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A study of twenty cases recommended for remedial reading and social case work services at the Brockton Child Guidance Clinic 1944-1948

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A STUDY OF TWENTY CASES
RECOMMENDED FOR REMEDIAL READING AND
SOCIAL CASE WORK SERVICES AT THE
BROCKTON CHILD GUIDANCE CLINIC
1944 - 1948

A Thesis

Submitted by
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CHAPTER I
INTRODUCTION

Introductory Remarks

It is now generally recognized that many cases of reading disabil-
ity show other related personality difficulties; that these are
frequently accompanied by disturbed social situations, unhappy home
relationships, physical impairments, or poor school relationships. Pri-
or to 1944, the reading disability was included in the category of poor
school adjustment or as a behavior problem. Since 1944, case work
services have been combined with some of the cases needing reading tu-
toring. This was an effort on the part of the social worker to reduce
or alleviate the causes of the reading disability. Many times the
case worker has been used principally in clarifying the home conditions
to the parent and helping the parent gain some insight as to how it is
affecting the patient. At other times, the social worker provided the
outlet for the emotional tensions either of the parent or of the pa-
tient, and still other times, the worker found it necessary to help the
teacher understand the patient by interpreting the reasons influencing
the patient's attitude or behavior and resulting in a disability in
reading.

Purpose of the Study

There are two purposes in this study of twenty cases referred
to the Brockton Child Guidance Clinic from 1944 to 1948 for remedial
reading and social case work services. One is to determine the causative factors such as social, economic, home situation, school and physical, which resulted in a reading disability. The other is to determine the role of the social worker in the treatment of these cases. In relation to the first purpose, the writer will attempt to show both the common factors which seem to be related to the majority of the cases and the related factors which are not common to the majority of the cases, but have their deleterious affects on reading; also if there have been any personality changes of either patient or the parent as a result of the reading disability. The other purpose is determining the effectiveness of the social worker's participation and if it is a wise policy for the social worker to continue such services in reading disability cases. The writer included the attitude of the parent towards this type of a disability and how this attitude affected the patient in his attempt to remedy this fault.

Method and Scope

To select these cases referred to the Brockton Child Guidance Clinic for remedial reading and case work services, the writer found it necessary to begin in the year 1944 as in this year reading disability became a separate entity. The writer found that the card index did not show what type of services were used in these cases. The writer then found it necessary to clear through all the cases marked reading disability and to separate those having the combination of reading tutoring and case work services from those needing only read-
ing tutoring. The writer found that there were one hundred seventy-seven cases of marked reading disability problems, but that of these one hundred seventy-seven cases twenty cases had the combination of case work services plus remedial reading; six cases had case work services discontinue due to the lack of staff help or the case work services were interrupted due to the needs of other emergency cases. This need, and insufficient staff, was one of the main results of the war. The remaining one hundred fifty-one cases were those given only reading tutoring.

These twenty cases were referred for reading disability from the public schools, from family welfare societies and agencies of Brockton, or from the parents themselves who hoped the clinic could help the child in correcting his reading disability.

The cases selected will vary as to the area of case work services. The area of case work services was decided either in conference with the team of the clinic, the psychiatrist, psychologist and the social worker, or after consultation with the psychiatrist by the social worker. Before any plans were made, all pertinent material about the patient was reviewed.

This study will show only results obtained where the case work service was with the parents, with the patient, making the teacher aware of problems causing patient's disability in reading, or the combination of these areas. This study will only show the areas in which the social worker participated.
The writer following the clinical procedure has included only patients with an average intelligence quotient or with an intelligence quotient of dull-normal, but with a good prognosis. The clinic considered dull-normal as those being under ninety intelligence quotient. The requirement of a good prognosis meant that the patient was not affected by any mental or physical disease or that the environmental conditions could be manipulated by the worker so as to increase the patient's possibilities of success in removing the disability. This requirement of a good prognosis was considered wise during the war years, and even today, as the staff has been greatly undermanned and the demands for case work services and other services of the clinic far exceed the ability of the clinic and the staff to handle them. Except in emergencies, it was decided to utilize the services of the clinic in needed cases in which chances of success were in evidence. This was not a defeatist attitude, but the facing of reality that some cases may not be successful and the time of the worker could be used to a better advantage. The load of the clinic, the long waiting list waiting for services to be given, and an undermanned staff caused the clinic to accept this policy. The study, then, is concerned mostly with the average intelligence group. Cases of superior intelligence were also referred to the clinic, but the writer found that in all these cases the only services given were reading tutoring and psychiatric services.

Though the clinic is situated in the Brockton High School build-
ing and the Brockton School Department provides some of the personnel of the clinic, the clinic has accepted referrals from other agencies such as the welfare department, catholic schools, traveling clinics, school nurses, parents, and even the courts. The clinic accepts cases referred from interested agencies outside of Brockton which do not have a child guidance clinic in their area. The clinic is also used as a referral center for other agencies and parents for information about other accessible resources; and parents wanting information about schools which cater to reading disability problems.

A schedule was devised and applied to each case to help the writer determine the factors related to the emotional blocking of the patient and what and where case work services were rendered. Each case was examined for the following information; what seemed to be the related factor for the emotional blocking of the patient such as insecurity in the home due to sibling rivalry or demands of the parents causing too much pressure on the patient; school relationships; attitudes of the parents as a result of the reading disability of their child; attitudes of the teacher both to the patient and to the parent. The writer by this schedule was able to determine the contributions of the social worker and how the social worker's contribution affected the results of the case. The writer also included the type of treatment and the area of treatment, if it was with the parent, the child

1 See schedule in the Appendix
or in contact with the school, and what type of manipulation was necessary such as the use of outside resources.

Limitations

Since this study consists of only twenty case studies, it will not attempt conclusions. This study might determine whether or not case work services can be utilized in combination with other services such as reading tutoring and speech therapy. The type of treatment given, the case work goals and the methods of attaining these goals will be studied with a view as to the results obtained. If the results show success and helped in eliminating the reading disability, then it can be determined if case work services were necessary. The detailed case presentations will show whether or not case work services were necessary.
CHAPTER II

BROCKTON CHILD GUIDANCE CLINIC -
PERSONNEL - AREAS OF CASE WORK SERVICES GIVEN

Brockton Child Guidance Clinic

The Brockton Child Guidance Clinic is part of the Massachusetts
Division of Mental Hygiene, which was created by law in 1922. The
primary importance of the development of the Division was a preven-
tive measure for juvenile delinquency and mental illness. In 1938,
September 13, the Division of Mental Hygiene acquiesced to the requests
of the Brockton community and established the clinic and in January,
1945, transferred the personnel from the Southard Clinic to the
Brockton High School where the clinic was located. Though Brockton
had psychiatric services in the Brockton Hospital Clinic, the commu-
nity felt that there was a definite need of a guidance clinic dealing
primarily with the problems of childhood.

The Brockton School Department utilized the clinic as an aid
to their educational system. They provided the personnel for the
reading classes and the speech classes. In 1940 the school depart-
ment and the staff of the clinic established classes for children
with a high intelligence quotient. These children have special prob-
lems of their own, such as not being sufficiently stimulated by the

1 Edgar C. Yerbury and Nancy Newell, "The Development of the
State Child-Guidance Clinic in Massachusetts". Reprinted from New
work if they are placed according to their chronological age and finding the work too dull, or finishing the work and having too much leisure which resulted in the loss of interest in the school work. This experiment has been so successful that it is considered a part of the function of the clinic procedures to recommend children for these classes.

Brookton originally started off with the clinic meeting one half day a week, but due to the efforts of the Division of Mental Hygiene, the clinic was able to remain open two full days a week. The clinic treats children between infancy and their fifteenth birthday, the largest group being between ten and fourteen years. The clinic tends to see more boys than girls. Exceptional cases over fifteen years of age are taken.

Personnel and Their Function

A full time psychiatrist who because of her medical background and psychiatric training was designated as the director.

The psychiatrist sometimes works with the parents or with the children, or with both parent and child. The initial contact with any case is usually made with the parent. When a referral is made, an appointment for the parent and patient is made for them to come to the clinic where an intake application is taken by the social worker.

2 See Intake Application in Appendix.
The psychiatrist is usually made aware of the problems of the patient due to the social worker giving the psychiatrist in writing and orally the intake history of the parent and the child. The social worker also makes sure that the results of the psychological tests are handed to the psychiatrist. If possible, the psychiatrist sees the parent alone and then sees the child. Sometimes this is not possible as the child refuses to be separated from the mother. The psychiatrist in these cases sees both parent and child together, but makes another appointment for the parent.

b. Two full-time trained social workers plus two or three students.

The role of the social worker during the first appearance of the parent to the clinic is to interpret the clinic's functions and acquaint the parent with the duties of the psychiatrist and the psychologist, and also to inform the parent that the psychiatrist would prefer to see the patient and the parent alone. The social worker usually makes the initial or first contact with the parent at the clinic by means of the intake, and during this time may be able to establish a good relationship with her. This intake application is a brief history of the problem and the environmental background of the patient. This history, or intake, is then given to the psychiatrist with the results of the psychologist's tests.

The social worker also observes the behavior of the patient
and when giving the intake to the psychiatrist states what has been observed.

During the intake interview the social worker must be aware of having the parent give vent to too much emotional tension as the social worker realizes that this emotional feeling should be reserved for the psychiatrist. The social worker understands that if the parent relieves herself of too much of her feeling and anxiety at the intake, she, the parent, might not be able to repeat the same material with the psychiatrist. This technique of keeping the emotional tone of the parent under control until the parent sees the psychiatrist requires a good deal of skill. Many times the results of the psychiatric interview are due to the ability of the social worker in having the parent withhold her emotions, yet at the same time get enough material to aid the psychiatrist in having a clear picture of the problem, the cause, and the background of the patient.

c. Two half-time psychologists

While the social worker is interviewing the parent, the psychologist tests the patient not only for intelligence quotient, but also for patterns of behavior exhibited by the child. The test used mostly at the Brockton Child Guidance Clinic is the Wechsler Bellevue. The psychologist does use the Merrill-Palmer test for younger children below the adolescent age. In addition the tests used are the Stanford-Binet tests, and for very young children the Gazelle Schedule is used.
The child also may receive performance or achievement tests. The pro-
jective techniques, such as the Rorschach and the Thematic Appercep-
tion tests, are also used, but not as frequently as the other tests.
The psychologist gives the results of these psychometric tests to both
the psychiatrist and the social worker.

d. Two reading tutors and a full-time speech therapist

These are staffed by the educational department and are
attached to and paid by the school system. The teachers are assigned
respective patients after the plan is made by the psychiatrist and the
social worker as to the type of services to be given.

An Educational consultant is supplied by the School Department.

A sort of liaison person between the clinic and the school.
She is paid by the school department and has a set of offices away from
the clinic, but in the high school. She receives all clinic referrals
from the school system and screens them as to their importance and needs
as to the clinic services. Also, she supervises the administering of
tests given from grade one to grade twelve in the Brockton school sys-
tem; she supervises all first grade and special classes and their re-
spective teachers. Usually a consultation is held once a week between
the social worker and the consultant in regard to the progress in the
clinic concerning school cases, recommendations of the clinic in regard
to transfer or promoting school cases and a review of possible new
cases to be admitted by the clinic.

Areas of Case Work Services Given by the Social Worker

a. For the Child
Since the reading disability cases comprise one-third of the case load, the reading tutors and the speech therapist are working up to their maximum capacity. Some reading classes consist of one person and others have as many as three. This arrangement has allowed for individual attention and at the same time relieves the patient of the inferiority feeling he has when he finds himself unable to compete with others of the same age or grade.

Before any new case is assigned to the reading tutor or speech therapist or receives any of the services of the clinic, the case is discussed immediately after the psychiatric interview, or during the weekly consultation between the psychiatrist and the social worker. The combined efforts of all concerned in getting a picture of the child are reviewed and plans are made as to the roles of the social worker and the psychiatrist and the goals to be obtained. This important part is called "team work". The team consists of the psychiatrists, psychologist, and the social worker. The team work is illustrated at the staff conference wherein each case is discussed and the plans made as to specific functions of each member of the team. At other staff meetings all people concerned with the referral of the case are invited, such as the educational consultant, the school nurse, a member of an outside agency, the speech therapist, the reading tutor, and any clinic member working on the particular case.

After the psychiatric interview of the parent and the intake interview by the social worker, both the psychiatrist and the
social worker determine whether the social worker is to work with the child or the mother or is merely to interpret to the school the needs of the patient. A majority of the times the psychiatrist will work with the child and the social worker will work with the mother and also do any manipulation necessary for the treatment.

The initial function of the case worker involves getting the social history. This is usually taken from the parent and includes habit training, methods of discipline, health history, and present physical condition of the patient, opportunities for play, character of play-mates, information about the siblings, and a brief school record.

Immediate environment and recent events are not always enough to enable one to understand the man in trouble. Sometimes his difficulties lie deeper. Its solution may be determined by early life and training. * * * A man is what he has been. He is truly a part of all that he has met and there is no better key to his present than what he has thought and experienced in the past.

The social history enables the case worker to determine what has helped in molding the child's personality and the causes of his maladjustment. The important information gathered this way is the emotional development of the child in relation to other people and to his family circle.

The social worker works with the child in many ways depending on the diagnosis and suggestions from the psychiatrist. The worker

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3 See History in Appendix

may help the patient use his aggressive nature in supervised sports by referral to the Young Men's Christian Association or the group activities of the Boy Scouts. If the patient needs encouragement, and support, in a guiding father figure, the worker may assume that role. Throughout, the worker will remain a friendly figure and must always be alert to the subtle passive hostility and resistance that the patient carries.

Mental hygiene recognizes that, although there is much yet to be known about this factor in human behavior which science only of late has begun to study seriously, there is abundant proof that the emotions are the most compelling of personal experiences. The happenings in childhood that appear later to have been most decisive in influencing character issue from the emotional experiences. Therefore mental hygiene must stress the emotional responses of the formative years.6

Dealing with the child may mean the changing of the environment of the child and thus removing the factors of the emotional disturbances, or having the patient identify with the worker and thus modify the emotional disturbances of the child through this identification.

b. For the Parent

With the development of the mental hygiene movement it was inevitable that attention should be directed to the problems of child-

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hood. As from every quarter new light was thrown by investigation upon the meaning of personality, it became increasingly evident that not only was childhood the golden age for mental hygiene, but the influence of parents was in most instances predominant in shaping the life of the child.\(^6\)

The usual procedure of the clinic is, after a referral is made either by the Educational Department, Family Service Agency, or by the parents themselves, to make an appointment for the parent to bring the child to the clinic. At this time an intake interview is taken from the mother or mother-substitute, or from the father if he brings the child. This is the first official contact the mother has with the clinic and is usually a good opportunity to orient the mother as to what the clinic means and to explain the duties of the psychiatrist and the psychologist. In this interview, the social worker receives information from the parent and completes the face sheet.\(^7\)

The face sheet shows factual data such as the parents' ages, origin, occupation, siblings' names and ages, patient's age, school, grade, how mother heard of the clinic and what mother thinks the problem is. The intake slip gives a little of the history of the patient and the family setting, and also the school history. At intake the social worker requires skill in preparing the parent for the visit to the

\(^6\) Ibid p. 95.

\(^7\) See Appendix for Face Sheet Form.
psychiatrist, obtaining necessary information without allowing the parent to relieve too much anxiety or emotion. The purpose is to allow such emotional relief or feeling of anxiety to be expressed in the presence of the psychiatrist who reviews the intake sheet and interviews the parent and then the patient. During this intake the worker should keep in mind that the plans may be made at the conference between the psychiatrist and the social worker that the social worker would treat the mother. Usually this requires a history-taking by the worker, and the relationship established during the intake interview is important both as an aid to treatment and as an aid in gaining more important material. The intake interview can be called the initial state of the treatment relationship. Usually the history is taken from the parent at the home, but may also be taken at the clinic. The home visit allows the worker to ascertain the possibilities that environmental conditions in and near the home may be related to the reading disability.

Psychiatric social case work with the mother is oriented to helping her explore the disturbed feelings she may have about her child and the problems the patient presents. A sense of failure as a parent is almost universally present, along with various specific expectations and misconceptions about the rule of the clinic and about the nature of her responsibility in the treatment process.8

Therapy with the mother requires defining the rules both the

therapist and the mother are to play. The therapist should point out
the purpose of the treatment so that the mother will be helped to see
the problem more clearly and to adopt a different attitude toward the
child, an attitude of understanding. The nature of the problem, name-
ly, difficulties in relationships between parent and child, should be
emphasized. The method to be used, the length of time and the diffi-
culties should not be minimized.

A parent may be expected to show resistance to treatment, she
has come in to get help on her child's problems and it is undignified
to have to shift the focus to herself. It is important, though very
hard, for the mother to accept her role as a person being treated.
If the mother expresses resistance to the role she is expected to play,
the worker must deal directly with that resistance. The worker must
understand the feelings of the parent about the child being referred
to the clinic and that the referral was not made by the parent. The
worker realizes that a person cannot change his attitudes and modes
of behavior unless he has the will to change, and the referral by a
mother of her own child would show a more cooperative and understand-
ing attitude than one in which the child was referred from another
source. Most of the patients who attend the clinic for reading tu-
toring have been referred by the school department after the mother has
been consulted.

Despite their desire to help the patient, the mothers may find
the clinic very threatening, especially when it brings out their guilty
feelings of being poor parents. A discussion of the feelings of guilt may help ease the resistance. A mother should accept the treatment voluntarily rather than because of outside pressure from the educational department, a relative, or the family society. It is felt that results of the interviews would be more fruitful when the mother has come to the clinic of her own accord. The social worker tries to offset this outside pressure by interpreting the services of the clinic and explaining fully the need for participation for each member involved in the difficulty, and the need for cooperation for all parties concerned.

The necessary tool of the therapist is the establishment of a good relationship. This relationship should be one of acceptance. Modern psychotherapy is founded on a relationship in which the therapist accepts both in principle and in feeling the person whom he is treating. Acceptance means that he adopts a non-critical attitude, and that he has respect for the person as a parent, that he understands her difficulties and that he can sympathize with the methods she has attempted. The therapist is also permissive, permitting the mother to continue as she does without any attempt at changing attitudes. The social worker shows confidence in the mother by reassuring and encouraging her about the possibilities of working out the problem successfully. Using these methods of approach the social worker may help the parent work out some of the guilt feelings and help in the treatment processes towards the parent and the patient.
Every therapist encounters what has been technically termed resistance, namely, the reluctance of a client to proceed in the elaboration of feelings. Resistance takes many forms, instead of expanding on how she feels towards her child and on her problems, a mother will tend to confine her discussion to less unpleasant topics. Withdrawal sometimes leads not only to slowing up the therapeutic process itself by long pauses, but to failure to meet at the appointed hour or to actual absences from the therapeutic sessions. There are many ways and forms which a person can employ to avoid further elaboration of unpleasant material. Resistance is the name for the various devices that a client uses to protect herself from the pain and anxiety which is aroused by too full and premature a confrontation of her unconscious motives.9

The therapist will endeavor to discuss and interpret the resistance to the mother and encourage the mother to discuss this freely. Under such conditions, a therapy aimed at freeing the parent emotionally also may bring about insight in the mother, and what before looked too difficult or impossible now becomes acceptable and tenable. Great skill is required to have the parent enter into a treatment relationship that is primarily aimed at her and not at the child whom she brought to the clinic for treatment.

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c. **Contact With The School**

Interpreting to the teachers the needs of the patient and gaining support of the teacher in bolstering the ego of the patient is one of the important factors in determining the success of treatment. The manipulation of this specialized environment requires skill, diplomacy and understanding in a worker. Many of the children identify with teachers and some express hostility to being forced to learn. Some of their hostility is brought from the home to the school. The teacher, being a figure of authority and reminding the child of authority at home, causes the patient to react toward the teacher as he would against the parent. Many patients come from homes in which the patient receives little or no attention or is jealous of a sibling, or is under too much pressure from the parents, or is frightened by the school setting. These emotional factors reflect on the patient's attitude in school.

The family usually provides the child with economic security, status in the community and "belongingness" to a group, plus the much needed affection and love. But the school can frequently recognize when a child is deprived of fundamental needs, physical and emotional, and can employ teachers who are emotionally mature, secure, and attuned to gaps in the child's life as he pursues his educational plans. In reality, the socialization of the child depends upon how sane and cooperative adults are and how much the adults in the child's world care about what really happens to him as he strives actively to
find his niche in society.10

The worker in many cases effects a change of schools or a change of teachers in order to bring about an improved situation for the patient. The social worker realizes that the child's reading problem may be an expression of a disturbance in the family which he has carried over to the school and in the treatment process contact with the school is often found of great value and almost indispensable. The worker realizes that the teacher's main job is the educational job of teaching the children, but should also remember that they are molding a child's personality through the child's identifying with the teacher or through transference. The worker realizes that many teachers have little knowledge of mental hygiene and how it affects the behavior of the child. Also, the worker realizes that teachers are human and may have their own problems which affect their personality. The social worker knows the limitations of teachers in their inability to diagnose and evaluate the degrees of maladjustment, and so the job of the social worker is to interpret these needs and the meanings of the behaviors to the teacher and plan a workable arrangement in the classroom by which the patient can be helped, if possible. The social worker may find a variety of reactions in this area from refusal to accept the worker's opinion as to the meaning of the behavior of the child

to the teacher's enthusiastic cooperation. A worker must understand the resistant behavior of the teacher as a fear of her own diminishing authority or the teacher's feeling of insecurity which makes her refuse to accept the opinions of experts.

Yet school systems and teachers have responsibilities not only for educating the youth, but for being aware of any type of disability of a child with an average or better intelligence quotient. The writer has stressed the relationship between the clinic and the schools because of the influence teachers may have on the social and emotional development of children. While it is true that the main formative influences have their roots in family experiences during the first five or six years of life, modifying processes go on continuously during the school years, and have important results on such personality traits as spontaneity, control of the imaginative impulses and creativeness and richness of cultural integration. Furthermore, the schools may and often do provide substitute experiences of all kinds for children whose family life is constritive and depriving. They offer children substitute parental identifications by means of which extensive ego modifications and ego strengthening may take place.11

The worker explains to the teachers that children spend most of at least eight years in school and that the school may be a pleasant experience for the child, but it may also be a breeding place for much

unhappiness, fear, day-dreaming, resentment and behavior disorders - of all sorts. The social worker emphasizes that children desire the teacher's approval sometimes as much as they desire that of the parent and that the child's behavior in school may be due to an attempt to gain the attention of the teacher. The worker aids the teacher in understanding the reasons for the behavior of the child and tries to influence the teacher to socialize him sufficiently to conform to the conventional standards as well as to the norms of class achievement.

The worker, by visiting the school teacher, through her knowledge of the results of psychological tests given the patient at the clinic, and by home visits and by history taking is well prepared to give a report on the needs of the patient. Also, by frequent visits to the school, the worker can determine if the teacher is accepting the interpretation of the patient's needs.

There are several features which are apt to call forth personality problems in school children:

1. Unhealthy relations to the teacher
2. Unhealthy relations to the classmates
3. Physical illness
4. Lack of recreational outlets
5. Being in the wrong grade
6. Frequent changes of school
7. Long absences from school
8. Late registration
9. Experiences of failure
10. Parental interference with school regulations

Personality traits which inhibit reading development appear as habits or various forms of behavior. The social worker interprets the symptoms that appear due to these personality traits.

A pupil with a meditative, dreamy disposition may daydream during reading lectures and then fail to develop his own effective reading habit. A pupil who is nervous or excitable often lacks the necessary concentration for satisfactory habit of reading; a timid pupil is handicapped by failure to respond voluntarily during the reading periods, the opposite type may cause lack of concentration and attention to the content. Such personality traits in the average intelligent child are due to some blocking and this emotional blocking is further accelerated at school.

In addition, a reading disability which persists over a long period of time leads to the feeling of inferiority which is manifested in the pupil's attitude to the entire school, and which may cause more or less serious personal maladjustment.15

The reading disability is due to some need of the patient and since the parents are unable to comply with the need, the services of the teachers are necessary. "A reading disability if allowed to continue, may in some cases give a child a low mental rank, placing him among those of general mental deficiencies."14

The social worker, through his interpretations of the various meanings of the patient's attitudes and behavior, is able to show that the reading process is very complex, consisting of a series of more or less habitual responses, including thoughts, feelings and attitudes, which are inherent in the patient and do affect his reading.


"The school's influence upon the social and emotional development of many children probably is of greater value than its contribution to their fund of academic information." 15

It has become generally realized that in addition to acquiring knowledge in schools, the children also acquire attitudes which they maintain throughout their life; that symptoms of maladjustment may appear due to inability to make a satisfactory relationship with the teacher causing the patient to react to the process of learning.

When a child of average or superior mind finds himself able to keep up with his class in arithmetic and to compete successfully in social relationship with his playmates, but sees most of his fellow pupils, including some who are less intelligent than himself, making progress in reading while he is failing and where, since the obstacle which has blocked him in the particular task is not understood, he is exposed to criticism, punishment and pressure from the parent and teacher and the characteristically brutal frankness of the children, the effect on his emotional life is apt to be far reaching. From these emotional stresses we have seen the development of several reaction patterns. Some children become apathetic and indifferent to school; others build a marked feeling of inferiority; while a few develop an antagonism towards the teacher and not infrequently are disciplinary problems. The emotional load seems to be particularly troublesome when

a younger brother or sister is making more rapid progress.\textsuperscript{16}

It is in these cases that the social worker plays a prominent part in acting as a liaison between the clinic and the school, between the school and the home, and between the clinic and the home. The social worker relates the progress of the patient at the clinic and interprets the causes of the patient's behavior to the teacher. The social worker also acts as an intermediary between the school and the home, endeavoring to solicit the aid and cooperation of the mother or father in eliminating the reasons for the reading disability.

The social worker also may aid in eliminating the cause of reading disability by treatment methods with the parent or with the child.

One of the most important responsibilities is to the school in convincing the teacher of the advisability of treating the reading disability as a symptom of an emotional reaction due to either the influences of the home, the school or the lack of a vital need to the child.

It is not difficult to understand the difficulties the non-reader will have in keeping actions within limits of school laws during the silent reading lesson and that, if forced to maintain a suppressed tension, this tension is going to find an outlet in other

ways. This outlet may not be within the standards set by society. The misbehavior of some of these non-readers also is an expression of wanting to be recognized; and knowing no other means they use aggressive behavior as a means of getting recognition, at the same time showing the rest of the class that despite their inability to read they are not inferior to them in getting recognition.

The school is now interested not merely in subject matter, but with the physical and the psychical state of all connected with classroom work, as well as all that happens in the name of teaching, with the intellectual struggle and effort, with the emotional tensions and social experiences of the children.

The school is concerned with the different type of child — the introvert and the extrovert, the easily fatigued and the energetic, the fearful and the courageous, the emotionally unstable and those in mental equilibrium. It deals with the unconscious forces, wishes and dream life while it shapes conscious thinking to approved patterns. It is concerned with promoting those ego satisfactions which are the outgrowths and radiation of the pursuit of independence and success, responses and recognition. It seeks to promote social adaptability that can be secured only through self-trial, self-understanding, self-judgment and self-control.17

17 Ira S. Wale, M.D., "Integration of the Child the Goal of the Educational Program," Mental Hygiene, 11, April, 1936, pp. 249-261.
In many instances the emotional experiences of a child during his first attempt to read produce undesirable emotional conditioning. Continued lack of success in reading leads to failure in school, which results in a feeling of inferiority in the child. Without acceptable compensations, the child may develop personality and behavior deviations. These deviations are usually rather mild and take the form of inattention, lack of interest and unfavorable attitudes towards tasks. Figures cited by Gates show eighty-two percent of a certain group of poor readers manifest unfavorable interest toward tasks. In seventy percent the unfavorable attitudes were probably due to difficulties in reading. Practically all writers agree that correction or marked improvement of the reading disability ordinarily results in better educational adjustment of such persons with the substitution of success for failure. The unfortunate behavior traits disappear and normal attitudes of cooperation develop.18

CHAPTER III

RELATED FACTORS CAUSING DISABILITY

In order to help the reader come to some conclusions regarding the study, the writer felt that it would be helpful to get a little of the background of the cases involved. The four cases were selected because of the different areas of social work treatment administered by the social worker. Tables of the various factors and information on possible related factors to the reading disability will be presented in this chapter. These factors will show how a large proportion of reading disability stems from the family problems and problems within the child himself, rather than from poor placement or maladjustment only in the school environment.

Although the reading disability is rife amongst the dull children, children of all levels of intelligence are liable to break down through some emotional factor at home, at school, or because of too much pressure within himself.

These twenty cases were practically all the cases closed during the years of 1944 to 1948 in which the combination of reading tutoring was combined with case work services. Thus this survey can be assumed to be a true picture for continuing the combination of these services,

1. Sex

Of the twenty cases closed during the years of 1944 to 1948, eighteen were boys and only two were girls. This was according to the usual clientele of the clinic. The clinic tends to see more boys
than girls.

From this one would presuppose that the boys were more prone to the reading disability, yet the writer feels that since the clinic seems to register more boys than girls, the ratio of eighteen to two is not representative.

A small but consistent superiority of females over males in general linguistic ability has been found by practically all investigators. Girls have been found to begin speech earlier than boys, regardless of whether accelerated, average, or retarded groups were studied; girls were found to use their first words appropriately sooner than boys; girls have been found to exceed boys in the extent of their vocabularies, as well as in the length of sentences and completeness of sentence structure, particularly in the early years of development. The early superiority of girls in linguistic abilities is maintained in both the elementary grades and in high school; for girls continue their advantage in scales of a predominantly linguistic character and in school achievement tests in reading, language, grammar and literature.1

Although the statistics of this study are not revealing, others have found that more boys have reading disability than girls. The writer feels that this may be due to the difference in the types of interests of boys of the clinic age. Their interests at this age are more in the physical outdoor activities with little thought of reading. The interests of the boys seem to be in the building of muscles and receiving recognition by excellency in sports and games. The interests of the girls are of a more passive style and may even include playing school and being the teacher or pupil.

The fact that a majority of the clinics register more boys than girls in their clinics may also be a reason for the majority of reading disability cases in the clinics being boys.

The New York Mental Hygiene Association lists out of a total of five hundred ninety-one, three hundred ninety-three boys. From this one could conclude that reading disability of the boys in comparison to girls could be four to two or approximately sixty-seven percent more boys than girls.

2. Age, Grade, Grades Repeated

In order to aid the reader in getting a clear picture of the twenty cases being studied, the writer broke the cases down so that the reader can note the ages of the patients, grades at time of referral, and the grades repeated, if any.

TABLE I,

AGE AT TIME OF REFERRAL

<table>
<thead>
<tr>
<th>Age of Child</th>
<th>No. of Children Referred</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 - 7</td>
<td>3</td>
</tr>
<tr>
<td>8 - 9</td>
<td>8</td>
</tr>
<tr>
<td>10 - 11</td>
<td>7</td>
</tr>
<tr>
<td>12 - 14</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
</tr>
</tbody>
</table>

One would infer from this Table that the difficult ages seem to be from eight through eleven, yet the writer feels that this is only the culmination of the reading disability that started at the age of six.

**TABLE II.**

**GRADE WHEN REFERRED**

<table>
<thead>
<tr>
<th>Grade</th>
<th>No. of Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>5 or over</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
</tr>
</tbody>
</table>

Table II shows that in the study of the twenty cases, grade 3 seems to be the grade in which most of the children are when they are referred to the clinic for the reading difficulty. This correlated with Table I in which the age of being referred to the clinic for the majority of the twenty cases starts at eight, the proper age for the third grade. It appears from this table that the child has already had much frustration due to his reading disability and the many symptoms caused by this disability have been pretty well ingrained or entrenched in the child. Again it may mean that the teacher feels that the difficulty in reading may be helped by the clinic services and uses this means before the reading disability becomes permanent in the
TABLE III.

GRADING REPEATED

<table>
<thead>
<tr>
<th>Grades Repeated</th>
<th>No. of Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>10</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4 and over</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>23</td>
</tr>
</tbody>
</table>

Table III amplifies the fact that the disability in reading probably began in the first grade, but due either to failure of the teacher to notice this and promotion of the patient in the hope that he would be able to make up the work in the next grade, or the teacher not being interested in the effect of the disability on the patient, the disability was not reported. In Table II most of the children in the study were in the third grade and Table III shows that the third grade is the most prominent in the reading disability. One would surmise from these tables that more stress is made on reading in the third grade than in all other lower grades.
3. Ordinal Position in the Family

**TABLE IV**

<table>
<thead>
<tr>
<th>Ordinal Position in the Family</th>
<th>No. of Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Only child</td>
<td>2</td>
</tr>
<tr>
<td>Oldest child</td>
<td>7</td>
</tr>
<tr>
<td>Youngest child</td>
<td>4</td>
</tr>
<tr>
<td>Middle child*</td>
<td>5</td>
</tr>
<tr>
<td>Second child in family of five</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
</tr>
</tbody>
</table>

*Includes family of three and families of five children.*

Table IV seems to show that in the twenty cases the writer used for study, being the oldest child or a middle child causes susceptibility to the reading disability. This seems to be contrary to the study made by Doctor Bennett as shown in Table V, page 35.

One highly suggestive bit of data was the tendency the author found for certain positions in the birth order of siblings to be characteristic of poor readers. The figures reproduce in Table V, page 35, suggest that being an only child or an oldest child is propitious to good reading while having elder siblings is apt to prove disadvantageous.

3 Chester C. Bennett, Ph.D. "An Inquiry Into the Genesis of Poor Reading," Teachers College Columbia University Contribution to Education, No. 755.
Yet it is probably true that one can find in the literature support for any position he may wish to take on the importance of the birth order in the family for personality or any other characteristics. In detailed clinical studies a child's position in the family appears important but the factors are so numerous and varied as to defy statistical generalization. Only children have had an unusual share of attention, but there is much doubt whether the status constitutes a psychological entity. In many studies only children show a variety of superiorities. Most of these seem attributable to the fact that they tend to be born into families of upper socio-economic status with parents who have larger incomes and more advanced information.

4. Occupation of the Father and Economic Status of the Home

There are many occupations listed in the study of these twenty cases and the variety of professions involved in the reading disability
suggests that the occupation of the father may have little or no bearing on reading disability in the children studied here.

TABLE VI.

OCCUPATIONS OF THE FATHERS OF THE TWENTY CASES STUDIED

<table>
<thead>
<tr>
<th>Occupation</th>
<th>No. of Fathers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salesman</td>
<td>6</td>
</tr>
<tr>
<td>Proprietor</td>
<td>3</td>
</tr>
<tr>
<td>Mechanic</td>
<td>3</td>
</tr>
<tr>
<td>Grocery Clerk</td>
<td>1</td>
</tr>
<tr>
<td>Ice Man</td>
<td>1</td>
</tr>
<tr>
<td>Laborer</td>
<td>1</td>
</tr>
<tr>
<td>Professional</td>
<td>3</td>
</tr>
<tr>
<td>Policeeman</td>
<td>1</td>
</tr>
<tr>
<td>Unemployed Veteran</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>20</strong></td>
</tr>
</tbody>
</table>

The study shows that of the twenty cases studied, ten were well off financially or were of comfortable circumstances, meaning that they could afford some of the pleasures in life such as automobiles, television sets, or were able to give the patient the educational material needed in excess of that issued by the school system. Nine had marginal incomes having little in the way of money to spend for any expensive luxury as indicated above and had difficulty in supplying any extra
educational material which could be used as an aid to reading. One was unemployed and was in the receipt of public welfare. This even distribution as to the economic status showed that in these twenty cases the status played little or no part in the reading disability.

Because the number of cases studied were limited to twenty no statistical conclusion is possible. Other studies have given some evidence that the economic status of the home plays some part in the educational achievement of the child.

Apparently all groups from the lower middle class, to use loose categories, on up the economic scale enter their children in school as early as permitted, and these children make normal progress. Below that level, either the children enter later, or difficulties in progress develop in a sufficient number of cases to affect the median, or both causes operate.4

Although economic and social influences may operate to inhibit the full development of intellectual powers or other gifts, they cannot act conversely. The dullard cannot be transformed into a brilliant person by an educational method. Some environmental factors may have a limiting rather than an accelerating power over intellectual development.5 Luxury and ease may cause a patient to feel that he does not have to try and may bring over-protectiveness by the parent with the patient having others doing things for him instead of doing things himself. The patient may take this feeling into school with him and

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make no effort to do things himself. This attitude may affect the reading of the patient.

Although it is true that environmental advantages can have only limited beneficial effect; nevertheless, there are distinct advantages which do accrue in terms of learning, apparent intelligence, means of competing with other children and special resources both for educational purposes and leisure time activities.

5. **Handedness.**

The study showed that one patient was left-handed, fifteen right-handed and four changed from left-handedness to right-handedness.

Needless to say, the left-handed person whose handedness remains unaltered will face a number of disadvantages, since all furniture is made and most activities are directed for those who are right-handed, and since left-handedness tends to make the child appear as a social oddity. In spite of these disadvantages, the personal and mental hygiene lost from changing handedness makes it hardly advisable. 6

6. **Presence of Parent in Home**

The writer defined as a unit a family where seemingly there is no dissension and where father and mother and children live together with the father the only member of the family working.

---

TABLE VII.

PRESENCE OF PARENT IN HOME

<table>
<thead>
<tr>
<th>Parent Working</th>
<th>No. of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>United home (unit)</td>
<td>12</td>
</tr>
<tr>
<td>Father deceased, mother working</td>
<td>3</td>
</tr>
<tr>
<td>Both parents working</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>20</strong></td>
</tr>
</tbody>
</table>

This study revealed that more reading disability cases in this study came from supposedly united homes in which there seemed to be happy family relationships, yet for some reason the patient became a reading problem. That eight cases came from homes in which there seemed there would be good cause for emotional tension on the part of the patient shows that these types of homes can affect the reading disability. The writer does not think that the type of home is important in this study, but does think it may be a factor in the emotional blocking of the patient towards reading.

Certainly the many factors that come first to mind in connection with environment are of very little consequence in determining individual intellectual differences; such things as bad housing, low wages, uncleanliness, unsanitary surroundings, unhealthy trade of the father, drinking and immoral behavior of the parents, crowded rooms, condition of clothing and so on. The effects of variations in such factors have been studied. The correlations found between any of these environ-
mental factors and the mental abilities of children are always very low, usually only three or four percent.7

7. Age of Parent

Though the writer feels this is not vital in causing the reading disabilities in the children studied, these facts are listed in Table VIII.

It will be noted that the ages of most of the mothers concerned with the reading disability seemed to be from thirty to forty years of age.

<table>
<thead>
<tr>
<th>TABLE VIII</th>
</tr>
</thead>
<tbody>
<tr>
<td>AGE OF MOTHER HAVING CHILD AT CLINIC</td>
</tr>
<tr>
<td>Age of Mother</td>
</tr>
<tr>
<td>----------------</td>
</tr>
<tr>
<td>20 - 24</td>
</tr>
<tr>
<td>25 - 29</td>
</tr>
<tr>
<td>30 - 34</td>
</tr>
<tr>
<td>35 - 39</td>
</tr>
<tr>
<td>40 - 44</td>
</tr>
<tr>
<td>Total</td>
</tr>
<tr>
<td>Mother older than father</td>
</tr>
<tr>
<td>Father older than mother</td>
</tr>
</tbody>
</table>

8. **Attitude of Teacher to Patient**

Records show that ten of the teachers liked the child and wanted to help him and ten disliked the child and wanted to get rid of him either by promoting him or transferring him to another room. The attitude of dislike held by the teacher may have been due to the hyper-critical parent who is extremely ambitious for children and somewhat envious of the intellectual prowess of her neighbors' children, or may have been due to the teacher's own personality pattern and inability to understand the causations of the patient's behavior. She does not recognize that it is the underlying factors, whether they be intellectual, physical or environmental, that produce these symptoms and with which she should be most concerned. Yet teachers are human and the writer believes that even those who pretended to like the child felt resentment against the mother for her lack of interest in the child and for not helping the child reach the academic level of the class.

Teachers through lack of understanding of the heavy responsibilities which many mothers have to carry in looking after a household with three or four children, to say nothing of the marital and economic difficulties with which they have to contend, sometimes develop an unsympathetic and hostile attitude which cannot help being reflected in their bearing toward the child. In fact, it is always the child who suffers most from the emotional conflicts of adults.  

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teacher feels this sense of guilt for her treatment of the child and tries to compensate for her guilt feelings by trying to help the child as much as possible and even by promoting the child as a means of relieving her guilt feelings.

It should be recognized that this promotion of educational accomplishment in pupils is the chief duty imposed upon teachers by the school system. If educational progress is not attained by children, the school has failed in its function and the teacher has failed in her job. The pressure for bringing children up to expected standards of school progress is as severe for the teachers as it is for the child. School work becomes the essential purpose of the teachers with which they naturally identify themselves. Children who frustrate this purpose are essentially attacking both the school and the teacher.9

The attitude of the teacher toward a possible remedy for reading disability also may increase the emotional block causing the disability. We must remember that some of the teachers cannot accept the fact that their methods of teaching may be at fault. That the patients have the mental capacity to perform the intellectual tasks of reading is illustrated by their intelligence quotients. The cases studied showed seven with an intelligence quotient of one hundred or over; ten with ninety or over, but under one hundred; two having eighty-five and one having eighty-one. The latter three were considered in the

dull normal category, but with a good prognosis, while the other seventeen were of average intelligence.

9. **Attitude of Parents and Child Towards School**

This study showed fourteen parents very critical of the school with two of the parents even threatening the teachers if the child was not promoted. Most of the mothers seemed to blame poor teaching techniques and improper teacher training as the causes of the reading disability. Four of the mothers were cooperative, willing to help the teacher in remediating the reading disability in ways such as promising to see or help the child do the homework or trying to get the patient interested in reading to other members of the household including the mother; yet even these four made mention that in the olden days, when one had to learn the alphabet and pronounce each letter separately, it helped most of them to read and had the thought that the modern way of teaching was at fault.

Laura Zerbes in her conclusions states:

Finally home conditions are found responsible for certain deficiencies. With the best of intentions parents often rob the child of all incentives to learn to read by reading to the child during the period when he should assume some responsibility himself. Occasionally the matter is made more complex by failure to realize that adult standards of literature cannot be imposed on children. Taste thrives best on material adapted to present interests and abilities of the child.10

The other two parents seemingly were indifferent to whether the

10 Laura Zerbes, "Attacking the Causes of Reading Deficiency," *Teachers College Record* XXVI, June 1925, pp. 856-866.
child was promoted or not, which showed possible rejection of the child and left it up to the teacher to assume a mother's role as well as her own.

As to the attitude of the child towards the school, the study of these twenty cases showed that sixteen of these children hated school the day they started. The reasons given in the records were laziness, inability to get along in crowds, poor teachers, sickness, many substitute teachers and unwillingness to leave the home. Four of the twenty liked school. All reading disabilities started in the first grade, but no action was taken until the child reached the third grade or higher.

10. Adjustment at Home

TABLE IX.

EMOTIONAL FACTORS AT HOME

<table>
<thead>
<tr>
<th>Factor</th>
<th>Children Affected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insecurity</td>
<td>20</td>
</tr>
<tr>
<td>Jealousy</td>
<td>13</td>
</tr>
<tr>
<td>Sibling rivalry</td>
<td>16</td>
</tr>
<tr>
<td>Parental rivalry</td>
<td>7</td>
</tr>
<tr>
<td>Overprotection</td>
<td>3</td>
</tr>
</tbody>
</table>

The twenty cases showed that all cases of reading disability revealed some form of insecurity due to home atmosphere. All twenty felt insecure at home due to a feeling of inferiority in reading.
Thirteen showed some form of jealousy; sixteen tried to compete with other members of the family, but in trying too hard showed a tenseness that might have resulted in the deficiency. This study showed that sibling rivalry was predominant in sixteen cases and especially in eleven of the sixteen in which another sibling was born from five to seven years later. The other two causes of inferiority feeling may be stated as parent rivalry in which seven of the children had not worked through their oedipus relationship. One case, though, included appearance of jealousy to the mother's "boy friend". Over-protection entered into three of the twenty cases. This over-protection was shown by mothers' efforts to induce the teachers to promote the children despite their disability.

These factors would not be noticed by the parent due to other compensating behavior of the child or the parent's inability to believe them because they were completely disguised.

11. Other Problems

It has been generally accepted that reading disability is a causative factor for many other problems. These include: day-dreaming, misbehavior, poor eating, poor sleeping, enuresis, aggressiveness, nail-biting, stealing, over-eating, restlessness, thumb-sucking and nightmares. McCallister:

In a study of twelve cases among eighteen found evidences of the influence of personality traits on reading development. The traits which were observed may be described as follows: dream, meditative disposition; nervous and excitable temperament; extreme timidity; impetuous disposition resulting in a tendency to jump at conclusions; and indifference.
The effects of these traits were noticeable in connection with remedial instruction. Pupils exhibiting such types demand various types of remedial treatment.

**TABLE X.**

OTHER PROBLEMS CAUSED BY READING DISABILITY

<table>
<thead>
<tr>
<th>Problem</th>
<th>Children Affected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day-dreaming</td>
<td>3</td>
</tr>
<tr>
<td>Misbehavior</td>
<td>5</td>
</tr>
<tr>
<td>Poor eating</td>
<td>3</td>
</tr>
<tr>
<td>Over-eating</td>
<td>1</td>
</tr>
<tr>
<td>Enuresis</td>
<td>2</td>
</tr>
<tr>
<td>Aggressiveness</td>
<td>2</td>
</tr>
<tr>
<td>Nailbiting</td>
<td>3</td>
</tr>
<tr>
<td>Stealing</td>
<td>2</td>
</tr>
<tr>
<td>Restlessness</td>
<td>2</td>
</tr>
<tr>
<td>Thumbsucking</td>
<td>1</td>
</tr>
<tr>
<td>Nightmares</td>
<td>1</td>
</tr>
<tr>
<td>Sky-timid</td>
<td>3</td>
</tr>
<tr>
<td>Poor sleeping</td>
<td>1</td>
</tr>
</tbody>
</table>

These twenty cases showed all of these additional problems so that Table X would seem to bear out the discussion on page 44 and

page 45 that the factors which may have caused the reading disability
may also have been the cause of other problems shown in Table X.

All these twenty cases showed improvement when the cases were
closed and the notable signs of improvement included both a change in
behavior and an improvement in reading.
CHAPTER IV
INTRODUCTION TO CASE PRESENTATIONS

Inasmuch as this study is based on the role of the social worker in cases requiring both remedial reading and social case work services, these cases will show the areas of treatment and the type of treatment involved in case work.

The first case will present the area of treatment with the child. In this case both psychotherapy and environmental manipulation was part of the treatment.

The second case will present the social worker's contact with the school in interpreting to the teacher the meaning of the patient's behavior and also keeping the teacher informed of the progress the patient was making in the reading tutoring lessons at the clinic.

The third will present the case work treatment with the mother. Special interest is shown in this case as the mother is usually the parent responsible for bringing the patient to the clinic and also plays an important part in the reading disability of the child. The mother's part in the treatment is an important one and to a large part the mother's treatability will have some direct bearing on the child's adjustment and success in reading. This case represents that type of relationship between the social worker and the parent in which emotional relief was obtained by the mother and assurance and reassurance was given by the worker.

The fourth case will present case work with the father. This
is rather unique in the work at the Child Guidance Clinic as most of the treatment has been with either the mother, the child, or in contact with the school. The clinic is making an effort to contact the father, feeling that this contact is necessary for success in treatment of the child. As a rule the patient is brought to the clinic by the mother with the father receiving all information concerned from her. As most fathers are occupied with employment during the hours that the social worker could contact him, most of the contact has been made with the mother. Father was able to arrange his hours as he saw fit as he was the owner and operator of the grocery store in which the mother acted as the clerk.

The writer will show through these case presentations the factors that are acting as emotional blocks to the child in reading. These cases will amply demonstrate that the reading disability is due to the unconscious tension in the child, and that the only means the patient has of showing his feelings is by the reading disability. Case one will show the elements of sibling rivalry, pressure from the home and fear of a setting that she only knew in the religious sort of a way. Case two will also include sibling rivalry, interpretations to the school of the meanings of these behaviors, and the effect when both parents work. Case three will show the effects of a nervous mother and the mother's attitudes towards the school and how this has affected the reading of the child; the mother also wants the child to be as good as the mother and father by graduating from high school as they did,
and unconsciously brings pressure on the child. The fourth case, case work with the father, shows the pressure of the father on the child in having her do as well or better than the neighbor's children; failure of the child meant his failure and a stigma to his pride and ego. Failure of the child is too much for the father to bear as it brings memories of his own failures.

The writer will show the importance of case work services in these cases. Without social case work service, plus remedial reading tutoring, the possibilities of success in eliminating the reading disability was in doubt. These case work services helped in treatment of the underlying factors of the disability.

CASE ONE

a. Case Work With the Patient

Marline was referred by the Catholic School to the Educational Advisor of the Brockton Public School system who in turn referred the child to the clinic. The patient was referred as a problem in reading. Patient, age nine years, eight months, was given a psychological test and a reading analysis. These tests showed an intelligence quotient of ninety-nine with weaknesses in rote memory and school learning. All her school work is much below her mental capacity with special disabilities in reading and spelling. She has been held back on account of this.

Marline is the third of a family of five with the fourth child being five years younger and the second child four years older. Mother claims that the patient was the favorite of the household until the advent of the younger brother. She claims that when the child first started St. Patrick's School she hated school and did not want to go. The first year she did not learn anything. She was promoted on trial to the second grade and now is repeating the third grade.

When Marline first entered third grade, she had attacks of indigestion followed by an attack of appendicitis and an
operation. Child lost two months of school due to the operation and on returning to the school did not even get a report card. Child broke down and the mother finally convinced the teacher to give her a report card even if it was a card showing all failures. Report card did show all failures. Comment was that the child day-dreamed and dawdled and also had a defeatist attitude.

Child did say, "I guess I can't learn to read," and wanted to forget about it. Patient showed much inferiority by being shy and timid.

Visit to the St. Patrick's School showed a classroom containing sixty children. The child's sister was doing well in the school. The teacher was unable to give the child any individual attention.

The child comes from a religious and strict Catholic family of five children with the older sister doing well in the same school and the younger brother doing well in a private nursery school. Child has much fear of the parochial setting of the St. Patrick's School. Child has become acquainted with that type of setting with the Church and child felt one had to be good to go to Church. This pressure of the church setting and her inner family conflicts affected her ability to concentrate on her school work. Patient shows much rivalry of older sister and younger brother and this intense jealousy has interfered with her being able to do good school work.

Relationship lasted for two years nine months, during which time psychotherapy and reading tutoring were given the child in order for her to receive a better understanding of the parochial setting and also have her gain some confidence in reading. The child was informed that the church setting was in the Catholic school as only the Catholic children were allowed to go; that this setting was needed in order to familiarize the children with the Church settings of that religion and that the setting had little bearing on either the teaching or the learning of the pupils. Treatment also included environmental manipulation such as a transfer of school and use of outside resources such as the Brownies.

The social worker allowed the child to relieve her hostility towards her brother and sister. This relief plus the confidence and encouragement by the worker enabled the child to be more out-going and less timid. The case was marked "improved" as both reading and behavior of the child showed remarkable improvement.
This child, who had been the favorite of the household for almost five years, had been superseded by her brother. This, supplemented by the mother's strict adherence to Catholicism, caused the patient to have both fear and respect for the school as symbolized by the Church admonitions.

The religious setting, plus the sibling rivalry, caused much suppressed anxiety in the child inhibiting both the desire to go to school and to learn to read. This inferiority and insecurity were intensified when patient could not learn to read. The desire of the child for sympathy and affection was further frustrated due to the size of the class at the parochial school, thus causing the child to feel completely lost and to feel that no one cared. Child had expressed a desire to go to public school, but mother who had all the children go to the Catholic school did not want the child to leave the parochial school, but finally was able to see the advisability of sending the child to a public school.

Despite the fact that emphasis was placed on the case work treatment with the child, in order to have success in treatment it was necessary to work with the psychiatrist who was treating the mother and also interpret the findings of the clinical team to the school.

CASE TWO

b. Contact with the School

Joseph, age eight, younger of two children, with the other child five years older. The others in the household include the paternal grandparents. The child was referred to the clinic through the welfare society as a problem in reading.
Child has an intelligence quotient of ninety-six with a weakness in reading. He is reading at a year and a half below grade level. Other problems include inattention and day-dreaming and nail-biting.

Father is an automobile salesman and intermittently is in and out of the home. Mother is a nurse and works periodically. Both parents are very lenient towards the child. Mother working most of the time has caused the child to be with the paternal grandparents most of the after-school time.

Brother is a very studious boy and does not need to be pushed hard to study or read. The mother and father both compare the work of the patient to that of the brother when brother was his age.

The role of the case worker in this case was with the school. This included interpretation to the school teacher the symptoms of the child's attitude and the meaning of these symptoms. The treatment included informing school of progress of the patient at the clinic and counter-acting principal's association that "child was lazy like the father" who also had attended that school. Through cooperation of the teacher and the principal, child's reading improved and his nail-biting ceased.

Though the specific role of the social worker was with the school, it was necessary to contact the mother by home visits to keep her informed of the progress the child was making both at the clinic and at the school and also have her gain some insight to the boy's needs. The psychiatrist treated the patient in order to help him gain the confidence needed. Both psychiatrist and social worker had frequent consultations in an effort to determine further plans for the case.

This child showed the effects of jealousy and sibling rivalry. True, the paternal grandparents allowed the patient to get the feeling of love and affection, but the in and out appearance of the mother may have given the patient the feeling that he was being rejected and deserted. Child has shown his desires when, by his failure in reading, he gets his mother's attention and much recognition from the mother who emphasized his reading disability and wants him to learn
to read. The fact that the brother is doing so well and he so poorly gave him a feeling of insecurity.

Mother feels her own guilt in the child's poor reading and tries to compensate for it by helping him or supplying tutors to alleviate the disability.

The school, in identifying the child with the lazy father when he was a student in the school, was quick to change the views when worker interpreted the meaning of laziness; that it was a symptom of lack of interest and could be removed by proper handling.

CASE THREE

c. Case Work with the Mother

Ralph, with an intelligence quotient of one hundred, is a husky boy aged ten and is the middle of five children. He has a sister three years younger and a brother three years older. Child has possible deafness in one ear as the ear drum is gone and the ear is chronically running. He was referred to the clinic by the local school nurse.

Mother is quite excitable and exasperated about the educational disability and does not know what to do. The family have gone through a severe time lately as grandmother recently died and in order not to allow the grandfather to live alone have sanctioned the child's sleeping at the grandfather's home. The grandfather seems to be the dominating figure and he refuses to move in with the family but wants to live in his own home.

Child entered grade one at six, but did not return after a siege of scarlet fever. He went to parochial school at grade one and on failing transferred to a public school. Child repeated third grade also and, while in this grade, was referred to the clinic. Child says his brothers and sisters get along all right in school work, but he does not, however, he excels in sports. Child's mother always talks about the other children as scholars.

Mother projects some of the failure of the child on the teacher and does not agree with the method of teaching reading
by sight and sound. Mother is also resentful of the way the teachers handle the child as she thinks they should be more tactful in handling him. She claims that those who handled him tactfully have gotten more out of him. Mother, herself, says when she is cross with the boy he becomes stubborn and completely withdrawn. Both mother and father graduated from high school and want the child to graduate. This nagging of the child to succeed in school has put too much pressure on him and resulted in his fear and anxiety of failing.

Mother also has another problem which has affected the emotional equilibrium of the child, the fear that the grandfather will remarry a woman who has a poor reputation. This has caused much discussion at the dinner table. Father is a submissive character, having little or nothing to do with the discipline of the home, and is completely dominated by the mother.

The treatment included the case work with the mother. This treatment was to relieve the mother of much anxiety and tension about the child's schoolwork and to get her to relax. Mother's ambition for the child to go to high school really was her own projections. Much friction and many emotional disturbances have been caused by mother's vacillating attitude towards patient's living with the grandfather, and worker's method of assurance and understanding caused mother to finally assert herself and be free from the domination of the grandfather and also not allow the patient to sleep there. This treatment lasted two years and five months and though "not completely improved", the pressure of the home influences on the patient was eliminated. The psychiatrist was treating the patient and the social worker, besides treating the mother, and interpreted the progress of the patient in the clinic to the school.

The social worker in this case gave reassurance and support to the mother who was ambivalent in her desires of emancipation from the grandfather. She aided the mother in gaining insight into the meaning of the patient's behavior and reading disability and thus was able to bring pressure to bear on the patient. The worker used her role as a means of allowing the mother to relieve some of the anxiety and feelings that the mother had stored within herself.
In this case we see a child, the middle of five children, with all others doing well in school and his younger sister only a year behind him in school, causing him to be a very disturbed and anxious person. He has an over-ambitious mother who cannot understand the academic failure of the boy. Child is involved in much sibling rivalry and to compensate for his feeling of inferiority sublimated this by excelling in sports. Child is also the victim of mother's vacillating wishes and to please and receive the praise of the mother willingly accepts the responsible role of staying with the grandfather. Mother knows this is wrong, yet fearing that the grandfather would do things against her wishes tries to appease her guilt feelings by using the child as the guardian for the grandfather. This outward rejection is felt by the boy, yet he feels that by obeying the mother he can win recognition and prestige.

Child had a reading difficulty in the first and second grade and again in the third grade, but to please the mother the school promoted the child. This being over-placed has caused tension in the home and anxiety in the child. The child's ability to find an outlet for his feeling in sports has helped carry the boy along until he received the aid from the clinic.

There is a possibility that patient may have resented the grandfather as being the dominating figure of the household. The mother's fear of the grandfather may have been felt by the child. This repressed fear of insecurity probably gave him the attitude of "I don't
The worker helped the mother see how the family situation would affect the patient and also helped the mother work out her hostility to the school and its way of teaching. Mother was able to see that patient received gratification in sports in order to compensate for his feelings of inferiority to the brother and sister. Worker also was able to clarify to the mother the feelings of the boy in knowing that the sister was catching up to him in school.

**CASE FOUR**

d. Case Work with Father

Jean, an eleven year old, friendly and responsive girl was referred to the clinic by the educational department as having a reading difficulty. Patient had an intelligence quotient of ninety-three. Patient also had the problem of being a finicky eater.

She is the oldest of two children, with the second child being three years younger. The patient is now on trial in the sixth grade due to the vehement demands of the father. He now fears that the clinic will recommend that the child be demoted. Father himself feels cheated of an education as he left school in the eighth grade. Father now owns and operates the neighborhood grocery store. The sibling failed in school last year, but received special tutoring and was enabled to pass a make-up examination for promotion. Father feels that the principal is taking out a grudge against him through the child.

Father, in order to stimulate educational progress, has offered the child bribes such as jewelry or expensive toys if she receives good grades. Father is the completely dominating figure with the mother playing the passive and submissive role. Mother is fearful of saying anything about the educational criticism by the father.

Treatment of eleven months consisted in attempting to get the father to realize how much pressure he was placing on the child due to his over-ambitious and dominating attitude; that the pressure caused much tension in the child and did not allow
her to do her best work. Though the case worker was not successful in reaching father or having him gain insight, the equilibrium of the home was established when the father realized that the clinic was not going to recommend demotion, as the child was improving through remedial reading tutoring.

Joan's inability to read was due to the pressure of the dominating father who is using her to realize his own ambitions. To the father failure of the children brings much guilt because of his memories of his own failure to graduate. There is rejection of the child implied by the mother's attitude of not defending the child against the pressure of the father. There is sibling rivalry also; father can point to the success of the younger child and how tutoring helped, meaning that father wants the girl to succeed in comparison to the younger brother.

There is a great deal of guilt feeling on the part of the father and he uses the demands on the school to show that he is a good father. This over-protection on his part by his wanting to protect the child from the stigma of being demoted is in reality a humiliating feeling he has due to his educational limitations. The father also feels that such a stigma would not allow him to face the community and would cause him to lose status. This selfishness and inflated egotism on the part of the father has affected the child who fears failure because she fears the father.

It is tremendously important that parents make every effort to understand the motives for the conduct of their children, for the motives are the fundamental matter rather than the conduct itself.
It is equally important that parents do not try to project into the lives of their children their own unfulfilled wishes and desires, whether associated with their demands for affection, their striving, their education, or their social ambitions. The child has a personality of his own, and he should have the opportunity to develop along lines that are suited to his particular individuality.¹

Despite the fact that the social worker was not able to have the parent gain any insight into the reason for the child's disability, the worker did succeed in establishing a good relationship with the father when he convinced him that the clinic would not recommend demotion for his child. This enabled the father to permit the patient to continue going to the clinic for remedial reading without any criticism from the father.

The psychiatrist worked with the child and social worker also contacted the school in regards to the needs of the child. The social worker did effect such a good relationship with the father that he gave the child his consent to engage in other activities such as Scouts and recreation activities.

CHAPTER V.

SUMMARY AND CONCLUSIONS

1. Purpose

The writer has attempted in this study of the twenty cases receiving case work services and reading tutoring to study the contribution made by the social worker. The writer also has attempted to determine factors related to the reading disability whether due to family situations, school situations or environmental conditions. The writer also studied the value of case work services to these twenty cases of reading disability.

2. Major Findings

The writer found that many factors included in the study had no clear relation to the causing of the reading disability. These factors include; sex, ordinal position in the family, occupation of the father and economic status of the home, handedness and age of parents. These factors which the writer found to be unrelated to reading disabilities have been found by others to be related to a reading disability; yet the writer feels though they may be related factors he does not term them as the common factors which affected most of the twenty cases.

One common factor in these cases seems to be that most of the children with reading disability were from eight to eleven years of age, but again the reading disability may have started earlier and have been ignored. We find that most repeaters repeated the second
and third grade. This fact indicates that the child may not have been a reader in the first grade but was still promoted or no attention was given to this difficulty. Most of the children hated school the first day, most of the mothers were critical of the teachers and the teaching methods, all showed other problems besides reading disabilities and when the reading disability was cleared up the other problems disappeared, and all showed some form of insecurity at home. Most of the factors seem to be related to the conditions prevailing at home such as parental friction, sibling rivalry or too much pressure on the individual to succeed.

The case workers were able to improve not only the reading disability, but also the relationships at home. The various plans of treating these patients were well represented in these cases where in order to treat the patient it was necessary to treat either the parent or to work with the school.

The fact that sixteen hated school from the first day may be due to a variety of conditions such as unpleasantness in the school environment itself, or the emotional disturbances of sudden emancipation of the child from the home. Whatever may be the cause, the teacher must be aware of the difficulties and try to offset the disturbances by making school life as pleasant as possible.

The study included the participation of the workers in encouraging and reassuring the parents as to the emotional needs of the children. The workers emphasized the feelings of the children on the
suddenness of losing the nearness of the parents when the children were left in school. The workers in this study interpreted to the teachers the feelings the children had on being placed in school, the possibilities that the school setting may have disturbed the children and the child-parent situation at home, and how these conditions affected his behavior in school and may have accounted for the reading disability.

The grave need of adjusting instruction and material to individual differences—a need which has been tried often in the recent past—is based on an incontrovertible axiom of reading instruction:

If children deal with reading materials and participate in reading activities which are at their level, they may improve; if they deal with materials which are too difficult or if they are obliged to struggle with tasks which are beyond them, they will probably not improve.1

Another common factor, that all reading difficulties in these cases studied started in the first grade, shows that in order to have prevented this occurring later in life, the disability should have been attended to in that grade. The writer feels that the failure of the teachers to notice or give much attention to this disability was due to many reasons, such as the personality of the teacher and the teachers having large classes are unable to spend too much time with a child who seems to lag behind the average of the class. Teachers, though feeling that a child has a reading disability, may hope that

promotion to a higher grade will be a stimulus for reading achievement. They fail to take into consideration that though they may have soothed the parents or eliminated their own responsibility by promoting the child, that same child is not equipped to handle further advanced reading without some kind of help.

An effort should be made to include in the curricula of teaching something about the mental hygiene of school children. There are a great many factors which lead to emotional disturbances in children. Pressure by the teacher is undoubtedly one of the leading factors to be considered especially in its relation to the establishment of good reading habits.

Teacher pressure is sometimes caused by administrative pressure, over-crowded classrooms, unreasonably heavy teaching loads and extensive academic requirements. Academic requirements have reached such high proportions in the past years that teachers have a tendency to demand quantitative rather than qualitative results, and much of the reading which is by the students is therefore sketchy and ineffective. They learn to skim through long, unmotivated, uninteresting assignments for facts which enable them to "get by", but they do not achieve much actual learning because there is no need for intensive reading or reflective action. This type of work results in disorganized learning patterns and creates a permanent aversion to reading.  

The common factor that most of the mothers are critical of the school methods of teaching and of the teachers should also be considered and some action should be taken to make these two more understanding of the work involved and the responsibilities of all concerned. The study shows the attitude of most of the mothers towards the school and their feeling is that the teachers are solely to blame or that modern techniques are not as efficient as those used during their school days. Many of the teachers, unable to conciliate the mothers, may unconsciously hurt the child by rejecting him because of the mother's attitude. The mother, in blaming the teacher, in reality is condoning the attitude of the child in hating the school. The fathers are also included in the same category as the child's failure reflects on their ability. This guilt feeling causes demands from the child which he is fundamentally unable to meet. A child not getting praise and support at home may find the same in school and this may cause other problems as well as reading difficulty.

The caseworker aided in improving the attitudes of the parents towards the school and the teachers' attitudes towards the parents by clarification to both of the needs of the child and the importance of having a good relationship between the home and the school. The caseworker also interpreted the school functions to the parents and also the home difficulties to the teachers. This enabled both parent and teacher to understand the difficulties and problems involved in each one's place.
The teacher's unsympathetic approach may make a child timid and even cause a feeling of hopelessness which will be a serious handicap in his efforts to read. As part of this unsympathetic approach, there is also a failure to praise the child for his efforts and success. An adult always finds well-earned praise acceptable; a child is even more eager for praise and is spurred to greater efforts because of it. Conversely, too harsh criticism will have a deleterious effect on the child's reading attempts. Criticism there should be when needed, of course, but it should always be given with an attitude of understanding and a desire to help.3

Another common factor which should receive consideration and better understanding by both the teachers and the parents, and which again can be done by closer and better cooperation between the school and home, is the factor that all twenty showed some form of insecurity at home either due to sibling rivalry or parental rivalry. The cases of being an only child, of which the study included two, showed in one insecurity due to the father being deceased and the mother working, and in the other both parents working. In these last two cases the child had a feeling of being deserted and neglected and felt the reading disability was a means of showing his resentment against this. The three cases of over-protection by the mother really showed an unconscious guilt feeling of distrust or rejection, and in all three cases...

cases the parents would not allow the child any responsibility. The mother, in one case, would even read to the child instead of allowing the child to read to her. These three cases showed mother's fear of emancipating the child and this distrust unconsciously was felt by the child. The workers in this study interpreted to the parents the needs of the child and the possible factors causing the reading disability.

The need to recognize reading disabilities as one of possibly several related problems is illustrated in this study of twenty cases. All included other problems besides the reading disability. As soon as improvement took place in reading, or there was an understanding of the causes of the reading difficulty, the other problems ceased. The improvement in all twenty cases was not only an improvement in reading but insight gained by the personalities concerned. Teachers, mothers and fathers learned that they might be the cause of the emotional blocking, and if they would help in removing the cause of the blocking then progress would be noted in the child. When understanding took place it was seen the child showed improvement and other problems disappeared.

The writer recommends the possibilities of the use of case work services as an adjunct to reading tutoring, as have been shown in this study. The use of case work services is an assurance to reading help and also an aid to the better understanding of the child by the teacher and by the parents. Social case work services also aid in diagnosing
the needs of the child and by environmental manipulation give the child outlets for his introverted tensions. Reading tutoring alone may help the child, and again it may not if there is no change in environmental feelings; but with the aid of case work services, the child has a greater chance of surmounting his emotional blocking.

Approved,

Richard K. Conant
Dean
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### APPENDIX

#### Clinic Case Number

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Grades Repeated

Problem as Referred

Other Problems

Patient in Clinic with

Family Background:

<table>
<thead>
<tr>
<th>(Step) Father:</th>
<th>Age</th>
<th>Occupation</th>
<th>Education</th>
<th>Religion</th>
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Others in Household

<table>
<thead>
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<th>School</th>
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<tbody>
<tr>
<td>Home</td>
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Patient's Personality Traits

- Not Working up to Capacity
- Withdrawn
- Feeling of Inferiority
- Defiance
- Unable to Get Along with
- Aggressiveness
- Restlessness
- Enjoys

Handedness of the Patient

Traumatic Events
Schedule (cont.)

Economic Status of the Home
Marginal
Comfortable
Dependent

Attitude of Patient when he First Started School

Attitude of Parent to Clinic
Attitude of Parent to School
Attitude of Teacher to Patient

Status of Patient in Home
Insecurity
Jealousy
Sibling Rivalry
Parent Rivalry
Over-protected
Inferiority

Attitude of Parent to Patient

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<tr>
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<td>Rejection</td>
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<td>Demanding</td>
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<td></td>
<td>Discipline</td>
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<td></td>
<td>Favoritism</td>
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<tr>
<td></td>
<td>Ambitious</td>
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Activity of Social Worker

Interpretation to Mother

Interpretation to School

Manipulation

a. Emotional Release for Mother

b. Emotional Release for Patient

Closing of Case

Improved = Show How

Unimproved = Why

Reasons for Closing

Interpretations

Schedule (cont.)
**Application**

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**Patient Born:**

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**Others in Household**

**Language Spoken in Home**

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<tr>
<th>Eyes</th>
<th>Ears</th>
<th>Known to Other Clinics</th>
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<p>| Clinic | Opened |</p>
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<tr>
<td>Problem</td>
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### Family Group

**Father:** Name, Age, Date and Place of Birth, Nationality, Racial Background, Occupation and Religion.

**Mother:** Same

**Siblings:** Same, School and Grade

**Others in Household:** Same

**Language Spoken in Home**

<table>
<thead>
<tr>
<th>Home Neighborhood</th>
<th>Condition at time of Closing</th>
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<tbody>
<tr>
<td>Poor</td>
<td>Unk. = Moved</td>
</tr>
<tr>
<td>Average</td>
<td>&quot; Mother unable to come</td>
</tr>
<tr>
<td>Superior</td>
<td>&quot; Contact discontinued</td>
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**Economic**

<table>
<thead>
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<th>Marginal</th>
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- Unimproved-irremediable situation
- Unable to accept treatment

<table>
<thead>
<tr>
<th>Opened</th>
<th>Closed</th>
<th>Reopened</th>
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</table>

- Improved = Satisfactory
- Symptomatically
- Situation
- Parental attitude

**PROGNOSIS**

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<th>Good</th>
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<td>Fair</td>
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<td>Poor</td>
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History

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. Handedness.

C. School: History as given by mother, including present grade, repetition of grades, child's and mother's attitude toward school. Report of school visits. 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. Does mother keep promises and is threatened punishment carried out?

III. Social Analysis

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.

IV. Plan