diagnosing and treating all the problems, both internal and external, of the maladjusted child. However, this thesis is concerned primarily with the social worker's function and her contribution to therapeutic results. The activities and functions of the psychiatrist and the psychologist are of interest to this investigator only as background to the subject of the study. Therefore, only minor attention will be paid to the psychiatrist's and psychologist's work in the cases presented. This is not to be interpreted as an implication that they play minor roles in the team or that the social worker's function is the major one. It is merely that for the purpose of this thesis the main focus will be on the social worker and her activities.

Twenty representative cases from the central files of the case records of five of the Commonwealth of Massachusetts Department of Mental Health Division of Mental Hygiene Child Guidance Clinics (Quincy, Brockton, Lowell, West End and Southard) were selected and analyzed with the previously stated questions in mind.

The twenty cases chosen for study were not picked at random. Sixty-three cases which were listed in

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1 See page 7.
chronological order in the early part of the intake books of 1942 and 1944 as having been referred for "poor school adjustment" were read, and of these, seventeen were selected as showing a variety of function on the part of the social worker. The remaining three cases were recommended by clinic personnel as having bearing on the purposes of this thesis.

A large portion of the school-age patients at the clinics are referred as having "poor school adjustment" as the presenting problem. Almost all the emotional and personality problems which beset school-age children may cause poor school adjustment so that the term "poor school adjustment" is a blanket designation of all kinds of problems which are first observed when the child enters school or has been there for awhile. "Poor school adjustment" may refer to any of the following specific problems: unhappiness of the child in school, aggressive behavior, daydreaming, not working to capacity, truancy, lack of interest, retardation when it is not warranted by the child's native ability, shyness, withdrawal, psychosomatic complaints, emotional upsets, poor relationship to teachers and contemporaries, reading disability, and other behavior personality problems.

Cases in which the patient had an I. Q. under 100 were not considered. Many school adjustment problems are
due to low intelligence capacity where the difficulty is inherent in the poor native ability of the child. Many studies have been made of children with low I. Q.'s, and whose emotional and personality problems stem from innate inability to keep up with the standard school work of their chronological age level. This thesis is concerned only with those children who would be able to do their school work with ease if well-adjusted emotionally and properly placed, but who have school problems caused by emotional and environmental factors.

It will be noted that several cases have been included in which the child's I. Q. is very high. These children have special problems of their own, such as not being sufficiently stimulated by the work if they are placed according to their chronological age, etc. However, one of the state clinics, the Brockton clinic, conducts a control group for the study of children with superior mental endowment, and in many cases intensive social case work is done with these patients and their families. To have omitted the high I. Q. group would have limited the scope of this study so that a complete picture of a state child guidance clinic worker's duties in school adjustment problems would not have been presented.

2 See page 33.
3 See page 10.
A schedule was devised and applied to each case with the purposes of discovering what the social worker contributed to the diagnosis, the treatment, and how her contribution affected the results in the case. Each case was examined for the following information: whether or not a social history was taken, whether treatment or only diagnostic service was given, whether or not there was case work with the patient and family, if there was manipulation of the school and other areas in the patient's environment, if group work and other agency referrals were made, and if there were staff conferences and other forms of cooperation of the clinic team.

Around all this, although this was not stated as one of the general questions, since the writer does not believe that a study of twenty cases is a sufficiently large sample to answer such a broad question, is the problem of whether a social worker may or may not do direct psychotherapy or whether she must confine herself strictly to environmental manipulation and relationship therapy on a very superficial level. This is a problem which is much discussed at present, and it is a background problem which the writer kept in mind while seeking answers to the specific questions previously stated.

A study of this kind may be used to evaluate current practice in dealing with poor school adjustment.

4 See schedule in the appendix.
It is useful to know how much stress is usually needed on adjustment of inner factors and home environment to ameliorate a school situation, and how effective the social worker's efforts as currently practiced are in the total picture of the treatment process. It is thus possible to discover the weaknesses and strengths and to formulate new methods of procedure if needed.

Since the cases were not picked at random but were chosen selectively at the discretion of the investigator, the gathering of statistics seems to have no value and this was not done.
CHAPTER II

COMMONWEALTH OF MASSACHUSETTS DIVISION OF MENTAL HYGIENE
CHILD GUIDANCE CLINICS

The Commonwealth of Massachusetts was the first state to provide by legislation, in 1922, for a Division of Mental Hygiene with the establishment of Child Guidance Clinics financed by state funds as one of its major activities. The state child guidance clinics emerged at the peak of the mental hygiene movement as the outcome of efforts to promote mental health by preventive and early correctional treatment. Concurrent with the remarkable rapidity of development of new psychiatric concepts of mental disease, from 1912 to 1922, the mental hospitals adopted social services which brought to light many pertinent aspects of life experiences of patients by means of investigations in the homes and collaboration with local agencies. This type of social service developed rapidly into a specialized profession forming a connecting link between the hospitals and the communities which they served, and providing a valuable medium for the interpretation of the principles of mental hygiene to the lay public. By 1922, Massachusetts was considered a leader in the new field of psychiatric

1 Nancy Newell and Edgar C. Yerbury, M. D., "The Development of the State Child Guidance Clinics in Massachusetts." Report of the Commonwealth of Massachusetts Department of Mental Health, Division of Mental Hygiene, 1944.
The document contains a block of text that is not clearly legible due to the quality of the image. It appears to be a page from a book or a report, but the content is not easily readable or translatable.
social service and its trained workers were in great demand by other states. Outpatient clinics were established for the supervision of released patients and for the treatment of non-commitable patients among whom were some children, chiefly delinquents.

In 1919 a great stride forward was made in the direction of child guidance by the establishment of the "Traveling School Clinics" which were established to carry out the provisions of the Acts of 1919 by the Massachusetts Legislature, making obligatory examination of all children who were three years retarded in school. At first school boards were afraid that there would be extra expense for special classes but eventually they began to see their value and began to refer many children whose difficulties proved to be due not to mental deficiency but to physical or environmental factors.

Other clinics for both adults and children were being formed in connection with mental hospitals and schools for the mentally deficient. Also, throughout the country, experiments in specialized clinics for children were being made, chiefly directed toward treatment of delinquency.

In this preliminary period, prior to 1922, one phase of clinical procedure was worked out which has remained standard to date, namely, the professional clinic team of psychiatrist, psychologist, and psychiatric
social worker.

In 1921 Dr. Douglas A. Thom made a survey of the possible contribution of psychiatry to the mental hygiene of young children. As a result, he helped establish and directed three clinics for young children which were known as "Habit Clinics." These were the first clinics established specifically for psychiatric therapy for young children. In 1922, Dr. Thom, with other leading psychiatrists, secured the establishment of the Division of Mental Hygiene under the Department of Mental Diseases, with responsibility for all matters affecting the mental health of citizens of the Commonwealth. State funds were appropriated for research and for children's clinics.

In 1923 three clinics were opened by the Division of Mental Hygiene in Boston and were promptly utilized by children's agencies, visiting nurses, and family welfare workers. From then through the years various clinics were opened. Some became parts of the outpatient departments of various hospitals, others were closed to leave funds for clinics in more populous areas. Originally, all of the clinics set up by the Division were for demonstration, and were to be turned over eventually to hospitals or private organizations. This plan has been carried out except in communities easily available from Boston.

By 1933, after ten years of service, the Division
was conducting nine clinics which were acquiring an aspect of permanence. Five of these were "community clinics" which were affiliated more closely with schools and social agencies than with medical centers. These were influential in the education of teachers through school conferences, and in the education of parents through Mothers' Clubs and Parent-Teachers Associations. The emphasis was upon the normal child with normal problems. This period saw the beginning of special services in the clinics such as speech correction, remedial reading and occupational therapy.

In 1940 the Brockton Clinic, in cooperation with the Brockton Public School system, established a special class for children with superior ability. Both the clinic and the school department were stimulated by their mutual interest in the intellectual, social, and emotional development of the child.

This was an experiment to determine whether a class set up for gifted children in the middle years of childhood could serve a mental hygiene function; whether it could be used as a therapeutic device for children with emotional problems, and as a preventive measure in helping intellectually superior boys and girls to avoid those pitfalls in personality development which are often encountered.

by the highly endowed.

This experiment differed from other classes for the gifted in its emphasis on preventive and therapeutic aspects. Findings of maladjustment were not a basis for rejection unless physical factors which could be aggravated by special class placement were present. The aim was to organize a class that would be of value not only to the well-adjusted youngster of superior abilities, but also to the highly endowed child with social or emotional problems.

Since 1933 changes in the State Child Guidance Clinics have been in the direction of stabilization and efficiency. The Division presently conducts, as a major function, six child guidance clinics on a weekly or bi-weekly basis. A full-time psychiatrist is assigned to care for five clinic sessions, while two part-time psychiatrists each care for three clinic sessions per week. Each of the psychiatric social workers is responsible for the management and social case work of two clinics, making a study of each child's background and environment, and assisting with the therapeutic program. Each part-time psychologist does the psychological work in two clinics.

Each week there is a staff conference for the purpose of discussing treatment programs and the disposition of

3 Edgar C. Yerbury, M. D., Director, "A State Mental Hygiene Program," report of the Commonwealth of Massachusetts Department of Mental Health Division of Mental Hygiene.
unusual cases. Once a month guest speakers are invited to address the conference on subjects related to the field of mental hygiene.

Clinical conferences are held at the various clinics between the clinic staff and interested professional people cooperating with the treatment program. At these conferences the child's individual problems are reviewed and the therapeutic procedures are outlined in order that agencies that are cooperating in the treatment program of the particular child may have a clear understanding of the therapy to be followed.

Instruction of students is an integral part of the educational program, both within the Division and in the state hospitals. Every year about eight social service students receive nine months instruction in field work in the Division while many more are affiliated with the mental hospitals. Students training as speech therapists are instructed in the Division by the supervisor of education. Remedial reading students and occupational-therapy students also receive nine months' instruction.

The state clinics follow a similar pattern of procedure.

When a referral is made, either the parent of the child or the person or agency making the referral telephones or writes for an appointment at the clinic, giving a brief
sketch of the presenting problem, stating age, sex, and school grade of the child. This advance information is useful to the psychologist who can prepare the proper materials for the psychological testing which usually comes in the first clinic visit. As a rule, poor school adjustment problems are referred by school personnel although frequently a parent can recognize that there is a problem and she herself makes the first move.

Both the parent (usually the mother or mother-substitute) and the child come to the clinic for the first visit. A social worker does an intake interview in which she procures face sheet information such as parents' ages, origins, occupation, siblings' names, ages, occupations, patient's age, school grade, how mother heard of clinic, and what mother thinks is the presenting problem. The social worker does not allow the mother to discuss the problem in detail which she may be eager to do since she usually has so much feeling about the child and his problem. The first detailed interview with the mother is reserved for the psychiatrist. If the mother should go into great detail in the intake interview with the worker, she might not be able to repeat the same material for the psychiatrist. Therefore, the worker's first contact with the mother is

4 See intake slip in the appendix.
kept on a rather superficial level until the psychiatrist
has made up her mind as to what the treatment plan would be.

After the worker has given the psychiatrist a
brief sketch of the intake material and a description of the
mother, the worker introduces the mother to the psychiatrist
who proceeds to interview the mother at some length. In the
meantime, the worker has attempted to establish a relation-
ship to the child whom she introduces to the psychologist.
While the mother is being interviewed, the child is tested
by the psychologist. If the child has come for speech
therapy, the mother is then introduced to and interviewed
by the speech therapist.

The psychologist interprets her findings to the
psychiatrist and the social worker. The psychiatrist then
interviews the child.

After the child has been tested, and both the child
and mother have been interviewed by the psychiatrist, the
psychiatrist usually tells the worker whether or not she
wants a complete social history. If she does, the worker
immediately makes an appointment to visit the mother at her
home, and she also asks for permission to visit the school.
Usually the mother gives this permission and is willing to
have the home visit.

The worker visits the school and interviews both
the principal and the teacher. The worker then visits the
home and obtains as complete a social history as the mother is able or willing to give. 5

The psychiatrist is presented with all this material and she makes a diagnosis and treatment recommendations. When the psychiatrist has decided what the therapeutic plan is, usually the patient and his mother have definite appointments at the clinic. The standard treatment plan is that the psychiatrist sees the child and the worker interviews the mother. The worker also makes occasional home visits. If the child is old enough, he may come to clinic alone and the worker makes regular visits to the home to see the mother.

5 See social history in the appendix.
CHAPTER III

PRINCIPLES OF CHILD GUIDANCE IN
SCHOOL ADJUSTMENT PROBLEMS

The aim of psychotherapy is the restoration to the normal level of the patient's psychic possibilities which have been dynamically disordered. The child guidance clinic does not aim primarily at the treatment of the symptoms but of the patient's life problems so that he may reorganize himself in order that normal growth and development may proceed.

With the increase in the capacity for normal growth and development there comes an increase in the ability to be happy and contented and to relate himself in a more meaningful way. Consequently the patient's efficiency will be increased and that primarily through the release of inhibited capacities. The patient will be able to accept greater responsibilities. He no longer will be utilizing his energies in a fruitless struggle, but on the other hand, will be able now to concentrate on the task of living harmoniously with himself and with others. Through psychotherapy the patient comes to an ever-increasing spontaneity by being freed from his crippling inhibitions, unconscious feelings of guilt, and need for punishment and is thus permitted

to express his true personality and to obtain satisfactions from life. He is aided, therefore, in adapting himself to his surroundings. As a result, too, his interpersonal relationships are improved, for there is no longer the need either for mistrust of others or the seeking of affection where it cannot be obtained.

The presenting\(^2\) symptom or chief complaint of the problem child, like the presenting physical symptom, offers a challenge in differential diagnosis. One cannot conclude from the chief complaint alone the nature of the factors involved in the conduct disorder.

Psychological and psychometric tests are important diagnostic procedures in child guidance work. A determination of the intellectual status of every child must be made. Many behavior and personality problems seen in clinics are best understood in terms of the child's capacities and abilities in relation to the demands which his environment places upon them. The questions of how much the child can be reasonably expected to learn and how much he has learned are frequently posed in terms of the school situation. They are just as pertinent to the demands of the child's family and to the general social situation in which he is forced to compete.

Once having determined the child's capacity to learn, the next question is whether he has achieved up to expectations. If the child is not achieving up to capacity, reasons for this must be sought. If the deficiency is in reading, there are tests available to make the analysis in terms of factors which have significance in this area.

Related to the problem of what a child can do is that of what he will do. In addition to the problem of the capacity of the child to meet the demands of his environment, clinicians are vitally interested in obtaining information concerning the emotional life of the child.

The social history is ordinarily the first introduction to the case that the child guidance team receives. As a rule, the social history is obtained by the social worker from those individuals who have been closely associated with the child. It usually contains specific data pertinent to the problem presented by the patient. Also, an adequate social history contains, irrespective of the type of complaint against the child, certain fundamental data even though such data may not appear to be germane to the problem at hand.

The purpose of the social study is to furnish as much information as possible to those studying the child in order that a correct understanding of his difficulties may be reached. The history is both a complete record as well
as an interpretation of stresses and a collection of significant facts.

Social histories are more or less uniform and contain certain basic informative data so that evaluation of and correlation between endogenous and exogenous factors can be made. What is relative and pertinent in the history can be determined only in the light of the findings of the entire diagnostic study. The multiplicity of factors which determines human behavior often makes it very difficult to determine with any degree of exactness which factor or factors are playing the predominant role in any given problem case. An adequate social history permits the evaluation of the data in the light of the total situation. An analysis of a child's problem based partly on a study of the material gathered in a social history, and partly on the psychiatrist's and psychologist's findings, will show in which sphere the emphasis for treatment should be placed.

Psychotherapy can be divided into direct and indirect forms. In\(^3\) the indirect form the emphasis is put on influencing and changing the environment of the patient. Here the effort is made to remove the stimuli for the emotional disturbances, and thus the problems with which the individual has to deal are modified. The therapy is aimed

\(^3\) Schumaker, op. cit.
on the one hand at modifying the environment completely, on the assumption that the parents are incapable of being helped to meet the child's most important emotional needs, or, on the other hand, at modifying the present environment whenever there is a probability that that is possible and feasible.

In direct form, the object of the therapy is aimed at modifying the child himself.

In treating any given case it does not follow that any one of these approaches, direct or indirect, will be used exclusively. In most cases of childhood psychic disturbances a combination of approach will be employed.

Since modifying the environment completely is always a drastic measure, most attention usually is paid to modifying parental attitudes in order that the child may remain in his own home.

In child guidance clinics, where it is customary to divide the treatment between the psychiatric social worker and the psychiatrist, the latter dealing with the child and the former with the parent, there has grown up the belief that it is wise to deal with the parent only in so far as the relationship to the child is involved. In cases of mildly anxious and unstable parents it is advisable to keep the therapy aimed at the area of child-parent relationship. However, in many instances the neurotic involvement of the parents is such that this is not sufficient. In many cases
it is better to take the parent on for intensive psychotherapy and deal with the child in many instances on a simpler therapeutic level than that undertaken with the parent. Under such conditions, a therapy aimed at freeing the parent emotionally will be of much greater value for this child than to deal with the parent only in relationship to the child's problem. Great skill is required in having the parent enter into a treatment relationship that is primarily aimed at him and not at the child whom he brought to the therapist for treatment.

One of the first principles of child guidance is that the parent must feel a certain anxiety or dissatisfaction with the self before the treatment can have some effect. Clinics struggle repeatedly with a situation with futile efforts, where no one in the family is concerned, but the child was referred perhaps by a court or a school authority. Anxiety and desire for help must be present in one or both parents or parental person as well as in the child. Even if the child were able to seek help himself, it is doubtful whether this could be offered to him or be sufficiently effective if one or both parents are not simultaneously interested and participants in the work of resolving their own conflicts.

Although there is no one therapeutic approach in child guidance, there are some goals common to all cases: that the child be made to feel that he can trust someone or something in the real world and that he be freed from the shackles of his unhappy past.

Such an opportunity can be furnished by the school. The transition from home to school is not great as he finds in the school an analogy to the home. The teacher presides over the classroom as the parents or the more dominating of the two parents preside over the home. The social treatment of the maladjusted child can therefore begin as soon as he is enrolled in school. If the teacher is kind and warm-hearted, she can become to the rejected, unwanted child the ideal representation of what he has craved in the form of maternal affection.

Some teachers do not comprehend the nature of the underlying causes of children's behavior. Being concerned with symptoms, discipline, and above all, meticulous good order, symptoms, as overt acts, blind them to the existence of deeper running conflicts and maladjustments. Thus, instead of dealing with emotional dynamisms of evasion,


retreat, and antisocial compensation, they are likely to attack such expressions of maladjustment as lying, stealing, truancy, cruelty, destroying property, etc., from the moral point of view.

However, assuming that the teacher is a well-adjusted, interested, warm person who is willing to supply the lack of love that the child receives at home, obstacles may still lie across her path. Either the mother or the child will provide these obstacles. The mother may not allow the teacher and child to form a smooth relationship but may follow the child right into the school room. She will forewarn the teacher of his naughtiness, his peculiarities. She may have such a compensatory overprotectiveness that she may annoy the teacher with her constant visits and interference that the teacher may also become annoyed. It does not usually occur to the teacher that the mother's incessant running to school with requests, with suggestions, with demands, with complaints about the child, is a constant attempt to control the child's school situation.

As for the child, himself, having lived in a state of rebellion and retaliation outside of school, he brings his behavior pattern into the school room. Even if the teacher does accept him and deal with him gently and kindly,

7 Ibid.
this very gentleness is a situation so new and unaccustomed that the child has great difficulty in adjusting to it. The maladjusted child, finding himself for the first time in an atmosphere of acceptance, goes out of his way to test this acceptance before he can be absolutely sure of it, before he can be sure that he is accepted as he is, regardless of what he does and how he behaves. A teacher who is not aware of this may easily fall into the error of rejecting and putting more pressure on the child, which may aggravate his problem behavior still further. This increases the teacher's annoyance and a vicious circle of misunderstanding between child and teacher is established.

Part of the answer to this is in an adequate preparation of people in teacher training schools in matters of child guidance and mental hygiene.

If the teacher does not have that training and understanding, one of the most important functions of a social worker in dealing with poor school adjustment is going into the school and making the teacher aware of these problems and eliciting her cooperation in helping the child intelligently.
CHAPTER IV

ETIOLOGY OF POOR SCHOOL ADJUSTMENT

An individual's behavior is the product of the action and reaction between himself and his total milieu. Therefore the factors producing pathological behavior are resident either in the individual himself or in his environment or in both.

When children\(^1\) are spoken of as possessing "good" personalities or as being well adjusted, it is usually taken to mean that the children are able to make relatively harmonious adjustments to the many personal and social requirements of daily living. A mentally healthy child is one who can conduct his affairs acceptably, who can integrate conflicting tendencies into socially acceptable patterns of response, and who otherwise gets along with a minimum of friction, fear or stress.

On the contrary, a child that is said to be "queer", "maladjusted", "neurotic" or even "pre-psychotic" is an individual who is not successful in adjusting himself to the expectations of his more normal associates. Such a child displays tendencies and engages in acts that are regarded as deviations from expected patterns of behavior. Psychologically he is described as suffering from personality

\(^1\) Thorpe, op. cit.
disturbances. He is a deviate or emotionally unhealthy member of the child population.

The present day conception of the etiology of deviate behavior is that there is a natural causation which operates in both the organic and psychological fields.

Childhood maladjustments may emanate from environmental factors, constitutional factors, or a combination of these. The environmental factors noted include: 1) inferior moral environment, 2) mentally unbalanced parent or parents, 3) emotionally disturbed, neurotic parent or parents, 4) pedagogical inadequacy of parents, 5) broken homes, and 6) lack of parental care and training.

Parental hostility with its intrinsic lack of approval and its frequent recourse to cold, nagging, compensatory overprotection is a major breeder of profound infantile unhappiness and retaliating misbehavior and is sometimes a forerunner of psychotic development.

Jordan lists the following as the general causes of maladjustment in children:

"A. Thwarting of Impulses and Desires
1. Hostility, ridicule, or indifference, real or imagined, of adults or associates, leading to a feeling of inferiority.

2 Kanner, op. cit.

2. Feeling of guilt because of sex delinquency.
3. Organ inferiority: a facial scar, enuresis, etc., leading to feelings of guilt or shame.
4. Too much coddling by fond parents leading to prevention of participation in community affairs.
5. Failure in school with its attendant ridicule from other children.

B. Undue Emotional Stimulation
1. Unnerving shocks leading to fear and extreme excitement.
2. The presence of nervous parents or relatives.
3. Continued overexcitement: e.g. daily attendance at movies.
4. Too intense urging by parents to attainments beyond reach by legitimate means.

C. Bad Home Conditions
1. Parental disagreements.
2. Lack of affection on the part of parents.
3. Parental separation when child is strongly attached to each.
4. Feelings of insecurity from family financial worries.
5. Unfavorable comparisons with other members of the family.
6. Inability to rise to family's level of aspiration.

The child's relation to his parents, to siblings, and to other persons in the home; the parent's attitudes toward each other and toward the child; unfortunate ideas about child training held by parents; unsatisfactory material aspects of the home—all play important parts in the child's development.

Often the parents' attitude to the child's outside contacts may be very important in the etiology of difficulties. In many localities it is probably of great importance when the parents are of foreign birth and their

attitudes have been well developed before they attempted to set up a home in a new country. The carrying with them of the social requirements of a different culture is reflected in the things they require of their children. Often such requirements may be in decided conflict with the experiences and information that the child has or learns from children at school or elsewhere.

The attitudes of the parents toward their children are very important--more important than their attitudes towards each other.

Desirable attitudes are shown in love and affection for the child, with at the same time recognition of the necessity of giving him freedom to build his own independent existence. Undesirable attitudes may be of many kinds, but all may be classed in three groups: 1) rejection of the child, 2) antagonism vs. favoritism for specific children, and 3) oversolicitude for the child.

The stable home, the feeling of security is fundamental to the child's mental growth. It is in the home that the child should be given stimulation and opportunity for growth and achievement along those lines that are placed under the term intelligence.

The child should have at least three things--security, independence, and guidance--as a minimum for the

5 See case of "Richard" page 51.
best personality development. If the parents are wise and congenial, if the home is stable, then the child will probably develop a wholesome personality and the chances are against the development of difficulties.

If the home is not a harmonious one, then some distortion in personality development is almost inevitable. He may resent the antagonism or injustice of a parent, or the obvious favoritism shown to a sibling. Real fears may be built up by a cruel father. The child may develop a feeling of inferiority because of the dominance, superiority, or strictness of the parents. Furthermore, he may remain dependent on the adults in the home because their attitudes do not allow him to develop independence.

Different children having essentially the same personality reaction to their family situation may show quite different behavior. The conduct of one child with inferiority feelings may be retiring, withdrawing, shy; a second child with a similar basic difficulty may be impertinent, disobedient, perhaps even aggressively vicious.

* * * * *

Adjustment to school is the second great adjustment which a child is called upon to make in his progression

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from infancy to maturity. The first is the adjustment to the family circle.

While school adjustment is not quite so decisive in its effects upon development as the family adjustment, it nevertheless plays a most vital part in shaping a child's destiny. It is becoming increasingly realized that in addition to knowledge, children also acquire attitudes, and while a good deal of knowledge passes with the years, attitudes tend to be retained throughout life. The child who leaves school with an attitude of sullen obstinacy, or hostility to authority, the child who has become habituated to blame, or accustomed to failure, the discouraged child, the child with a grievance, are all just as surely heading for unsatisfactory citizenship as the child who leaves school without having gathered the normal complement of knowledge.

Although the establishment of satisfactory relations with both teachers and children enters into it, adjustment to school is mainly concerned with the child's reactions to the process of learning; and symptoms of maladjustment, therefore, are liable to appear whenever that process is interfered with. The nature of those symptoms is usually determined by the temperament of the child, and may take almost any form from violent aggressiveness, delinquency, to abnormal fears, anxiety, or even physical disorders.
A suggestive list of the symptoms of school maladjustment is presented below. The presence of one of the following symptoms does not necessarily indicate serious maladjustment. It is the composite picture of the child that it is necessary to secure. If his attitudes and habits shut him off from wholesome interactions with his associates, then he is in danger of being malnourished socially, or maladjusted.

For the purposes of convenience, the symptoms are listed under the categories of anti-social and unsocial:

Symptoms of an Anti-Social Child

1. Self-centered, always tries to be first, seeks to bully and dominate the other children.
2.Insensitive to the rights and feelings of others, derives satisfaction from hurting others.
3. Exhibits no feelings of friendliness or good will toward his classmates.
4. Is unable to work or play with his associates without friction.
5. Exhibits a violent temper whenever his desires are not met.
6. Exhibits no feeling of group consciousness and assumes no responsibility for the welfare of the group.
7. Wears a perpetual scowl, carries a "chip on his shoulder."
8. Exhibits an insolent and rebellious attitude toward all rules and regulations, is a chronic disturber of working conditions in the class room.
9. Actions seem to be motivated by feelings of revenge and of "getting even."

7 Arthur D. Hollingshead, Ph. D., Guidance in Democratic Living, pp. 173-175.
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Symptoms of an Unsocial Child

1. Seems shy, timid, and self-conscious.
2. Exhibits no feelings of self-confidence, is easily embarrassed and becomes "emotionally upset," whenever he takes part in class discussions.
3. Actions seem to be controlled by feelings of inferiority and fear of failure.
4. Seems unhappy and crushed by feelings of anxiety and worry, manifests no enthusiasms.
5. Finds no pleasure in group contacts, withdraws and never participates voluntarily in group activities.
6. Is docile and conforms, so as to protect himself from the displeasure of the group.
7. Is a chronic day-dreamer.
8. Is usually alone and seems to have no close friends.
9. Exhibits exaggerated feelings of superiority and holds himself aloof from all social contacts.
10. Concentrates all of his attention upon one pupil and seeks to possess him, is uninterested in the other members of the class.

Frequently the inability to learn may be the major and most important symptom of dysfunction, in which emotion plays a major role.

Emotional motivations for learning as a product of growth become more clear as one works with those who, in spite of average or above average endowments, cannot attain results commensurate with their inherent potentialities. The acquisition of knowledge is the first step to ability, and factors, whether they be anatomical or emotional, which affect learning, will have their repercussions upon the application of learning. Those emotional factors which condition the motivations prompting the acquisition of knowledge

will have a profound effect upon the utilization of knowledge. More and more the emotional motivations behind the acquisition of knowledge are sensed as motivations which govern in general the instincts: anxiety, sadism, masochism, the parental constellation and sibling patterns.

Although maladjustment is particularly rife amongst the dull children, children of all levels of intelligence are liable to break down, either because of inherent instability, or because they have been subjected to abnormal strain. Frequently one comes across really clever children who are giving trouble not because they are being pressed, but because their intelligence has been underestimated.

A child\(^9\) with a high I. Q. may be normal in size and appearance but is much older mentally than his age level, which throws his adjustment to his group out of balance. He learns his lessons quickly, is bored with the activities of his grade, if he is in the proper grade chronologically, and may work off his excess energy in unprofitable mischief. He attracts attention by his clever remarks and develops a desire for the center of the stage. He bosses children of his own age, but is rejected by older and larger children whose interests fascinate him and challenge his ability to compete with them. Emotionally and physically he may be on

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the same level as his chronological age.

The role which success, when it carries with it a sense of achievement, plays in the development of the child's personality is generally recognized by students of child life. On the other hand, the part played by persistent failure, with a resultant feeling of inferiority to one's fellows, in producing personality difficulties, is being emphasized by those who have devoted themselves to the study of delinquent and maladjusted children.

Dr. Marion Kenworthy writing on the subject of inferiority feelings and the disordered behavior to which they lead, mentions four main causes of such feelings: first, inability on the part of the child to rise to the level of his family's aspirations for him; second, too easy success at an early age, resulting in a false sense of security, which is rudely shattered by later experiences of failure; third, an unduly intense drive toward a standard of achievement unattainable by legitimate means; fourth, unfavorable comparison with others in the family circle, especially with siblings.

A child cannot participate successfully in group

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10 Mary B. Sayles, The Problem Child in School, p. 67.

activities if he is crushed by feelings of inferiority and insecurity, or if he regards the members of the group as his enemies.

A change in school environment is often among the most effective measures in readjusting a child. On the other hand, with a child whose attitudes and reactions towards life are essentially unhealthy, whose whole body and mind seem involved in a desperate struggle towards ends he cannot hope to achieve, a change of environment alone cannot work a cure. The social adjustment of these pupils becomes therefore, a problem of child guidance.
CHAPTER V

INTRODUCTION TO CASE PRESENTATIONS

Inasmuch as clinic service is offered in cooperative teamwork by the psychiatrist, social worker, and psychologist, individual cases vary in the relative amount of therapeutic responsibility carried by the different members of the team. Therefore the cases which will be presented in Chapters VI, VII, VIII, IX, and X, will be divided into the following classifications:

Chapter VI will present one case in which the only service given by the clinic was remedial therapy in reading.

Chapter VII will present three cases in which the major portion of the treatment was carried by the psychiatrist with a relatively minor amount of assistance from the social worker.

Chapter VIII will present nine cases in which the responsibility for treatment was shared equally by the psychiatrist and the worker.

Chapter IX will be concerned with six cases in which the social worker carried the major portion of the treatment with the psychiatrist acting primarily as a diagnostician and consultant.

Chapter X will present one case in which social service carried the major portion of treatment. In this case two social workers worked cooperatively, one worker sharing
the direct psychotherapy of the patient with the psychiatrist, the other worker working in the area of family manipulation and sharing the school manipulation with the first worker.

To further the understanding of the diagnostic and treatment processes affectuated by the clinic, a general composite description of the twenty cases as originally referred follows:

The ages of the children ranged from five years and seven months to thirteen years. Thirteen patients were boys. Thirteen children were referred by school department personnel, four by physicians either private or from clinics, and three children were brought in by their mothers on the mothers' own volition.

I. Q.'s ranged from 102 to 155 and their school grades ranged from the first to the eighth grades.

The children came from varied economic and social backgrounds. The parents ranged from the almost completely uneducated to college graduates. One parent was a baker, another a garment worker, another a registered nurse, and still another an architect. Three children had alcoholic fathers. One of these fathers lived away from home and the mother was hopelessly in love with a married man. Two of the alcoholic fathers lived at home, one on extremely bad terms with the mother. The third alcoholic father was on relatively good terms with the mother, but both parents had illnesses
which forced the family to be publicly supported. One set of parents was divorced and another pair was separated. One child's parents were dead. One child's parents came from extremely different cultural and religious backgrounds which caused friction in the household. One child was adopted. One mother was psychotic, one was extremely ill and excitable, and another had heart trouble.

Several cases are worthy of note in that their etiologies reflect what apparently are cultural factors in the parents and are very difficult to treat or modify.

In addition to the problems for which they were referred to the clinic, fifteen of the children had associated emotional conflicts and problems which were evident in their lives at home as well as at school. These problems were as follows: anxiety neuroses, over-dependency, fear of father, lack of friends, withdrawal, daydreaming, shyness, immaturity, rejection by mother, poor relationship to contemporaries, resistance, negativism, masturbatory practices, hostility to mother with a like response from her, stuttering, psychosomatic symptoms, too much pressure from an over-ambitious mother, temper tantrums, unhappiness, tense relationship with father, rejection by parents who ridiculed the child with resultant jealousy of siblings, domination of siblings, aggressiveness towards contemporaries, hysterical blindness, nocturnal enuresis, overprotectiveness by mother.
This preliminary survey indicates how large a proportion of the school maladjustments stem from family problems and problems within the child himself, rather than from poor placement or maladjustment only in the school environment.
CHAPTER VI
A CASE IN WHICH THE ONLY SERVICE GIVEN BY THE
CLINIC WAS REMEDIAL THERAPY IN READING

Charles was a nine-year old boy with an I. Q. of 108
who was repeating the fourth grade. He was referred
to the clinic for having difficulty with his reading.
He was seen by the psychiatrist and was given psycho-
logical tests by the psychologist. The psychiatrist
decided that there were no emotional or personality
problems involved. She recommended that he have
remedial reading lessons and he attended clinic for
a period of eighteen months.

The worker had one clinic interview with Charles's
mother during the first intake visit. After that,
the worker recorded the date of each visit, tele-
phoned the mother twice, once to find out why Charles
had not been attending clinic. He had been lying to
his mother, saying that he had been coming to clinic.
The second call was a check-up to find out how well
he was doing in school. His mother said he was doing
very well as his teacher was a very understanding
person, and the mother was planning to send him on
to junior high school. Both the mother and the worker
agreed that the case could be closed. The case was
closed with Charles's condition considered as improved.

In this case the social worker served to see that
the case progressed according to the recommendations of the
psychiatrist. The worker followed the patient's progress
and kept track of him as she recorded the dates of his clinic
visits. Her duties were of a mechanical nature: recording
and telephoning, and her function was on a superficial level.
Nevertheless, by keeping things running smoothly and con-
sistently, she was instrumental in keeping the boy to his
remedial lessons which improved his condition.
In all cases assigned to a worker, whether she is doing intensive case work or merely keeping track of visits to the clinic for remedial therapy, she is expected to perform the mechanical tasks of telephoning, writing messages, recording the dates of all clinic visits stating the purpose of the patient's visit and whom he saw at the clinic, contacting him and his mother if he has been absent several consecutive sessions or if his attendance has been irregular.

In all of the cases in the following chapters these duties are a part of the worker's assignment and, unless stated otherwise, it is to be assumed that in addition to their other contributions to diagnosis and treatment, the workers fulfilled these automatic, mechanical responsibilities as well.
CHAPTER VII
THREE CASES IN WHICH THE PSYCHIATRIST CARRIED THE
MAJOR RESPONSIBILITY

In this group of three cases the major portion of the treatment was carried on by the psychiatrist with a relatively minor amount of assistance from the social worker.

Case No. 1

Fred was the eight-year-old child of a Jewish couple who had great ambitions and plans for him. Although his I. Q. was 110 he was doing very poorly in school. He was stuttering, was "nervous," and had many fears and psychosomatic symptoms, particularly vomiting. Living with the family was his maternal grandmother, an immigrant who had come to this country as a young girl and who had not had opportunities for education nor had she been able to give her children a good education, as her husband had deserted her. Mother's brother had married a very wealthy girl and mother felt a great deal of competition with this sister-in-law. Both mother and maternal grandmother were putting a great deal of pressure on Fred and even though he was doing so poorly in public school, he was entered in Hebrew school.

The psychiatrist's diagnosis was that the patient was feeling overwhelmed and insecure because he was failing in school. She recommended that the case be transferred to the Southard Clinic where he could get special tutoring. He continued at the Southard Clinic, getting special tutoring, and both the mother and the patient saw the psychiatrist regularly. The worker's only duties in this case were to keep track of visits,

1 The Southard Clinic was established October 1, 1943, under the joint auspices of the Division of Mental Hygiene and the Psychopathic Hospital. The Division of Mental Hygiene withdrew from the Southard Clinic February 3, 1945, in order to give increased service to other cities.
record them and record her observations of the patient in the waiting room: how he occupied his time, and how he related to the other children in the clinic.

After a few months the patient was transferred from tutoring to speech therapy. He eventually seemed to improve both in his speech and in his reading, and he was promoted to the next grade in school on trial. He did well in this grade, and since mother's responsibilities at home had increased and she could no longer bring the patient to clinic, the case was closed.

The social worker's function in this case consisted mainly of taking a very full social history which made it possible for the psychiatrist to make an accurate diagnosis since it made her aware of the special social and cultural factors involved.

In certain Jewish families a great deal of pressure is put on the children to do extraordinarily well in school and to take training in many other fields: music, Hebrew, dancing, etc. Usually, prognosis is very poor as it seems difficult to give such ambitious parents insight enough to make them modify their aims. Therefore, a full social history is very valuable in such instances as the psychiatrist can make a much better estimate of how much effort the clinic ought to put into the case considering the probability of poor results.

In addition to getting the history, which included a school visit, this worker maintained a somewhat superficial relationship with both the patient and his mother during their clinic visits.
Except for taking the social history, the worker had no direct effect on the treatment of the patient. Her treatment function was primarily of a mechanical nature, recording dates of clinic visits, etc.

Case No. 2.

Barry was a tall, handsome, nine-year-old boy with an I. Q. of 130. He was referred to the clinic by the school department for not working up to the capacity of his native endowment. He came to the clinic with his mother who was a hostile, domineering type of woman. She had very definite ideas of her own and it was evident that she would not accept suggestions or criticisms from the clinic.

The psychiatrist's diagnosis was that the boy was of superior intelligence and had a normal personality. She recommended that he have occasional interviews with her and she would also see the mother in regard to giving him greater opportunity to develop, commensurate with his capacity.

The worker visited the school and interviewed the teacher who was very hostile to the mother. The boy would do little work. Mother would tell the teacher that she would take care of the situation and then he might occasionally turn in an assignment about two weeks late. Mother tried to keep complete control of the school situation.

She resented very much the clinic procedure of having the child seen alone by the psychiatrist and the psychologist. They came to the clinic four times when she began to break appointments. The psychiatrist closed the case as not improved as the mother was so resistant, overprotective, and rigid.

Five months later a worker from the Division of Child Guardianship read the clinic record, as the mother had made an application for foster home placement of the boy.

The worker in this case also kept track of visits and maintained only superficial relationships with both the
boy and his mother. The worker made one school visit which gave the clinic further insight into this mother's hostility which finally manifested itself in such extreme form as complete rejection of the child.

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The third case in this group followed a similar pattern of procedure. The psychiatrist saw both the patient and the mother and the worker stayed in the background doing the mechanical tasks of recording dates of visits.
CHAPTER VIII
NINE CASES IN WHICH RESPONSIBILITY FOR TREATMENT WAS SHARED EQUALLY BY THE PSYCHIATRIST AND THE SOCIAL WORKER

In this group of nine cases, the responsibility for treatment was shared equally by the psychiatrist and the social worker. These cases fell into three classifications. In the first classification there was one case in which the worker worked exclusively with the home environment. In the second group there were two cases in which the worker concentrated on school manipulation. In the third and largest group there were six cases in which the worker manipulated both the family and the school situations.

Family Manipulation

Case No. 1.

Claire was a ten-year-old Jewish girl of superior intelligence who was shy and retiring and not doing well in school. Her parents were well educated and wealthy. Mother, who was the more aggressive parent, was extremely ambitious for patient. Claire had a younger sister with whom there was considerable sibling rivalry as the younger child was the exact opposite of patient. She was aggressive, self-assertive, and was able to win more of mother's approval. Mother put a great deal of pressure on patient, forcing her to go to Hebrew school, to study dramatics, dancing, and having her privately tutored against the wishes of the school. Mother had very rigid ideas about allowing patient to mingle socially with boys and had not given patient any sex instruction. Mother was very hostile to Claire, probably for not measuring up to her ideals and ambitions.

The treatment plan was that the patient was to be seen
by the psychiatrist and the social worker would see the mother to help her gain understanding of Clair's behavior and reactions.

The worker attempted to give mother some insight into the rivalry situation; into the fact that Claire needed a little encouragement and praise instead of constant pushing and punishment. Treatment with mother progressed very slowly as her rigidity made it impossible for her to accept understanding of her own patterns of behavior and its effects on patient, and she was not able to change her attitude toward patient.

When Claire was to be promoted, mother, on the advice of Claire's teacher, but against the advice of the psychiatrist, went to Claire's new teacher to tell her all of patient's problems. The psychiatrist felt that Claire ought to start afresh without any prejudicial knowledge on the part of the new teacher. However, mother's hostility was such that she had to ally the new teacher with herself against Claire. The case was closed with the patient's attitude a little improved. The mother had not changed at all.

This is a case in which a little psychotherapy was done with the patient although the psychiatrist felt that it really was not necessary. It was the worker who had the major responsibility of changing mother's attitude, which was the real problem. However, in a period of sixteen months in which the worker had seventeen interviews with the mother, she was unable to effect any change.

The psychiatrist worked directly with the patient and very frequently saw the patient's mother. There was no material environmental manipulation of any kind. Work was carried on a strictly relationship interview basis by both the psychiatrist and the social worker.

One of the important contributions of the worker
in this case was the social history. She was able to go into the home and get some understanding of the socio-economic status of the family. It was possible to estimate the mother's social ambitions and her need to have the child excel, not only in school, but in other outside activities which are expected of the children of the same status as the patient.

The worker was able to get the family picture and see the sibling rivalry situation in the setting of the home. She was also able to get a more complete picture of the mother's rigidity.

In this case, therefore, the worker made a significant contribution to both the diagnosis and the treatment in the case. She contributed to the understanding of the situation by getting the social history in the home setting. Also, since it was the mother who was the real cause of the difficulty in the child's life, and since it was the worker who was attempting to handle the mother's personality difficulties, then the worker made an important contribution to the treatment process.

School Manipulation

Case No. 2.

Anne was an eight-year-old girl with an I. Q. of 155 and who was physically much overdeveloped. She was brought to the clinic by her mother at the suggestion of her family physician as mother felt that Anne was making a poor adjustment in school.
Mother was an intelligent, attractive person who was able to discuss with the psychiatrist and the worker the family relationships and her attitude toward the patient which was rather intolerant and hostile.

No social history was taken as the psychiatrist felt that she was able to make her diagnosis without a complete history. The psychiatrist worked with both the mother and the patient. The psychiatrist recommended that the worker interpret to the school Anne's mental superiority, and attempt to get her placed in a higher grade which would be more suitable to her mental ability.

The worker did a great deal of work around the school situation. She contacted the teacher and principal, who did not think that the patient was extraordinarily superior. They felt that there were others in the class who were "just as bright." However, Worker contacted the Director of the Division of Educational Investigation and Measurements and Anne was tested. Her I. Q. was 155 and it was recommended that patient be advanced one grade. This was done and patient adjusted very well.

In the meantime, through clinic contact, mother seemed to gain better understanding and control of the patient.

In this situation, the worker worked only in the area of environmental manipulation. The only relationships, interpretations, etc., that she used were in connection with her contacts with the school. She was able to put into action a rather phlegmatic principal and teacher.

The psychiatrist made all the diagnosis and took as much history as she wanted. The psychiatrist worked with both the patient and the mother. The social worker was able to work out the school situation satisfactorily and helped effect at least a partial adjustment on the part of the patient.
Case No. 3.

Louise, almost eight, with an I. Q. of 143, was brought by her mother to the clinic on account of poor school adjustment. She was unhappy at school and her mother thought she should be further along. Mother and patient were interviewed at the clinic and it was decided that Louise should be in a higher grade. Her teacher, with whom she had a poor relationship, disapproved of the plan. However, with the aid of the city school consultant, and after several interviews by the worker with the principals of two schools, Louise was placed in a rapid-advance class. In the meantime, mother was given some insight into the fact that she was jealous of patient because of her good relationship with father.

After a short stay in the rapid-advance class, Louise was placed in an advanced grade and she seemed to be doing well. The case was closed for the first time, after thirteen months' contact with the clinic, with the patient's condition considered as improved.

Five months later the case was opened again, and then reopened a year later as patient's "nervousness" and school maladjustment had reappeared. This time it was learned that mother was pushing Louise and was conceited about her ability.

The psychiatrist decided not to continue psychotherapy or case work. The worker visited the school to make further interpretations and suggestions but no more was done at this time. It was decided that it would be better to have as little attention called to Louise and her problems at this time and the case was closed.

This is a case in which the psychiatrist worked with both the mother and the child. The worker did have one lengthy history taking interview with the mother, otherwise her work was entirely in the area of school manipulation: interpreting the clinic's findings and decisions, and working them out with an antagonistic principal and teacher. The worker made ten visits to the school.
The case was discussed at five full staff conferences and the worker interpreted the clinic staff's findings to the school.

This worker had little contact with either the patient or her family. The worker worked on the problem in its practical aspects in the area of school and scouts. All psychotherapy for both the mother and the child was done by the psychiatrist. Therefore, in this case, the psychiatrist and the social worker shared the work of environmental manipulation since the psychiatrist was attempting to ease up mother's pressure on the child while the worker was adjusting the school environment.

Family and School Manipulation Combined

Case No. 4.

Richard, aged nine years and seven months, with an I. Q. of 145, was referred to the clinic by his school as a poorly behaved, maladjusted boy, not functioning anywhere near his capacity. The boy's parents were German-born, imbued with the Hitlerian ideology of pride in their "pure Aryan" ancestry and contempt and hate for the Jews, but who verbally protested their dislike of Hitler and nazism. During the war they were very sensitive about their background and felt that the community was against them. Richard was "highstrung", easily upset by teasing. The school was much perturbed as they felt that he was not being stimulated to his full capacity and ability.

The patient was studied at the clinic and referred to the class for children with high I. Q.'s. In the meantime the social worker did case work with the mother around her physical health, which was poor, and she gave her reassurance concerning the community's
attitude to the family during the war.

The worker also did some environmental work in regard to the boy's problems. She contacted the library for reading material for him. She did a great deal of work in the school situation as this child aroused much prejudice and hostility. The worker had to do a great deal of interpretation to the school to protect him. In spite of this, he did not adjust well in the special class and had so antagonized the teacher and principal that he was on the verge of being expelled. During all this time Richard was having therapeutic interviews with the psychologist.

Finally it was decided that he go to a private school and the family decided on a fashionable and high grade military school. This seemed to be an excellent solution as it served to satisfy both the boy and his family. Military training and discipline seemed to fit right in with their patterns of militaristic thought and feeling. At the same time, since he was going to a really patriotic American school of excellent reputation, the family's prestige in the community was elevated considerably. With the one move, they seemed to solve all their external problems so that they were all much more comfortable in their environments, the boy at school, and the family in the community.

The boy's marks and behavior improved considerably and for a short while he was much happier. However, as the year progressed, he developed stomach trouble and pains in the knee for which he received medical care at the school. His marks went down, which the colonel in charge explained as being due to his illness.

The clinic's record ends on the note that he would go back to military school next year, have better luck, and do better.

This is an interesting case in which intellectual factors were intertwined with emotional problems to bring about bad adjustment in school. The patient was much too bright for the ordinary school program which left him bored and unstimulated. At the same time he and his family had the
paranoid emotional patterns of the Hitlerian ideology in a community at war with that ideology.

This case was known to the clinic for more than five years. It was different from most cases in that for part of the time the psychologist instead of the psychiatrist had therapeutic interviews with the patient. Otherwise, it followed the usual pattern of having the worker do case work with the family and the school.

This worker was able to function with an excellent command of objectivity. She was able to work consistently and sympathetically with a family who seemed identified with the enemy and which apparently was so identified by everyone else with whom they came in contact.

Case No. 5.

Joseph, a tall, shy, rather retiring boy, the middle sibling of three and the only boy in an Italian home where both parents were born in a foreign country, had a marked reading disability. Both parents worked outside the home and there was little supervision in the home after school hours. The parents were inclined to be overstrict with him and criticized him severely since his sister did much better school work. Joseph had adopted an "I don't care" attitude at the time of clinic referral.

He was given intensive remedial help in reading at the clinic along with his psychiatric interviews. The worker gave considerable help to his teacher who seemed to have a personal dislike for him. His mother was given some interpretation of his feelings and both she and father were counselled to be more loving towards him if they could. Eventually, at the instigation of the worker, he was transferred to another school and he improved rapidly. Because of his manual ability, it was recommended that he enter vocational trade
school. Both the mother and the school principal were carefully made aware of the clinic's recommendations. The case was closed with the patient somewhat improved.

The psychiatrist worked directly with the patient while the social worker did intensive case work with the family and the school. She was able to discern the teacher's prejudice. She tried to soften the teacher's attitude but since she was not successful she approached the principal and made him aware of the teacher's feelings and the boy's problems, with the result that after much discussion he was transferred and given another more understanding teacher. The worker visited the school eleven times and telephoned four times before this was accomplished.

The worker also kept track of the patient's visits to the reading therapist and when Joseph stopped coming she telephoned his mother who had not been aware that he had stopped. This worker also worked out a camp placement for the boy, first approaching the mother to suggest it and get her permission, and then getting him placed in a YMCA camp.

This was a case in which very little psychotherapy was accomplished but in which there was much manipulation of the school situation and a little manipulation of the family environment. Therefore, improvement in the case was due to the worker's efforts: the easing up of the hostile school situation, the easing up of the hostile family situation, seeing to it that the patient continued with his remedial
reading therapy, and getting him a camp placement which he enjoyed since he did relate well to his contemporaries.

Case No. 6.

Laura, aged eleven and a half, with an I. Q. of 110, in the sixth grade, was referred by her physician because of poor school adjustment. Patient was the younger of two siblings of American-born parents. Her home life was very unhappy as her father had been an alcoholic until two years previously when he was stricken with Addison's disease. Since then he was unemployed and partially disabled. Mother worked at the time of referral but had to stop on account of an acute heart condition and the family was going on Aid to Dependent Children. Father was always disagreeable to patient, calling her feeble-minded. He always favored the older girl who was much frustrated by her lack of attractive clothing. The older sister picked on patient a great deal.

The psychiatrist's recommendations were that the worker obtain a social history, reassure mother that patient really was a bright girl, and recommend to the father that he show less hostility to the girl. The psychiatrist would see the patient and her mother at the clinic and the social worker was to make home visits.

The patient was sent to camp one summer but she refused to go the next summer. The worker visited the home several times and although mother was able to tell worker her troubles no real gain was made. Father did not respond to case work. He felt that patient was taking too much time from school to go to clinic and the case was closed with the condition essentially the same as at the time of referral.

In this case both the psychiatrist and the worker cooperated to handle the home situation which was the real problem. However, there were so many reality factors of illness of both parents and the irritability that usually goes with it, of economic pressure of people on relief, and
rivalry between two sisters who have too much work responsibility in the home and not enough satisfactions, that the case had to be given up without any headway having been made.

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In the three remaining cases in this group the psychiatrist did the direct therapy with the patient while the worker did case work with both the school and the family.
CHAPTER IX
SIX CASES IN WHICH THE SOCIAL WORKER CARRIED THE MAJOR PORTION OF TREATMENT

In this group of six cases the social worker carried the major portion of the treatment with the psychiatrist functioning as a diagnostician and consultant.

In three of the cases the worker's case work was exclusively in the area of school manipulation. In the other three cases her work was a combination of family and school manipulation. There were no cases in which the worker worked exclusively with the family without other environmental manipulation.

School Manipulation

Case No. 1.

George was an eight and a half year old boy with an I. Q. of 107, who was referred by his school as being withdrawn, a daydreamer, fearful of and not mingling with the other children.

He was the younger of two children of a psychotic mother and a rather hardpressed hardworking man of low income. Mother had been at a state mental hospital and was going through another episode although she was not hospitalized. George had been closely tied to mother and through her influence, was rather distant from father.

Social service in this case had two goals: to discuss with father the possibility of having mother go back to the hospital, and to make it possible for the boy to mingle with his contemporaries.

Worker had conferences with the school principal and
teacher. Worker was able to interpret some of the pressures this boy was under and it was agreed that the teacher would call on him more often without seeming to press him and frighten him. In the meantime, he was referred to a day camp. The camp counselors were also informed of his problems and the camp personnel gave him special attention. At first, he did not want to stay at the camp but within a few days he became very much interested and was happy there. He talked of nothing else. He was able to mingle with his contemporaries and when he went back to school his social adjustment was much better. In school he was much more alert, participated in many extra-curricular activities and improved a great deal.

Mother did not have to go back to the hospital for the time being because she seemed suddenly to become normal and even had enough insight to laugh at some of the stories she had told during her spell of psychosis.

No social history was taken as the state hospital sent their history of mother which was very detailed and inclusive.

This is a good example of improvement being directly effected by environmental manipulation by the social worker. The interpretations to the school were a factor in giving the teachers understanding of the patient's problem, and a constructive way of dealing with it was decided upon by both the teacher and the worker.

The same thing happened with the camp placement. The worker interpreted the problem to the camp director and he and his workers were able to pay more attention to the boy and gear their program to his special needs.

This is also a good example of cooperation of agencies, school, and camp, in dealing with the problems of one patient. The worker was able to interpret to each what
the other was doing so that the program was consistent. The worker, in this instance, was the link which connected the patient's various environments to each other.

Case No. 2.

Rose was seven, with an I. Q. of 102. She was doing poorly in school and her mother brought her to the clinic. Rose felt that the teacher discriminated against her, that the teacher did not like her so that she never gave her any of the "good" things to do such as holding the flag, running errands, etc. Mother identified very much with Rose in her feeling about the teacher. She had a great deal to say about this teacher who so flagrantly discriminated against her child.

The plan of clinic treatment was to give the girl remedial tutoring in reading and speech. She also needed an eye examination and worker followed this up. The most important part of worker's assignment was to work out the situation with the school, particularly with the antagonistic teacher.

She visited the school and discovered that the teacher did think that Rose was an especially disagreeable child and her attitude generally was disparaging and punitive towards both Rose and her mother. The teacher kept asking worker if she did not think that Rose should repeat her grade. Worker felt that the child should be moved to another school but she did point out to the teacher that Rose really needed praise and reassurance. Worker finally had a conference with the teacher, the principal, and the school nurse. Worker interpreted the psychiatrist's recommendation that the girl be promoted because of her intellectual ability and the blow that not being promoted would be to her. In the meantime, she had been getting remedial reading and speech lessons at the clinic. She was finally promoted and moved to another school where the teacher had more warmth, understanding, and tolerance for her.

In this case also, the worker did a great deal of environmental manipulation for the child, particularly in the school situation. The worker was not able to modify the
teacher's attitude but she was able to influence the principal to transfer the child to another school where she adjusted very well.

The psychiatrist did little direct psychotherapy with the patient. The worker maintained relationships with all concerned and effectively worked out all treatment plans.

Case No. 3.

James, not quite eleven years old, with an I. Q. of 108, was retarded in school since he was only in the fourth grade. He had had illnesses which retarded him but he did well until he came into his current grade when he suddenly lost interest. He was suffering a cardiac disorder at the time of referral but he was able to participate in gymnastics and swimming.

He disliked his teacher intensely because he considered her very unattractive. Otherwise he was fairly well adjusted in his relationships and environment. The clinic recommended that he join some neighborhood house and mother was urged to see a private psychiatrist for treatment for herself. She was also urged to send patient to camp.

Worker visited the school but the interview was very unsatisfactory as the teacher was very antagonistic as she felt that the child was lazy.

Mother lost interest in treatment and although both the patient and his mother needed help, the case was closed.

This is an example of a case in which full service was not indicated but in which the social worker had varied responsibilities. Although she did not take a full history, her intake interview was lengthy and filled with history material. She made one school visit, and during clinic visits she interviewed the mother, relayed information from
the psychiatrist concerning the child's physical condition, and the psychiatrist's recommendation concerning camp. The worker also contacted the New England Hospital for Women and Children several times concerning the patient's physical condition. The worker was in constant contact with the psychiatrist about the case and carried out all the recommendations.

Although this was a part-service, unsuccessful case, the worker functioned completely in her capacity as the social worker in the child guidance clinic team.

Family and School Manipulation Combined

Case No. 4.

Helen, aged ten, with an I. Q. of 140, was in the fifth grade and was referred to the clinic by the school department as a candidate for the control group of bright children.

Helen was the oldest of three siblings in a home in which the parents had separated two years previously because of father's abusiveness and a sexual maladjustment between the parents. Mother was an extremely tense and unstable person, with many neurotic traits, who was in love with a married man. The children were surprisingly well-adjusted and Helen was, on the whole, a well-adjusted child. Her one problem seemed to be that she was not achieving as outstanding a record at school as her intelligence would lead one to expect. Because of this, and because of the unstable environment, combined with mother's over-solicitude for the children, Helen was considered an excellent candidate for the control group.

1 See page 10, Carlson, op. cit.
A complete home and school history was obtained and the clinic's findings were interpreted to mother. She, however, resisted the suggestion that Helen go to the control group as mother could not bear to be separated a whole day from one of her children. She appeared very tense and repressed and worker referred her to a neuro-psychiatric clinic, making the appointment for her.

Patient was entered in the control group but since mother was unhappy about it, a staff conference was held and it was decided to enter her in the school special class for superior children. Worker made the arrangements with the superintendent of schools and then visited the home to interpret the new plan. Mother was out and worker told the patient the plan. A few days later, worker received a telephone call from mother stating that she had entered patient into the parochial school.

The worker gave full service to this case and the psychiatrist remained in the background after the initial study was made. The worker took a complete social history, worked intensively with the school situation, worked intensively with the mother to whom she gave reassurance and support, made interpretations, did some counselling, and attempted to get her to go to a neuropsychiatric clinic.

Case No. 5.

Melvin was a thirteen-year-old boy with an I. Q. of 117 who was in the eighth grade and who was very much bored with school and therefore directed his energies in school towards being mischievous and aggressive. He was referred to the clinic by the principal of the school because of his very poor school adjustment. His parents were exceedingly hostile and seemed to feel that the school principal had insulted them and their son by suggesting that they come to a child guidance clinic. Father was a very high strung excitable man who was particularly aggressive in the first interview. He wanted to know if various other boys about the city who were known to be school problems
had been referred to the clinic. The parents were allowed by the worker to express their hostility and a long interview was held. It was evident that these parents were really very much upset over their bright youngster who was rejecting school so completely and they were at a loss to know how to help him.

Gradually worker was able to interpret clinic service in a more positive way and to prepare them for clinic help. Their cooperation was enlisted and their attitude was very different upon leaving the clinic. Patient was found to be a very bright boy but thoroughly bored with the school routine. Worker, who was familiar with the school program of their particular city, felt that not too much flexibility or enrichment could be arranged in that particular school. As clinic interviews with the patient continued, it was found that he was really interested in attending an agricultural school. Worker suggested a special agricultural school as a possibility and eventually placement there was arranged. Patient liked the school very much and continued doing very well there.

This was a case in which environmental manipulation having regard to the true interests and aptitudes of the patient effected the cure. Very little psychotherapy as such was carried on by the psychiatrist.

This is a good example of effective cooperation between the psychiatrist and the worker in finding out the interests of the patient. The psychiatrist and the worker pooled their ideas in making the diagnosis and planning treatment, with the worker carrying out the practical details of the treatment plan.

The social worker made a major contribution to the successful solution of this case. She kept the patient in treatment by successfully interpreting the clinic's function to the parents, and she carried out the final solution of
helping to get the patient placed in the agricultural school.

This worker made no home or school visits. All her contacts with the family were by clinic interview and her contacts with the school were either by letter or telephone.

Case No. 6.

Arthur, aged twelve years and eight months, in grade seven, with an I. Q. of 140, was referred by the principal of his school for refusing to attend school because he suffered severe emotional upsets. He vomited, had dizzy spells, was extremely pale and tremulous.

His home environment was a complicated one. His father, a Protestant of Yankee origin, made only a marginal living, and his mother was an American born Roman Catholic of Italian extraction. Patient had two younger brothers. In addition to patient's immediate family there lived in the home maternal grandmother and her unmarried son and daughter. Maternal grandmother indulged patient, who was extremely fond of her, and he preferred her company to that of his contemporaries. He had a good relationship with mother but he was a little afraid of father who was stern with him. However, he and father shared such interests as stamp collection and mechanical pursuits. Father was a quiet person who read a great deal, hardly ever went out, and gave evidence of emotional instability, irritability, and possibly occasionally mild, depressive states.

Patient was pleasing, quiet, slowmoving, a procrastinator, very affectionate. He showed a normal degree of social response and at times was quite talkative.

His first "upset" occurred when the family moved from one city to another and he had to change schools. In September of the year of referral he had entered the A. School, attended one week, and complained that he did not know any of the boys so that he was very unhappy. He asked to be transferred to the B. School where he had more friends. This was arranged but the patient's abnormal reaction to school attendance still continued. He found it impossible to go to school.
He would cry and sometimes became nauseated at the prospect. His mother consulted a physician who said that Arthur was undergoing a "nervous upset" and recommended that patient be left out of school. A home teacher was arranged. In a few weeks patient made another attempt to return to school but again found himself unable to do so. Arthur and his mother were then referred to the child guidance clinic. Both parents were very willing to have the clinic study the patient's problem.

After patient's first visit the clinic staff had a preliminary conference and it was decided that he was undergoing an emotional upset which was occasioned by a particularly sensitive make-up rather than by external factors. It was decided that the home teacher should be discontinued, and it was the worker's assignment to make this suggestion to the principal. Worker also discussed the situation with the home teacher.

Patient kept coming to the clinic either alone or with his father but he did not appear to be making progress. On the eighth visit he became interested in the occupational therapy class where he acted normally in relation to the other boys.

The psychiatrist then recommended that worker investigate the possibilities of the special transfer class. Worker contacted the city educational consultant and discussed this with her and with the school principal. Worker also interviewed the attendance officer, making him see that strictness and punishment at this time would be very harmful to the child. The attendance officer agreed and he guided his dealings with the boy by the clinic's recommendations. Worker also visited the home and reassured mother who was upset and somewhat bewildered about patient's unusual problem.

At one staff conference it was decided to have the boy studied at a children's aid home. The worker made the necessary arrangements with both the parents and the Home but the boy refused to cooperate. Several conferences were had with the various school department personnel and he finally was transferred to a school with an excellent manual training department, and whose principal was a very understanding person. Worker was able to enlist his interest and he consented to let patient take only manual training, with the hope that gradually the patient would be able to take the full course.
With just a little resistance, the boy gradually began to go regularly to school. His program was enriched little by little so that eventually he was taking the full program. Occasionally he would have a spell of nausea and paleness, but his warm feeling for the new principal was so great that Arthur used his will-power and forced himself to stay in school.

When the question of promotion came up, the school deferred to the clinic's recommendations. He was given an achievement test and it was decided to promote him. In the meantime, he had joined the Boy Scouts and had become very active. The case was closed after eighteen months, with the patient much improved.

This is a case in which the worker's function was to work indirectly rather than directly with the boy. She worked completely around the problem. The only contact and relationship that she had with the child was in passing in the clinic and in explaining to him what was done to change the situation for him.

The worker was the pivot around which the entire case operated. She contacted the various schools. She consulted with the various school principals. She carried out the recommendations of the psychiatrist and she was able to urge on the attendance officer the necessity for permissiveness and understanding instead of the use of sternness. This worker also worked directly with the parents. She gave them support, understanding, encouragement. She praised and encouraged the principal for his understanding way of handling the boy when his spells seemed to come back. She contacted the children's home and when the situation seemed too difficult for the parents to carry through, she stepped in and
completed the task for them, although finally the boy himself refused the placement.

When the principal, who had done such good work with the boy, decided that he thought a physical examination might be profitable, this worker arranged for it. She explained it to the parents and to the boy and they consented to it even though he had very recently had one which had been negative.

This worker could be considered as a liaison between the psychiatrist's recommendations and the outside world as far as the boy was concerned. This worker went to each individual and carefully explained the problem and elicited the intelligent sympathy of those who were in a position to be either constructive or destructive, and worked out a positive solution to the boy's problem.

This is a good example of a worker who works strictly in the area of environmental manipulation. Her use of relationship, understanding, counselling, was with individuals in the patient's environment rather than with the patient himself.

The cure in this instance was brought about almost exclusively in the area of social service and environmental manipulation. It is safe to say that the improvement in the patient was directly due to the effective work of the social worker. She made the major contribution of service and treatment. The psychiatrist made the recommendations, and
also did a little work with the boy. However, the boy resisted the psychiatrist because she seemed like a teacher to him and several times he had one of his nervous spells before coming to the clinic. Therefore the psychiatrist could do very little in the area of direct psychotherapy. Her main function in this case was to make diagnoses and recommendations, and many of her recommendations were based on the material brought to her by the social worker. Several staff conferences were held concerning this case and in each the worker brought in diagnostic material which was used in making the final recommendations.

The psychologist's major contribution to the case was her determination of the boy's ability to go into the next grade.

To sum up this worker's function in this case: She manipulated the environment for the patient. She was able to work successfully with the school personnel and they carried out all the recommendations of the clinic as much as possible. She gave understanding and support to the parents who were very much bewildered by this problem. Also, she interpreted to them all that the clinic was trying to do. She maintained only a superficial relationship with the patient but worked intensively with all those surrounding him. Through her efforts the case was successfully concluded when the boy had learned to control his symptoms so that he
was able to function fairly comfortably in school and in his social contacts. Also, the worker was able to give the mother some insight into the boy's dependence on her and when the case was concluded, the mother was starting a little program of her own of gradually detaching the boy from herself and becoming more independent. The case ended, therefore, with a cure of the presenting symptoms and the beginning of the possible resolving of some of the basic conflicts within the boy.
CHAPTER X

A CASE IN WHICH TWO SOCIAL WORKERS COOPERATED TO CARRY OUT THE ENTIRE PLAN OF TREATMENT

The following case was one in which social service carried the major portion of treatment. In this case two social workers carried out the entire plan of treatment, including direct psychotherapy of the patient.

Case of Eddie Norris:

Eddie, thirteen years old, in the seventh grade, was referred by the school department's educational consultant for refusing to attend his assigned school. His I. Q. was within normal limits although he was too disturbed to be tested accurately.

His mother had died when he was two years old. A half year later his father hired a housekeeper who reared him until he was thirteen and to whom Eddie became very much attached. This housekeeper, Rose, quarreled with father and left the home. One month later, three weeks before school started, the father died and the four children in the family were divided among a paternal and a maternal aunt. Eddie and his oldest brother were to live with a maternal aunt and he was transferred to the school in this aunt's neighborhood. As soon as school started, he began to stay away from school. Later he said it was because he was hoping that he would be expelled and perhaps sent back to live with the housekeeper whom he missed very much. Just before the case came to the clinic, Eddie was transferred to still another school as he had gone to live with his paternal aunt in another district. He kept running to the home of the housekeeper. This annoyed paternal aunt and she finally forbade these visits, which served to increase Eddie's hostility.

The psychiatrist recommended direct therapy by a male social worker with the purpose of giving the boy a male identification figure. His own father had been a rather weak person and Eddie had always been hostile to him. It was hoped that this relationship with the
male worker would fill the need for a father figure. Another worker was to do case work in the area of environmental manipulation. This meant that she would work with the school and with both the paternal aunt and the housekeeper who were very hostile to each other.

Miss S., the worker with the aunt and the housekeeper, did a great deal of clarification to both. In her interviews with the aunt the worker spent considerable time discussing patient's feelings and fears, explaining from an objective viewpoint the confusion and strain of the change of circumstances and the meaning of it all to Eddie. The worker helped the aunt to see the role of the housekeeper in this situation since she had been practically a mother to the boy for so many years. The strong attachment to Rose was explained and the need of warmth and understanding of the patient was emphasized. The worker explained how important it was to continue allowing the patient to see Rose.

In subsequent interviews the worker repeated the material so that eventually the aunt assimilated it and gave it back to the worker as her own views.

Miss S. contacted the housekeeper and again discussed Eddie's feelings in the situation, how much attached he was to her and how painful it would be to suddenly detach him from her. On the other hand, the worker explained the necessity for taking the long view of the situation and think of Eddie's future, how much better it would be for him to become a part of his own family instead of straining to be with her away from them. Worker felt it would be possible for him to retain a fondness for her and also build a sound, loving relationship with his own people too.

Miss S. therefore, was able to get the cooperation of both women involved. The aunt was to allow Eddie to visit the housekeeper, and the housekeeper was not to talk with hostility of the family but was to encourage him to participate as much as possible in the family life. Both women, with a few lapses, did the best that they could in sticking to this goal. Every so often it was necessary for the worker to go over the same material with each woman when her hostility to the other broke out and spoiled the situation. The worker also helped the aunt with difficulties with the other children as well.
In the meantime, Mr. J., the male worker, developed a relationship with Eddie. This was difficult as the boy was very unresponsive, but by starting with discussions of horses, which interested Eddie, the worker was able to make some headway. Mr. J. identified with Eddie in his attachment for the housekeeper and he went to see her. Mr. J. sided a little with Eddie when the aunt refused to let him visit. Also, when the boy erupted into some very bad behavior in school, the worker made it clear that he still accepted and liked him. Eventually enough of a relationship had been established so that on the last visit the boy did not want to part from the worker. Previously the worker had discussed the need for an education, for a job, and for the planning of his future. At the time of the last interview Eddie had not thought of getting a job, but at the end of the school year he talked of looking for a summer job. He had become interested in school, basketball, and had made friends so that he did not always seem so anxious to go back to Rose. His interests expanded and they interfered with the time needed to visit her. He had become much more a part of the paternal aunt's family.

Both workers had contacts with the school. Miss S. worked with the educational consultant and Mr. J. worked with the principal of the school since most of his interviews with Eddie took place at the school and Mr. J. saw the principal very frequently. The principal had held a staff conference of the school personnel and they had developed so much understanding that when Eddie erupted into very rude behavior, the teacher involved ignored the situation entirely and within a few minutes it had blown over and the boy seemed to have forgotten it and was going along contentedly with his activity.

This case had three distinguishing features:

1. The entire plan of therapy was carried out by social service with assistance from the psychiatrist and the psychologist only in the areas of diagnosis, consultation, and recommendation.

2. Two social workers cooperated on the one case, each working in his own area. One did intensive therapy
directly with the patient in addition to a little environmental manipulation of the school situation. The other worker had almost no contact with the patient and did all her work with the patient's environment.

3. The patient did not want treatment and refused to come to the clinic. The worker, therefore, went to the patient by seeing him at school during school hours with the consent and cooperation of the principal.

Although the usual procedure in a child guidance clinic is that the psychiatrist treats the patient and the worker deals with the environment, in this case the situation had to be changed. The patient was very hostile to the psychiatrist as well as to the clinic as a whole. It was not possible for the psychiatrist to follow the patient to the school but the worker could do so very conveniently.

The male worker tried to put across to the boy his interest in him, an interest that was firm no matter what the boy did. He gave the boy warm acceptance, understanding, and a certain amount of companionship. He did his best to relate to the boy and to allow him to release his hostile emotions and develop enough relationship so that he could be influenced towards more stability and happiness.

The worker who was handling the environmental situation had to do a great deal of psychological work. She gave both ladies emotional support, acceptance and reassurance.
She was able to inspire each to stick to the treatment goal of helping Eddie to adjust. This worker also had an excellent relationship with the educational consultant and it was possible for her to elicit a great deal of cooperation from the school department.

The responsibilities of the two workers dovetailed. Each worker remained in his own area and there never seemed to be any overlapping. Possibly this was due to the fact that one of the workers was the supervisor of the other so that she knew exactly what was happening between the male worker and the patient.

To summarize: This is a case in which the plan of treatment was carried out almost exclusively by the social service part of the clinic team. This service was shared by two workers, one of whom dealt almost entirely with direct therapy and the other with the environment. A third interesting point in this case is that the client did not want service. Nevertheless, the clinic, represented by the social worker, went out to him and urged it on him, with fairly positive results.
CHAPTER XI
SUMMARY AND CONCLUSIONS

This study was made with the view of finding out what contribution the social worker of a child guidance clinic team makes to the progress of a case. It was also attempted to determine what a social worker's functions and duties are in treating school problems.

Of the twenty cases studied, there was one case in which the only service given by the clinic was remedial therapy in reading. No social history was obtained and there was no social service or psychiatric treatment.

Of the remaining nineteen cases, there were three cases in which no social history was obtained, but in which treatment was given. These three cases showed improvement when closed.

There was one case in which a social history was taken, but no treatment given. This case also seemed to show improvement.

In the remaining fifteen cases, full service was given, including the taking of a full social history. Eight of these cases showed improvement and seven did not improve.

There was one case in which the only treatment given was family manipulation. This case was closed as not improved.

There were seven cases in which the only service given by the worker was school manipulation. Of these seven
cases, three were closed as improved.

There were ten cases in which the worker did both school and family manipulation. Of these, six were closed as improved.

Most of the children's problems were not due to factors in the school situation alone even though they were referred as school problems. They were due to difficulties in the children's personalities or to factors in the home environment, or a combination of both. School placement and poor teacher relationship as the sole causes of the problems were in the minority.

Treatment depends on diagnosis. As previously stated, each problem is approached on an individual basis presenting a problem in differential diagnosis. As each case is approached on the basis of differential diagnosis, so must treatment in each case be approached on an individual differential basis. Since the causes of the symptoms varied so much, forms and procedures of treatment also varied greatly.

Each child was studied thoroughly so that differential diagnoses could be made. If the child needed intensive psychotherapy, then emphasis was placed upon the psychiatrist's work as a therapist. If the problems stemmed mainly from environmental pressures, then the social worker's function was stressed. If it was a problem of the child's having inner conflicts which were aggravated by outer
circumstances, then both the social worker and the psychiatrist shared equally in the therapeutic plan, each functioning in his own area, with a few exceptions.

One can divide the social worker's function into five areas:

1. Relationship within the clinic team itself, manifesting itself in close cooperation with the other members of the team, as well as with all the members of the entire staff. This is particularly important in the diagnosing of problems and presenting material at general staff meetings.

2. Diagnosis, in which the social worker takes an important part, as she obtains the social history which is so vital to the diagnosis.

3. Mechanical work which facilitates the smooth progress of a case and in which some case work skill may be necessary in understanding such things as the proper timing and wording of a letter or telephone call.

4. Environmental manipulation, which necessitates the use of much case work skill. Environmental manipulation can be divided into several areas:

   a. Manipulation of personalities in the patient's family.

   b. Manipulation of personalities in the school situation.
c. Material manipulation, which may include referrals to other agencies for practical assistance, referrals to camp, medical referrals, etc.

5. Direct psychotherapy with the patient. On rare occasions the social worker is called upon to do this.

In a child guidance clinic there is no environmental manipulation of the practical kind in which the social worker can give material aid to the client. Practically all manipulation is in the area of psychological assistance to those personalities which surround the patient, at home and at school.

In this use of relationship, the worker must be most skillful since many of the people she deals with are not "clients" in the sense that they feel that they need help. On the contrary, in many cases, the persons dealt with, particularly school personnel, may resent what they consider the intrusion of the social worker.

One may summarize a worker's specific duties as follows:

The worker is responsible for the mechanical duties in a case: she records dates of clinic visits; she keeps track of the child, following him up if he is absent for any length of time; she telephones and writes messages for the psychiatrist; and she generally keeps things running smoothly.
The worker may act as background assistant to the psychiatrist without taking active part in treatment. She brings in the social history and other diagnostic material to the psychiatrist. The worker maintains a superficial relationship to the patient and his mother; she observes their behavior in the clinic; and the worker is in a position to make school visits which serves to give the psychiatrist further insight into the case. In a sense, in this type of case the worker plays the part of the consultant to the psychiatrist.

The worker may share treatment equally with the psychiatrist. In such cases, both direct and indirect psychotherapy are used to help the child's situation. The psychiatrist works directly with the child while the social worker works in the area of the child's environment. Inasmuch as she usually takes the history, and is also taking an equal part in treatment, the worker shares both in the diagnosis and the treatment of the child's difficulties.

In some instances, the worker works exclusively with the school situation and the psychiatrist works with both the child and the mother. Since the mother is considered a part of the child's environment, in such a situation the psychiatrist and the worker may be considered to share in manipulating the child's environment. However, the most common form of sharing responsibility in treatment is that in which the
psychiatrist does direct psychotherapy with the child, while the worker manipulates both the family and school situations.

The worker may carry the major part of the treatment while the psychiatrist serves as consultant and diagnostician, and the cure itself comes about through the manipulation of the environment without direct help for the patient himself. Everything is done around him, and the worker seems to link all his environments together. She works out family and school situations for him. She gets him camp placement. When several agencies are working together on the same case, she is able to interpret to each what the other is doing so that the total program is consistent. The worker is the driving force in this type of situation while the psychiatrist remains in the background, ready to assist as a consultant when needed, but otherwise taking a passive role while the worker is very active.

On rare occasions, the social worker may work directly with the patient on a psychotherapeutic basis.

This brings up the question of whether or not a social worker should work in the area of direct psychotherapy. In the one case in this study in which the worker did work directly with the patient, the outcome was favorable.

This question of psychotherapy by the psychiatric social worker seems to have no definite answer currently. There is constant discussion back and forth and as these
discussions go on there seems to be a gradual clarification of just what the function of the psychiatric social case worker is.

Dr. Szurek\(^1\) believes that an experienced psychiatric social worker can do better psychotherapy than a junior inexperienced psychiatrist if only because the social worker has generally less prestige obstacles within herself to look for supervisory help from a psychiatrist sooner than the beginning junior psychiatrist.

According\(^2\) to the American Association of Psychiatric Social Workers the specific competence of the psychiatric social worker is determined by her professional education which includes supervised practice in psychiatric social work.

Either in "manipulative" or "environmental" social work, or "intensive social case work," the same depth of understanding of the client, the same quality of concern and consideration for his request for service, the same skill in making service available through the medium of a relationship which by its very nature facilitates the client's capacity to make and act on his own decisions in respect to social difficulties he is encountering--is required of any and all social settings. However, it is still social work, focused not on

\(^1\) Szurek, op. cit.

the resolution of intra-psychic conflict per se, but on helping the client experience and deal with whatever conflict he may have in respect to using a specific kind of social agency service, to deal with an immediate problem or problems he is meeting in the environment.

Nevertheless, in one of the cases cited a male social worker was used as a father figure to resolve some of the patient's hostility to his own father. This is contrary to general practice, yet all circumstances were favorable to this type of use of the social worker and the outcome was a successful one. Therefore, it would seem that no set rules can be made but that the use of the social worker as a psychotherapist should depend on individual circumstances: the needs of the case and the ability and training of the social worker.

In treating a school problem as in all other symptoms, the worker, along with the whole clinic team, works on the total situation of the child: his inner conflicts and outer pressures. Child guidance treatment in a school problem is usually the same as child guidance in any other presenting symptom, except that when a child's symptoms have come out as a school problem, he may have so annoyed his teacher and principal, that the worker has to go into the

3 See Chapter X, case of Eddie Norris.
school and relieve some of the pressure which the child, through his problem behavior, has brought down on himself.

In dealing with school adjustment problems, the social worker's function is emphasized to a greater extent than in dealing with other problems. When the problem is caused by, or aggravated by school placement and relationships, it is the social worker who can go into the school to help put into effect the treatment prescribed by the psychiatrist. The worker can carry the clinic's recommendations into the school and help work out the solution.

Even when the problem is one of inner conflict in the child or his parents, the school has to be handled, interpretations have to be made, and some teachers have to be enlightened most tactfully, so that the social worker's part in school problems is of major importance.

* * * * *

One may make the following general conclusions from the study of these cases:

The social worker's duties in any given case and her contributions to therapeutic results are not limited to any set patterns of procedure. She does what she has to do as the need presents itself in the problem. Her duties may range from the mechanical duties of keeping track of clinic visits for remedial therapy in reading or speech, to skilled
case work with a hostile mother who does not and cannot realize that she is the cause of her child's problem and that she needs help. The worker may contribute the most or the least to the treatment results. The treatment plan is based on diagnosis, and the worker's share of treatment is determined by the area in which the cause of the problem is found. If the cause of the problem is in the environment, the worker is the therapist; if the cause of the problem is in a psychic conflict, the psychiatrist is the therapist; if the cause of the problem lies in a combination of inner conflict aggravated by environmental pressures, both the psychiatrist and the worker share in therapy.

School problems are treated little differently from other problems except that there may be a little more intensive work with school personnel when the origin of the problem is of a situational nature, or when the child's behavior has served to bring school pressure down on him.

* * * * * *

The writer would like to make two recommendations:

First, in spite of so much opinion to the contrary, the writer feels that psychiatric social workers in child guidance clinics should be used for direct therapy under the guidance and supervision of a psychiatrist. There is a shortage of psychiatrists in the clinics, while there is an
increase in the clientele. The value of the psychiatrist's training and service could be multiplied many times if she delegated her therapy through trained workers.

The second recommendation is that the clinics should attempt to better their relationship with the schools through various public relations plans. Many schools are very definitely unaware of modern concepts of personality development. Some are very resentful of the child guidance social workers who come into the schools trying to help them.

Some program of public education ought to be worked out, possibly that of sending attractive and dynamic speakers into school and parent-teachers' meetings to enlighten both the school personnel and the parents as to the value of the modern mental hygiene programs. This might change the attitudes and tactics of many teachers, thereby reducing the number of school problems referrable to a clinic. At the same time, it would make it much easier for the individual social worker to go into a school on a case as she would be more welcome, the school would be more receptive to clinic recommendations and there would be more and better cooperation between clinic and school workers so that case work results in a school problem would be more successfully and easily achieved.

Approved,

Richard K. Conant
Dean
BIBLIOGRAPHY

Books


Articles and Reports


Newell, Nancy, and Edgar C. Yerbury, M. D., The Development of the State Child Guidance Clinics in Massachusetts. Division of Mental Hygiene, Massachusetts Department of Mental Health, 1944.


Thom, Douglas A., M. D., and Nancy Newell, "Hazards of the High I. Q.," Massachusetts Department of Mental Health Division of Mental Hygiene, reprinted from Mental Hygiene, Jan. 1, 1945, pp. 61--77.

Yerbury, Edgar C., M. D., A State Mental Hygiene Program, Massachusetts Department of Mental Health Division of Mental Hygiene, published by the National Committee for Mental Hygiene, Inc., 1943.
APPENDIX
Schedule

1. Age___ Sex___ Grade___ IQ___

2. Prob. as referred: Associated Problems___
   Age, last grade, relig. ec. status occupation other pertinent data

3. fa
4. mo
5. sibs

6. Others in household
7. Other influencing friends
8. Other influencing relatives
9. Personality problems of patient:
   poor school adjustment: lack of interest___ truanting___
   misbehavior___ not working to capacity___ insufficient
   school facilities to interest___ withdrawn___ hostile___
   daydreaming___ other___

10. Physical development of patient:
    Health: good___ bad___ explain
    Development: mature___ immature___ good___ bad___
                 appearance___ other___
    Handicaps: sight___ hearing___ limbs___ cosmetic___
                 other___

11. Emotional development:
    relationship to mo
       "   " fa
       "   " sibs
       "   " Others in household
    relationship to contemporaries___ to teachers___
(Schedule continued)


13. Treatment Service ____________

14. Diagnostic Service ____________

15. First clinic visit: Wkr's share in procedure

16. Social history: obtained____ not obtained____
   how used____________________

17. Social Diagnosis:

18. Treatment plan:

19. Case wk with fam. and others in pt's environ.: environmental manip: relationship:
   emotional release interpretation
   supportive therapy
   counselling

20. Case wk with pt:
   supportive therapy
   environ. manip.
   relationship
   emotional release
   counselling
   group work referral
   other agency referrals
   manip. of school situation
   worker's relationship to school
   cooperation of school
(Schedule continued)

other educational resources contacted

21. Cooperation of several workers on one case

22. Worker's relationship to psychiatrist

23. Worker's relationship to psychologist

24. Use of conferences:
   Staff
   Staff and other cooperating agencies and personnel

25. Mechanics of worker's functions:
   tel____letters_____home visits_____read other
   agency's records_____verifying records_____clinic
   interviews_____school visits_____other_________

26. Worker's use of community resources: financial_____
    medical____group work agencies____other
    agencies_________

27. Closing of case:
   Improved:
   Not improved:
   Reason for closing:

28. Worker's record

29. Treatment summary
(Social History)

S. S. Record

Name

Age:

Address:

Telephone:

Source:

Problem:

FAMILY GROUP

Fa. - Name, age, date and place of birth, nationality, racial bkgrd., occupation and religion

Mo. - Same----date of marriage

Sib. Same----School and grade

Others in Household----same

Language spoken in home

Home

Neighborhood

Poor

Average

Superior

Economic

Dependent

Marginal

Comfortable

Clinic

Opened

Closed

Reopened
I  THE CHILD

A. Present Situation: Describe the child, his problems, and circumstances that resulted in his being brought to clinic. Include worker's observations of child's behavior. State what child has been told about visit to clinic. Give child's and family's attitude toward problems and clinic.

B. Social Reactions: Give picture of personality traits and make-up. Describe attitudes and behavior at home and in neighborhood; e.g. ability to get along with adults and children. (Age, sex, type, etc., of companions.) Use of leisure time (interests, ambitions, hobbies, skills, membership in clubs, etc.) Methods of discipline, sex instruction, child's reaction to both. Right or left handed? Discipline: training for responsibility, control, methods of punishment and child's reaction to them.

C. School: History as given by mother, including present grade, repetition of grades, child's and mother's attitude toward school. Report of school visit: Give scholarship, effort, attitude toward work and classmates, parents' contact with school, if any, impression of room as a whole, and teacher's attitude toward child and clinic. Handedness

II  ENVIRONMENT

A. Personalities in household and family relationships: Include information re. patient's paternal and maternal relatives when significant. Brief historical sketch of members of household. Include education, health, and economic situation. Relationships among members of household.

B. Home and Neighborhood: General description of home, type of neighborhood, and accessibility to community resources. Placements outside the home, camp.

III  EVALUATION

Sum up social history. Analyze the relationship between patient's problems and the social situation. Parents' attitude toward patient's problem and attendance at clinic. Prognosis
The text on this page is not legible due to the quality of the image. It appears to be a page from a document, possibly containing paragraphs of text, but the content cannot be accurately transcribed.
(Intake slip)

APPLICATION
CHILD GUIDANCE CLINIC

NAME

ADDRESS

TELEPHONE
NAME

BIRTHDATE & PLACE

OCCUPATION

RELIGION

FATHER

MOTHER (Maiden)
NAME

School Grade

SIBLINGS - 1.
2.
3.
4.
5.

OTHERS IN HOUSEHOLD

BIRTHDATE

BIRTHPLACE

PROBLEM

SOURCE

NAME

GRADE

TEACHER

SCHOOL

CLINIC

REMARKS

DATE