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An evaluation of school consultation referrals

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AN EVALUATION OF SCHOOL CONSULTATION
REFERRALS

A Thesis

Submitted by
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CHAPTER I

INTRODUCTION

The most rewarding feature of Social work in a child guidance team in a school system is the fact that psychological and psychiatric services can be offered to parents as part of the educational experience of their children. Many parents can take the first step toward using clinical help more easily when it comes to them as part of the growth experience of the child in school and is offered as one of the many new educational features they are beginning to take for granted. Whenever a child is referred to the social worker by the school rather than by the parent it requires additional skill to help such a parent to accept his child’s problem and to involve himself in working on it.¹

When the social worker has obtained the parents’ participation in working with her, the next step in working with the others on the school clinic team is acting as a consultant to the school personnel (principals, teachers, and nurses) and helping the parent toward referral to outside agencies if the problem is one that cannot be handled.

adequately by the school and involves parental relationships.

The Worcester Youth Guidance Center is jointly financed by state, federal and community funds. In the fall of 1950 the state hospital assigned a psychiatrist to work part-time at the center and on the school clinic. The center in turn provided a psychologist and a social worker from its staff to work with the psychiatrist as a team. Its focus became that of direct service to the schools in consultation. Each worker on the team acted as a consultant to a group of teachers. However, the social worker continued to see parents to discuss the psychosocial diagnosis of the child and refer the parent to an outside agency. Parents were seen twice usually to determine their involvement in the child's problem and their willingness to act on the findings of the diagnosis. Only those parents who felt they wanted help (in the social worker's judgment) were referred. Because of this function of the social worker the investigator became interested in discovering some of the factors that influence the effectiveness of referrals. Effectiveness is defined for the study as occurring when clients who were referred actually followed through by applying to the agency and accepting its services. Therefore, this study is an attempt to make an evaluation of school clinic referrals by answering the following questions:
1. What types of problems presented were referred?
2. What was the method and procedure used in referring clients?
3. What was the outcome of referrals?

**METHOD**

The study is based on thirty-five cases selected by the writer and seen by the school clinic in Worcester which were referred to other social agencies during the period of September 1950 to June 1954. Such a span of time was covered because the writer allowed for holidays and summer vacations observed by the public school system. During these times, the social worker did not see parents. The cases were selected from the record book of the Worcester Youth Guidance Center for cases filed under the period of 1950-1954. School clinic cases are listed in the files with the letter "S" in the left column of the book. Following this is the case number, the client's name, worker handling the cases, and intake date. The school clinic cases are filed numerically. The names of the agencies and procedure used were found on fact sheet and in the actual running record of the cases. Follow-up material on referrals was obtained through letter or telephone calls to agencies using the follow-up sheet.
LIMITATIONS OF THE STUDY

An important factor in the diagnostic thinking of the caseworker in referring a client is the person's feelings about being referred and his attitudes toward the agency of referral. Sometimes this determines if the individual can follow through with the referral and if a positive relationship can be made with the new agency. The school clinic worker took this into consideration in terms of timing and method used in referring. However, many of these cases and interviews have not been dictated or recorded because of insufficient time on the part of the worker and the large case load that was being carried.

The referral agencies were most cooperative and helpful to the writer, but did not have time or the number of secretaries to gather the material concerning the clients' attitude in the early interview. Therefore, this is the major limitation of the study in terms of attitudes toward referral and the importance of timing and procedure used. A further study of the writer's follow-up would have determined if the clients that made contact were seen for a period of time in treatment and if there had been any modifications in their attitudes and relationship to the child. The findings of the study could only show if the parents made contact, because the majority of the cases had
not been fully dictated. Investigating the child's behavior in school after his parents had been seen in treatment would have further indicated positive or negative aspects of school clinic referrals.

**AGENCY SETTING**

Joint participation between clinic and school becomes an important part of psychiatric-social treatment of the child. As far as possible we encourage participation of all members of the team, psychiatrist, psychologist, and social worker.²

School clinics began in 1919 in Massachusetts when the general court made it obligatory for children who were three years retarded in school to be examined and special classes formed for them if ten or more such children were present in the school. The examination services were provided by the state hospitals and state school, who assigned a psychiatrist to give psychiatric and physical examinations, and a psychologist who did formal testing and the psychosocial history taking.³ When the clinic evaluated

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their services after ten years, they found that out of every ten children examined for mental retardation, seven were having difficulty adjusting to school because of some emotional problem. At this point, the clinics were under mounting pressure to give more services which would include these children.

As child guidance clinics were becoming more a part of community life, they began taking an active part in the mental health of the community through education of parents in mother's clubs and parent-teacher associations and further adding to the education of teachers through school conferences. In Worcester, the Child Guidance Clinic, under the direction of the Worcester Child Guidance Association, was organized in 1926 as an independent unit of the Mental Hygiene Clinic. It is a direct outgrowth of a service to the community originally supported by the Worcester State hospital.

In 1947, when Dr. Joseph Weinreb became the director of the Worcester Child Guidance Clinic, the name was changed to child guidance center in order to help the community use its services easily without being influenced.

by the agency's previous affiliation with the state hospital setting. In 1950, the program for school clinics called for the children to be seen and tested by a psychologist and the parent to be seen by a social worker. The recommendations and findings were to be discussed with the school and with the parent. The center now provided the psychologist and social worker while the hospital assigned a psychiatrist for the school clinic team. Dr. Weinreb felt that the center should give the schools more service.

Along with their new interest in helping communities, the center changed its focus in 1953 with the development of more consultation services. In this type of service, the staff is available on an advisory basis to agencies when they are dealing with children's problems.

Mothers were seen for not more than two interviews at the decision of the social worker, if it was felt they wanted and could use help. If the problem was one that could not be adequately handled in school, referral was indicated to: Family Service, Southard Clinic, Bay State Society, Boys' Club, Boston Psychopathic, private psychiatrists and the Youth Guidance Center. Therefore, today the service is no longer called school clinic, but school

5 Vaughn, op. cit., p. 118.
consultation services. Beginning in 1954, the Center had two parts to its School Consultation program: One, as a testing service and two, as a consultation service. Since many schools do not have their own psychologist, the Center has extended its testing service through its psychologically oriented staff members to help the schools meet their needs as specified under the law. (The writer used the term "School Clinic" in the study because school consultation is a recent term and the cases selected covered a period when the name of the service was gradually changing.)

Under the program, the three disciplines of the staff, psychiatry, psychology, and social work provide personnel to offer this service. Teachers who are upset about the children in their classes, may talk over their problems on a regular weekly basis with the consultant who visits the school.

A difficulty in this program is that many times the school consultants relationship with the school personnel is threatened. How much interpretation of his function is given, and how he is accepted is important. His relationship with the school may hinge on such things as how he gets along with the school principal or nurse. He is not a permanent member of the staff and may not be available when an emergency arises. The school consultant has a difficult position and it is firmly expressed that he must
fit himself into the context and structure of the school. He meets the same emotional resistance in some teachers as he does in mothers who come to a child guidance center. Many times the role of the teacher is as a father or mother substitute, particularly since she represents authority to many children and is the elementary school child's first close contact with an adult outside of his own family. Many times the teacher may treat her pupils in the same way in which her parents have treated her. The feeling of failure due to having to ask for help with her pupils exists in the teacher as it does in the client.  

CHAPTER II

SOME THEORETICAL CONSIDERATIONS IN MAKING REFERRALS

Preparation of the client for referral is of primary importance and necessarily requires the knowledge of the client's needs and understanding of the problem and kinds of services offered by agencies in the community.

Agencies need to learn to differentiate more accurately those families or individuals who will profit mostly by relationship therapy, by indirect or environmental treatment of emotional needs, or by information about community resources.²

This implies that making referrals requires some of the skills which are basic in casework. The worker must have the ability to evaluate the client's capacity and problem, and to select the appropriate form of treatment within the time limit available. Sometimes referrals have to be made within brief contact, because of the nature of the referring agency and its function. In school clinic cases, the worker usually saw parents not more than twice. Within this short period, the worker brought to the

relationship with the client, who was the parent in the cases, his skill and knowledge, which he used toward stimulating self-reliance, increasing insight, developing a sense of trust and helping the parent accept referral to another agency.

The major problem both in methods of referral and selection of cases for referral, continues to be a lack of understanding of function and limitations of different agencies and analytical thinking by the agency in preparing the client for referral and the time involved. 3

Careful evaluation of the client and the situation will determine the procedure the worker selects in referral. At times it is necessary for the worker to serve as a buffer between the client and a new agency, giving him sufficient understanding of his problem so that he can use the assistance available. In each instance, the worker attempts to impart to the new agency the knowledge already gained so that treatment will start at the most favorable point. When the client can follow through with referral; that is, make the initial contact with the agency and use the services given, it suggests that there are some definite requirements if referral is to be made skillfully. In order to give a clearer understanding of some of the

considerations in making an effective referral, the writer will present some of requirements which is a vital part of the casework service.

1. The worker must have at hand knowledge of various agencies in the community in order to know quickly which agency is equipped and willing to give the kind of service which the individual requires.

2. In interpreting the referral agency's services, the worker should avoid specific or implied promises of what the agency can or will do.

3. The worker must be aware at all times of the emotional strain of the situation so that she may know when to leave the responsibility of adjusting to referral with the client or act as a buffer and interpreter to the other agency. In some situations, she may leave the contact very largely to the client as a part of the casework treatment in building up his initiative and strengths. In other cases, she may find it desirable to make an individual introduction of the applicant by phone, letter, or face-to-face contact with the worker in the agency of referral.

4. Careful interpretation should be given to the client about the reason for referral. If this is not discussed between worker and client, the referral may block
treatment because of the client's sense of frustration and resentment.

Skill in making an effective referral seems to depend a lot on the worker establishing a diagnosis; that is, exploring and understanding how the client met his life situations in the past, and how he can meet the present difficulty. 4

Method and procedure in making referral are constantly being re-evaluated by social agencies in order to understand the dynamics involved in helping a person use another agency and its effect on treatment.

The most important thing in any contact, but especially in that where referral is involved, is to set the keynote of the client's participation and responsibility on as high a level as he is capable of at the time. He is not allowed to dump his problem, only to be justly indignant that it is tossed back when he is beginning to feel relieved.5

In light of the casework concept, the client and worker together try to understand the problem and what decisions he wants to make in terms of what he wants to do about it. Whether or not the client is able to get the practical help he asks for, he is constantly being prepared to utilize his own resources.


5 Ibid., p. 183.
CHAPTER III

DESCRIPTIVE ANALYSIS OF THE SCHOOL CLINIC REFERRALS

INTRODUCTION

The purpose of this chapter is to present the findings of the study. The material is intended to give an understanding of the types of agencies the cases were referred to, the method and procedure in referring cases, and the outcome of the referrals. To give a clearer picture of the problems for which referrals were made.

DEFINITIONS OF REFERRED PROBLEMS

TABLE I

PROBLEMS PRESENTED IN THIRTY-FIVE SCHOOL REFERRAL CASES FROM 1950-1954

<table>
<thead>
<tr>
<th>Problem</th>
<th>No. Referred</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aggressive</td>
<td>7</td>
</tr>
<tr>
<td>Fearful</td>
<td>7</td>
</tr>
<tr>
<td>Withdrawn</td>
<td>6</td>
</tr>
<tr>
<td>Sexual Identification</td>
<td>4</td>
</tr>
<tr>
<td>Immature</td>
<td>3</td>
</tr>
<tr>
<td>Ineffectual</td>
<td>1</td>
</tr>
<tr>
<td>Atypical</td>
<td>1</td>
</tr>
<tr>
<td>Stuttering</td>
<td>1</td>
</tr>
<tr>
<td>Depressed</td>
<td>1</td>
</tr>
<tr>
<td>Stealing</td>
<td>1</td>
</tr>
<tr>
<td>Setting Fires</td>
<td>1</td>
</tr>
</tbody>
</table>

Total Cases 35
Aggressive is defined for the study, as that behavior of children who initiated fights in the classroom, pushed other children around and dominated them in recreational games. The seven children so labelled were all verbally aggressive toward the teacher. Their I.Q. ratings were high, but their performances were below par for their ratings. A typical example of this group was described by the school clinic team:

is overaggressive in the classroom. He frequently fights, hits other children and is destructive in class. He is verbally aggressive to his teacher and his performance is below his ability.

Fearful is defined as characteristic of those children who were frightened in class, as evidenced by trembling, becoming tense or crying when called upon or during the school hours. Their I.Q.'s ranged from average to high, but their performances were from average to low. An example of this group as described by the school clinic:

gave the impression of hiding from the teacher, as she spent much time in her desk or behind her book. When called on, she was either unable to give the answer or gave an absurd answer after becoming tense, tearful and tightening up.

Withdrawn is defined as characterizing those children who were mostly anti-social, kept to themselves and tended to day-dream to a great extent in class. Their I.Q. ratings were average, but their performances were far below their ability. One of the cases in this group:
day-dreams a great deal and has
not been able to finish his work, and has
not been working to his capacity in class.
He has trouble getting along with other
boys and is unable to compete with them
in sports although he is exceptionally
good in athletics.

Cases classified as sexual identification problems were
those children who were having difficulty assuming their
normal sexual role. Their mannerisms and way of relating
to other children in class indicated an identification with
the opposite sex. Their I.Q.'s were scored average, but
their performance was below ability. An example of this
group:

is a big boy, muscular enough,
but he definitely has minor effeminate
mannerisms. He shrugs his shoulders and
shakes his head at times in an effeminate
fashion. He has trouble with boys in his
class who fight him and call him names,
including "sissy." He is of average
intelligence, but has doubt as to his
sexual identification. He appears to be
assuming a feminine role.

Ineffectual is defined as describing those children
whose behavior showed marked fluctuation in relation to
their abilities and personality. In this group, I.Q. ratings
were high. However, their performance fluctuated from high
to low. An example of one of these children as described
by the clinic:

can be cooperative and a happy
little boy; at times, however, rather
than attempt anything new, he just sits
and sulks. He is according to his teacher
"able to do better but does not give himself a chance." Things go smoothly and then, if he feels he is wronged, he reacts negatively. He can snap out of these moods just as easily as he goes into them. His I.Q. is high.

The atypical child is one who has not developed up to his chronological age in emotional and motor function and control. This is indicative of poor ego development with no evidence of organic disease. The school clinic defined one child as atypical:

The teacher felt he was "totally unmanagable; he walked around like an "ape," and his speech was often unintelligible, and he could not learn. "He walked around in a bizarre fashion with head bent over and arms waving back and forth across the front of his body. There were frequent gaps, fragmentation and loose associations with no complete sentences attaining goal ideas. His intellectual level could not be ascertained because of his difficulty in understanding instructions. The possibility of organic disease must also be ruled out.

One case classified as depressed was marked by sadness and melancholy in class, and the tendency to withdraw. This child's I.Q. was exceptionally high, but his performance was below his ability. The school clinic described him thusly:

He could not seem to concentrate, and this was preventing his school progress. He appeared preoccupied and tense. He worries a lot about his studies and achievements and claims the other boys don't want him. He is sad and frequently discouraged.
One case classified as **stuttering** because of a speech difficulty: the inability to pronounce words and be understood. There were no physical symptoms that could be found as the basis for this child's stuttering. His I.Q. was average and his performance was average, except in areas of verbal expression and achievement. The school clinic described this child:

He has been stuttering for the past three years. He has a very difficult time speaking and frequently makes the sound of air coming out of his larynx. It is evident from psychological test and the interviews that he is extremely immature, and a frightened boy who is so afraid he will say the wrong thing that he is unable to get the words out.

The remaining two classifications were those which fall into over-anti-social acts which had as its basis an emotional disturbance: **stealing** and **setting fires**. Both of these children were of low average intelligence, but their performance was below this ability.

**LATENCY AND ADOLESCENCE**

The age range of the cases fall into periods of the child's psychosocial development: latency and adolescence (Table II). The children from age six to ten were considered to be in the latency period, and those from age eleven to fifteen were in the adolescent period.
### TABLE II
AGE AND SEX OF THIRTY-FIVE SCHOOL CLINIC REFERRALS ACCORDING TO LATENCY OR ADOLESCENCE

<table>
<thead>
<tr>
<th>Age</th>
<th>Females</th>
<th>Males</th>
<th>Total Number of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>3</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>7</td>
<td>5</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>9</td>
<td>1</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>10</td>
<td></td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total Latency</strong></td>
<td><strong>6</strong></td>
<td><strong>19</strong></td>
<td><strong>25</strong></td>
</tr>
<tr>
<td>11</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>12</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>13</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td><strong>Total Adolescent</strong></td>
<td><strong>1</strong></td>
<td><strong>9</strong></td>
<td><strong>10</strong></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>7</strong></td>
<td><strong>28</strong></td>
<td><strong>35</strong></td>
</tr>
</tbody>
</table>

Latency begins with the resolution of the conflict of the oedipal period. The child turns from the intense tie to his family and the world revolving around his home to the social world of his peers, of his school and of his neighborhood for much of his emotional outlet. The parents, nonetheless, continue to be of paramount importance.6

The child's step into a wider environment, although offering relief from tensions that are related to the interpersonal relationships in the family, presents new

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hazards. He cannot feel safe in this new world he is exploring unless he can also feel assured that, when anxiety or frustrations become unbearable, he can return to the primary relationships that gave him security. The cases that fell into the age range eleven to fifteen were in the adolescent period.

Adolescence is a stage of emotional growth. It is a period in which many conflicts dormant since childhood return to be solved. It is also a period of new problems created by physical changes at pubescence, and created by society's attitudes and demands of the adolescent. The adolescent is struggling to gain security through heterosexual maturity. This implies that he is able to transfer successfully feelings originally directed toward the parent of the opposite sex to a love object that is socially acceptable.

It implies a capacity for emotional gratification in the biologically determined role to which the individual was born. 7

The most obvious manifestations of the psychological change fall into two general categories. First, there is an awakening of sexual interest, now conscious and verbalized and acted out according to the mores of the peer group.

Second, there is increased pressure from within to be freed of infantile dependency and to achieve adult status.

The implications of the two periods of the child's development as related to problems presented may indicate some basis for his behavior and reactions in the classroom. We may expect that the problems presented by those children in the latency period have some relation to parental relationships and developmental history, particularly during infancy. The child is just becoming adjusted to the outside world and many times his first real relationship to others outside of the family is in school. The way in which he relates to his teacher, peer group and the way in which he adjusts in school is an outgrowth of how he has been handled and what controls have been utilized with him at home. In some instances where direct expression is limited or restricted at home the child displaces his feelings and reacts or acts out in school as he would like to do at home. In the adolescent period there are also indications of parental relationship and emotional experience but more in terms of how the child has learned to handle his feelings. We may expect more inconsistency during this period because of physiological changes and its influence on emotional growth in terms of dependency needs and strong independency feelings and the beginning of closer relationships with the opposite sex.
The school clinic team decided on the type of agency for referral in terms of the type of problem, the basis for the problem and the type of service needed. The psychiatrist and psychologist saw the child for psychiatric evaluation and psychological testing. The social worker saw the parents to interpret the school clinic findings, the parents' involvement in the problem and to help them toward referral.

**OUTCOME OF CLINIC REFERRALS**

Cases were referred to the Worcester Youth Guidance Center on the basis that both parent and child needed psychotherapeutic services. Cases were referred to Family Service because the parents were having difficulty handling the child because of their own marital problems and situation. The cases were referred to private psychiatrists for analytical services and the parents were financially capable of paying fees for a psychiatrist.

**TABLE III**

**OUTCOME OF THIRTY-FIVE SCHOOL CLINIC REFERRALS**

<table>
<thead>
<tr>
<th>Agency</th>
<th>No. Made Contact</th>
<th>No. Referred</th>
</tr>
</thead>
<tbody>
<tr>
<td>Youth Guidance</td>
<td>9</td>
<td>18</td>
</tr>
<tr>
<td>Family Service</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Private Psych.</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Southard Clinic</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Bay State Society</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Group Work Agency</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>18</strong></td>
<td><strong>35</strong></td>
</tr>
</tbody>
</table>
One case was referred to the Bay State Society because the agency offered speech therapy services and the child's problem was that of stuttering. One case was referred to Southard Clinic because of it being a special developmental problem: an atypical child.

One child was referred to a group work agency because the school clinic team felt the problem related to lack of social adjustment and relationship with peer groups. The clinic felt this child needed positive relationships with children of his own age.

The two procedures used in referring cases were: phone call to the agency in which the social worker gave the client's name and the reason for referral; and direct suggestion, in which the worker gave the client the name, address and phone number of the agency. Six cases were referred through phone call and twenty-nine were referred by direct suggestion. The method used in referring cases was seeing parents at least twice to help them understand the school clinic's diagnosis, to understand their needs and to help them accept referral.

A little more than half of all the cases followed through with the referral. The procedure used in referring cases was significant since all the cases followed through with referral were those where direct suggestion was made to the clients. This may indicate that the relationship
the school clinic social worker had with the parent was a positive one in terms of helping them accept referral. Another implication may be that parents become more involved and interested in helping their child when the problem involves school adjustment and achievement.

CHARACTERISTICS OF TWENTY TYPICAL CASES

In order to understand some of the possible factors that may have influenced the parents following through with referral the writer will present the general characteristics of twenty cases: number of siblings, the child's place among his siblings, parents' relationship and attitude to the child and its connection with the problem presented. In discussing parental attitudes, the writer used The Dynamics of Parent-Child Relationships by Percival M. Symonds as a guide to define attitudes. This book is based on the general idea that parent-child relationships are determined primarily by the attitudes of the parents which spring from the dynamic forces within the parents' personalities. Variations of parental attitudes tend to fall into groups corresponding to the two fundamental responses of love and hate. Therefore, we may speak generally of negative feelings when these relationships are based on parental hate and hostility, and positive feelings, when the relationships are
based primarily on feelings of love and the parent can handle and accept the child in a secure and loving way.

The writer selected twenty cases, ten who made contact with agencies and ten who did not. These cases were selected on the basis that they represented the highest number of cases referred and fell into one period of psychosocial development: the latency period, age six to ten.

**CASES THAT MADE CONTACT**

In four cases, the problem presented was fearful. In two of these cases, the mothers were overprotective and the fathers were not present in the home (both in the armed services). The school clinic diagnosed these children as having problems around solving their close attachment to their mothers. As a result, the children were afraid of the school environment and unable to assert themselves and perform in relation to their abilities.

**TABLE IV**

**DESCRIPTION OF CASES THAT MADE CONTACT WITH AGENCIES**

<table>
<thead>
<tr>
<th>Name</th>
<th>No. of Sibl.</th>
<th>Place of Child in Family</th>
<th>Parental Attitudes Toward Child</th>
<th>Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Mother</td>
<td>Father</td>
</tr>
<tr>
<td>Jan</td>
<td>1</td>
<td>Youngest</td>
<td>Overtly hostile</td>
<td>Deceased Fearful</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Punishing</td>
<td></td>
</tr>
</tbody>
</table>
TABLE IV (Cont'd.)

<table>
<thead>
<tr>
<th>Name</th>
<th>No. of Sibl.</th>
<th>Place of Child in Family</th>
<th>Parental Attitudes Toward Child</th>
<th>Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Mother</td>
<td>Father</td>
</tr>
<tr>
<td>Pete</td>
<td></td>
<td></td>
<td>Overtly hostile Punishing</td>
<td>Deserted Aggressive</td>
</tr>
<tr>
<td>Dot</td>
<td>3</td>
<td>Next to oldest</td>
<td>Overtly hostile Punishing</td>
<td>Rejective neglect &amp; denial (Alcoholic) Withdrawn</td>
</tr>
<tr>
<td>Joe</td>
<td></td>
<td></td>
<td>Over-protective</td>
<td>Rejective neglect &amp; denial Aggressive</td>
</tr>
<tr>
<td>Sid</td>
<td>3</td>
<td>Next to oldest</td>
<td>Over-protective</td>
<td>Rejective neglect &amp; denial Ineffectual</td>
</tr>
<tr>
<td>Ted</td>
<td>1</td>
<td>Oldest</td>
<td>Over-protective</td>
<td>Armed Services Fearful</td>
</tr>
<tr>
<td>Sam</td>
<td>3</td>
<td>Oldest</td>
<td>Over-protective</td>
<td>Armed Services Fearful</td>
</tr>
<tr>
<td>Louis</td>
<td>1</td>
<td>Oldest</td>
<td>Over-protective</td>
<td>Passive Ineffectual</td>
</tr>
<tr>
<td>Jean</td>
<td>3</td>
<td>Next to oldest</td>
<td>Accepting warm &amp; sincere interest</td>
<td>Rejective Fearful Overstrict</td>
</tr>
<tr>
<td>Mary</td>
<td>1</td>
<td>Youngest</td>
<td>Accepting warm &amp; sincere interest</td>
<td>Divorced (tries to withdrawn turn child against mother)</td>
</tr>
</tbody>
</table>
In one case, the father died in a fire and the mother repressed her grief and was rigid and hostile in terms of handling the child. The clinic team described the child as being afraid to come to school because of fearing mother would disappear as her father had if she left her house, and anxious about her father's death. Two cases were described as aggressive. In one case, the father deserted his family and the mother was openly hostile to the child. This mother seemed to be identifying the child with his father. The child was described as reacting to his mother's hostility and having conflicting feelings about his father. The other child's mother was overprotective and controlling while the father was rejecting. The child was described as reacting to his fears about father and against a controlling mother. Two children were described as withdrawn. Both of the children were diagnosed as being unhappy about the home situation and having the need to retreat from reality. In one case, the father was an alcoholic and abusive to the child, and the mother was dependent on her own parents and projected feelings about the father onto the child by being overtly hostile. In the other child's family, the oldest sister was favored, by relatives, and the stepfather; however, the mother accepted this child in a loving way and showed warm and sincere interest in her welfare. The mother had remarried and the natural father
was trying to control the child and turn her against the mother and stepfather. In the remaining two cases described as ineffectual, the children did not seem to know what was expected of them. Their relationship with their parents was insecure. In one case, the father was chronically ill, emotionally disturbed, dominating and strict, while the mother was accepting and giving to the child in spite of the home situation. However, this was an inconsistent type of situation and handling of the child. In the other case, the mother was overprotective, dominant, while the father was passive. The child seemed confused over his parents' roles and their inconsistency.

In eight of the mother's attitudes there existed expression of parental hostility and rejection. The most obvious expression of hostility were from those mothers who were overtly hostile to their children by frequent punishment and verbal scolding. An unconscious expression of hostility and rejection is overprotection. The excess of protecting and loving the child hinders his play for fear of accident, prevents the child from doing his own homework for fear of failure, or limits his social contacts for fear of wholesome influences, is preventing him from maturing, developing independence and enjoying normal activities and relationships. When the parent fails in his obligation of
parenthood he is showing hostility to the child and rejecting him. Three of the fathers in this group were rejective by neglecting the child's care and needs and denying him love and simple pleasures within the father-child relationship.

**CASES THAT DID NOT MAKE CONTACT**

Three cases were described with the problem being that of withdrawal. In this group both parents openly rejected the child denying him love and pleasures in the home, and generally neglecting his needs. The child seemed to be reacting to his parents negative feelings about him by a wish to retreat from reality and withdraw in the classroom environment.

**TABLE V**

**DESCRIPTION OF CASES THAT DID NOT MAKE CONTACT**

<table>
<thead>
<tr>
<th>Name</th>
<th>No. of Sibl.</th>
<th>Place of Child in Family</th>
<th>Parental Attitudes Toward Child</th>
<th>Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Mother</td>
<td>Father</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Rejective Rejective Withdrawn</td>
<td>Thru neglect &amp; denial</td>
</tr>
<tr>
<td>Gloria</td>
<td>1</td>
<td>Oldest</td>
<td>Rejective Rejective Withdrawn</td>
<td>Thru neglect &amp; denial</td>
</tr>
<tr>
<td>Keigh</td>
<td>2</td>
<td>Middle</td>
<td>Rejective Rejective Withdrawn</td>
<td>Thru neglect &amp; denial</td>
</tr>
<tr>
<td>Ann</td>
<td>1</td>
<td>Youngest</td>
<td>Rejective Rejective Fearful</td>
<td>Thru neglect &amp; denial</td>
</tr>
<tr>
<td>Kurt</td>
<td>2</td>
<td>Youngest</td>
<td>Rejective Rejective Aggressive</td>
<td>Thru neglect &amp; denial</td>
</tr>
<tr>
<td>Paul</td>
<td>2</td>
<td>Middle</td>
<td>Overtly hos-Passive Stuttering</td>
<td>tile Punishing</td>
</tr>
</tbody>
</table>
TABLE V (Cont'd.)

<table>
<thead>
<tr>
<th>Name</th>
<th>No. of Sibl.</th>
<th>Place of Child in Family</th>
<th>Parental Attitudes Toward Child</th>
<th>Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Mother</td>
<td>Father</td>
</tr>
<tr>
<td>Bob</td>
<td>2</td>
<td>Oldest</td>
<td>Overly hostile (Projects own ambitions onto child, Excessive control)</td>
<td>Overly hostile</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Withdrawn</td>
</tr>
<tr>
<td>Earl</td>
<td>2</td>
<td>Oldest</td>
<td>Lacks controls (Immature)</td>
<td>Rejective Fearful neglect &amp; denial</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leo</td>
<td>2</td>
<td>Middle</td>
<td>Lacks controls (Immature)</td>
<td>Divorced Aggressive (Alcoholic)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jim</td>
<td>1</td>
<td>Oldest</td>
<td>Lacks controls</td>
<td>Divorced Ineffectual</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mark</td>
<td>1</td>
<td>Oldest</td>
<td>Over-protective</td>
<td>Passive Immature</td>
</tr>
</tbody>
</table>

In two cases, the problem presented was aggressive. In one such case, the parents rejected the child and preferred his sisters. They were inconsistent in handling him and frequently argued about this. The child did not seem to know what was expected of him because of lack of consistency and the feeling that he was unloved. The other child feared being hurt because of frequent beatings from his alcoholic father. His mother was described as immature and not able to control or set limits on the child. He was trying to protect himself against getting hurt by acting
out in the classroom. Two cases were described as fearful. In both of these cases the parents openly rejected the child. They preferred the older siblings and compared the child to them. The children were diagnosed by the clinic team as feeling unaccepted and feared performing or competing with other children. One case was described as ineffectual. The mother in this case was described as immature and lacking in controls. The parents were divorced and the mother remarried. The child did not seem to know what was expected of him or how he should act in the classroom. He was a baby on one hand and then overmature on the other. One child was described as immature. His mother was overprotective and insecure. She was a refugee whose parents were killed in the gas chambers of Nazi Germany. Father was described as passive. The school clinic felt the child was afraid to grow up, and his mother needed to overprotect him because of her own anxieties around his growth and what might happen to him. One child was having difficulty with speech and was a stutterer. His mother was described as overtly hostile, dominating, while father was passive. The child was fearful of mother and his own feelings about her. The clinic said of this child that he was afraid to speak in school because of feeling he might say something bad.
COMPARISON OF CASES THAT DID AND THOSE THAT DID NOT MAKE CONTACT

Of those people who followed through with referral (Table IV), five mothers were described as overprotective. In many of these cases, the father was either out of the home or rejective. The highest number of cases who did not follow through with referral (Table V) were those mothers who were described as rejective through neglect and denial of the child. It is interesting to note that the fathers in these cases were also rejective. This may indicate that it was easier for the overprotective mothers because of the need to prove themselves "good mothers." Another part of this is their anxiety in wondering if the child is normal or capable, many overprotective mothers who have much of the responsibility of the child, seek help from clinics in order to get reassurance that the child is alright. Therefore, we cannot conclude getting help with the problem was an entirely positive step for the overprotective mothers because of the fact that their very concern in getting help might have been further way of overprotecting the child. Getting help and understanding, their relationship with the child's behavior may have been a more threatening experience for the rejecting parents since it was more apparent that they were acting out their hostility toward the child, therefore making them more
resistant to the casework relationship. The mothers who followed through with referral fell into three major groups: overprotective, overtly hostile and accepting. Of those who did not follow through there were four groups: rejective, overprotective, lacking in controls and overtly hostile.

In the group that made contact with the agencies, the parents brought out their feelings and conflict in marital relationship in the interview with the school clinic social worker.

The child's behavior and make-up was more clearly seen as related to the parents' marital status, roles and personalities. Perhaps in these cases, the mothers were more aware or disturbed about the situation in the home and therefore, seeing the problem as a part of their own conflicts and more ready for help with it. In only one of the cases which did not follow through with referral was the father out of the home with the exception of another where there was a stepfather. Table V shows that generally both parents had strong negative feelings toward the child. This may indicate that along with these feelings was a lot of guilt in terms of their reactions in getting help.
CHAPTER IV

SUMMARY AND CONCLUSIONS

To make an evaluation of school consultation referral the writer attempted to answer the following questions which may, she felt, have been influential in the effectiveness of referrals.

1. What types of problems presented were referred?
2. What were the methods and procedures used in referring clients?
3. What was the outcome of the referrals?

Of the thirty-five cases studied, there were eleven problems described. The diagnoses of the problem and some of the apparent basis for the problem showed that they were closely related to the home situation and parental relationships. This indicated that referring the parents to an agency would be beneficial in terms of helping the child to adjust to the school environment and improve relationships at home. Seven children were described as aggressive. The implications were that these children were acting out in the classroom as a way of handling their feelings about a hostile controlling mother and reacting to lack of consistency in the home. Of the seven cases described as fearful, there were two major bases for the child's fear of the
school environment. Some of these children were (1) having problems solving their close attachment to mother and others (2) felt insecure and unaccepted in their homes and reacted in school by fearing to perform or compete with other children. There were six children who seemed to have the need to retreat from reality; they were described as withdrawn. They seemed to be unhappy about the home situation and were reacting to parents' negative feelings about them. Four cases were described as having problems around sexual identification; these children seemed to be threatened in terms of assuming their natural sexual role. They seemed to be threatened in the home situation and reacted by assuming mannerisms of the opposite sex to protect themselves. Three cases referred were described with the problem being ineffectual. These children's personality and school achievement fluctuated and fell below their ability. Most of these children seemed confused over their parents' inconsistency and expectations of them, for they did not seem to know what was expected of them outside of the home, particularly in school. Two problems were described as being anti-social acts: stealing and setting fires. These children were found to be acting out as a way of handling their strong feelings about parents and the home.

The remaining problems were described as depressed and atypical. One child who was depressed was diagnosed as worried about his school achievement and the home situation. The other child was atypical, which is a specific type of problem
involving physical and emotional growth. There seem to be some emotional traumata connected with the failure to develop psychosocially and physically.

The method and procedure used in referring the clients were seeing parents for at least two interviews and then referring them if they expressed the wish and need, by phone call or direct suggestion. Those clients who followed through with referral were those where the social worker gave direct suggestion in reference to the agency. This seems to indicate that the relationship with the school clinic social worker was a positive one in terms of understanding the diagnosis and the need for help with the problem. A further implication is that these parents had strengths in terms of the ability to accept help. The outcome of referrals showed that a little more than half of those referred followed through to making contact with the agency. This indicates that referral was effective in the cases studied and the possibility that parents are more willing to become involved in getting help for themselves and the child when it involves school adjustment and achievement. However, another implication which may have its negative aspects is that school may represent an authority to the parent and he may feel it is his responsibility to get help. If it were possible to follow up the attitudes of the parents toward the referral agency and the way in which he was helped, it would have given a clearer picture of how he felt about being referred and getting help. This is a limitation
in the study and provides material for further study in terms of evaluating referrals and their place in the school system.

The highest number of cases fell into the latency period. This seems to indicate the existence of a greater number of disturbances during this period. In Siegfried Micael Turner's thesis, "A Survey of Fifty-five Cases Examined by the Worcester Youth Guidance Traveling School Clinic in 1950-1951," he found that of the fifty-five cases he studied, thirty-nine cases fell into the latency period. He explains the preponderance of cases in this age group as it "may be due to the introduction of more formalized academic procedures to which basically disturbed children may react more openly at this age. It must be also recognized that by the time children reach the age of eight, they have usually had two years of schooling, and by then the teachers may be in a position for judging whether the child is adjusting to school in a normal manner (p. 24)." An important factor in understanding the reasons for the large number of cases in this age period is recognizing that this is a period of adjustment for the child to the outside world and new experiences. Many times his first real experience and relationship with the outside is when he begins school at age six. The way he has been handled by his parents and how he reacts to them determines to a great extent how he will adjust and relate to others outside and in the classroom.
This points out the importance of parent-child relationship in influencing school adjustment. In Mr. Turner's thesis forty-four cases showed evidences of disturbed parent-child relationships or between mother and father. It is interesting to note that out of forty-six cases, he found only two parents to be "warm and understanding" this correlates somewhat with the writer's study and comparison of twenty cases in the latency period, in which only two parents were described as accepting and warm.

In order to obtain a more detailed significant picture of the effectiveness of the referrals a follow up and study of the cases that were seen in treatment in terms of relating it to adjustment and behavior in school is suggested. This would help in determining if modification in parental attitudes and parent-child relationships has encouraged good or poor school adjustment and achievement.

Accepted:

David Landy
Research Instructor
BIBLIOGRAPHY


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APPENDIX

SCHEDULE I

REQUEST TO AGENCY CONCERNING SCHOOL CLINIC REFERRALS

Name (of child) (writer filled in)

Date of Referral (writer filled in)

Intake date

No. of interviews to date

Present Status of case (closed or in treatment)

Reason (for closing or continuing treatment)
## SCHEDULE II

PSYCHOSOCIAL CHARACTERISTICS OF PROBLEM CHILDREN

(used by writer in obtaining case material)

<table>
<thead>
<tr>
<th>Name</th>
<th>Sex</th>
<th>Age</th>
<th>Number of siblings</th>
<th>Place of child among siblings</th>
</tr>
</thead>
</table>

Parents relationship and roles

Description of parents and their personalities, attitudes toward child

Mother

Father

Child's reaction and relationship in home as related to school.