1954

A study of the use of the Rhode Island Mental Hygiene Clinic by the social workers at Rhode Island Child Welfare Services in twenty-five cases referred for psychiatric help during the year 1953.

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Boston University
A STUDY OF THE USE OF THE RHODE ISLAND MENTAL HYGIENE CLINIC
BY THE SOCIAL WORKERS AT RHODE ISLAND CHILD WELFARE
SERVICES IN TWENTY FIVE CASES REFERRED FOR
PSYCHIATRIC HELP DURING THE YEAR 1953

A Thesis

Submitted by
Timothy Francis Ryan
(A.B., Boston College, 1951)

In Partial Fulfillment of Requirements for
the Degree of Master of Science in Social Service
1954
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CHAPTER I

INTRODUCTION

Purpose of Thesis

This study was undertaken to analyze and evaluate the use of the psychiatric facilities of the Rhode Island Mental Hygiene Clinic located at the Children's Division of the Doctor Patrick I. O'Rourke Children's Center in Providence, Rhode Island by the Child Welfare Services' social worker during the year 1953.

Much precious time and energy has been expended to bring this costly mental hygiene service to the Children's Center, resulting in a closer working relationship and richer kind of service now being available to meet the needs of the more acutely disturbed children under the custodial care of the Rhode Island Child Welfare Services. Since it also gives to such children an opportunity to enjoy as complete a way of life as possible, despite being deprived of normal family living, the writer decided to evaluate the use of the Mental Hygiene Clinic's psychiatric facilities to determine, if possible, how they are being used. From a systematic study of the cases of some of the children referred to the clinic for psychiatric help, the writer hopes to be able to present a clearer picture of how the psychiatric facilities are being used and perhaps conclude with recommendations of ways in which the agency may be better able to take fuller advantage of the services being offered.

The study will be based on twenty five cases referred to the
Mental Hygiene Clinic during the year 1953. The writer will endeavor to answer the following general questions.

1. What were some of the reasons on which referrals were based?
2. What were some of the treatment recommendations?
3. How did the Child Welfare Services social worker follow through on these recommendations?

Scope of Study

The study will include twenty five cases in which the psychiatrist was consulted during the calendar year 1953. The particular cases to be studied were chosen from those of a total of one hundred and ninety three children referred for psychiatric help during this period. This figure represents only the individual children referred during the period under study, not the total number of interviews, as some children were seen more than once, for a total of four hundred and forty three psychiatric interviews. From the total number of individual referrals every eighth case was selected in order to obtain as complete a representative picture as possible of the types of problems that were referred to the psychiatrist. This study embraced all aspects of the Child Welfare Services.

Sources of Data

In selecting the cases to be discussed, the case records of the Mental Hygiene Clinic and the Child Welfare Services were perused. In almost all of these records the writer found an adequate psychiatric social history which had been prepared for the psychiatrists use by
the referring social worker. This history contained a brief descriptive background of the child's early life experiences which served as a guide as to the reasons for referral. In order to determine the outcome of the psychiatric interviews with recommendations, the writer then read the individual diagnostic summaries prepared by the psychiatrist. It then became necessary to again read the social case records in the agency's files to ascertain if and how the recommendations had been carried out. In many instances, the writer was able to obtain additional information from discussion of the cases with some of the Child Welfare Services social workers who had made the original referrals and also with those workers who currently supervise the children.

Material for this thesis was also drawn from a review of literature in the field of social work related to this study.

Limitations

Unfortunately, several of the social workers who had initiated the referrals were no longer in the employment of the agency and it was necessary to read their recordings to determine the extent of the follow through on the recommendations. In several of the cases the referring social worker did not prepare a social history for the psychiatrist's use and the writer had to draw descriptive backgrounds of these cases from the social case records. At times, lack of fruitful material in the recordings also hampered the workers' efforts. Since the writer feels that he is not equipped to discuss treatment recommendations, he will not infringe on this area other than to point
out whether or not these recommendations have been carried out.
CHAPTER II

DESCRIPTION OF SETTING

Child Welfare Services

The Rhode Island Child Welfare Services is the legislatively constituted agency for carrying out the public child welfare program in Rhode Island. The agency consists of two divisions; the Children's Center and the Child Placing Unit.

The Children's Center is a direct derivative of Rhode Island's first step in a specialized program for children, the establishment of the State Home and School in 1884. The original purpose of this institution was to care for dependent and neglected children who were not considered to be vicious and/or criminal. The development of the child placing program brought about a change in the focus of institutional care. The Children's Center is now geared for temporary care with intensive study and treatment service available, enabling newly committed children to gain more security and understanding of their situations within a group setting.

The Child Placing Unit provides foster home care for those children who require long-term substitute care away from their families and need the strength and security of a home and family relationship. Emphasis is always placed upon the preservation of families if this may be accomplished through available resources. The maximum degree of continued cooperation and participation by the family is encouraged when separation is necessary.

The following types of services are offered by the Rhode Island Child Welfare Services.
1. Children who require indefinite substitute care because of the inability of their families to provide adequately for them are committed to the agency through the Juvenile Court. Some of them receive protective and preventive service in their own homes or with relatives, while others must be placed in various types of foster care. This phase of the program consumes the greater portion of services, time and funds.

a. Institutional Group Care is provided at the Children's Center. It is used primarily as a reception, study and training institution where the needs of the child are evaluated to determine the most suitable plan and to give direction in casework planning toward the reabsorption of the child in the community with parents, relatives, or foster care, or towards more specialized treatment.

b. Foster home care is provided by the Child Placing Unit for such children as will profit from placement and for whom homes can be found. Homefinding service is offered to families wishing to open their homes to children.

c. Protective and preventive service and casework service to children in their own homes are offered to families and children in nine rural towns where other children's services do not exist through federal funds.

d. Special services - by law, all adoptions and child marriages are referred by the Juvenile Court for investigation and subsequent reporting to the court prior to hearing and decision. Inquiries from out-of-state agencies relating to dependent or neglected children are handled for study and follow-up when indicated. Consultation service on any problem affecting children is made available on a statewide basis.

e. Licensing service - The licensing of all child placing agencies, child care institutions and day nurseries, and private homes boarding children under the age of sixteen is a responsibility of this division, as a matter of legislation.

The Child Welfare Services also carries the primary responsibility for the public child welfare program of the State. In addition to direct care,

This agency carries the usual state responsibility for coordination of public and private services to children in order to meet more effectively the total needs of all the children of the State.

The medical needs of the children are met through utilizing all available medical resources in the community, supplementing the program developed by the agency's medical staff. Hospital clinics, well baby clinics, and the state and federal health programs are available to children cared for by the agency and are used to a maximum degree. Two staff nurses are available at all times for consultation and supervision of the health and medical problems of the children under care.

The system of cottage living at the Center emphasizes the value of group living for certain children with emotional or personality problems. Since some children cannot accept substitute parents and others have problems that are not acceptable in a community setting, the cottage system offers to these children an opportunity for group living where emphasis can be focused on their development. This phase of child work has been receiving greater recognition through research in the field of group therapy and group dynamics.

**Mental Hygiene Services**

Among the facilities available to Child Welfare Services are the State Mental Hygiene Services located in the Children's Center. These have been a step forward in providing more adequate psychological and psychiatric services to a greater number of children in need of them. This has helped to establish the Children's Center as a study and treatment
home for all children under public care. Although only a few children can receive intensive therapy, it is possible for all children under care to have psychological and psychiatric examinations.

The Child Welfare Clinic, about which this study is concerned, is serviced by the Division of Mental Hygiene Services at the Children's Center. Four part-time psychiatrists offer a total of twenty-six hours psychiatric services weekly; a psychologist one full day or seven hours; a psychometrist thirty-five hours, and a psychiatric social worker twenty-eight hours. In addition, there is a full-time stenographer.

This clinic provides psychiatric and psychological services for diagnosis and treatment of those children adjudicated neglected or dependent by the Juvenile Court of Rhode Island. Its services extend to natural parents, foster parents, and adoptive parents whenever the need arises. The clinic teams offer consultation services to the various workers in the Child Placing Unit.

The focus is also on prevention and much work is done in studying and evaluating all new commitments to the Children's Center, since these children are invariably from broken homes.

In 1952 group therapy sessions were started. They are conducted by a psychiatric social worker under the direction of the clinical psychiatrist. Transcriptions of these sessions are recorded and are used as a teaching device for the entire staff of Child Welfare Services.

**Caseworker's Role in Referral**

Inasmuch as the Child Welfare Services social worker plays an active
role in a child's living experiences and concerns himself with matters pertaining to the total placement of the child, he has the responsibility to understand as well as possible the personality of the child.

When it is felt that psychiatric consultation is needed so that the worker may gain a clearer understanding of his role with the child, parents, adoptive parents, foster parents, teachers, or cottage personnel, a referral is made after discussion with the supervisor. A psychiatric social history is prepared by the caseworker. This gives him an opportunity to know the child better and to see more clearly the relationship of events in the child's life as possible causative factors for his present situation. Also, a request for psychiatric services may help the worker to better carry out the agency's responsibility to the child and the community and enable the worker to get a clearer understanding of the meaning of the child's behavior deviations. The worker is expected to recognize such deviations and assume responsibility for casework planning.

**Psychiatrist's Role**

The psychiatrist assumes responsibility for diagnosis, treatment and recommendations to the worker, who, in turn, integrates these recommendations into the total casework process.

**Services**

There are two major areas of psychiatric services offered by the Mental Hygiene Clinic to Child Welfare Services, namely, consultation and treatment.
A. Consultation Service

The caseworker takes primary responsibility for describing the child and his problem to the psychiatrist. Focus is on the presenting problem, the child's family, community and interpersonal relationships, special aptitudes and interests, school achievements, psychometric findings, attitudes toward institutional living, foster home placement, physical appearance and personal make-up. Most important is a knowledge of the child's past familial relationship, what activities he enjoys and performs well and what he wants to do. It is equally important to know the real attitudes of a foster parent towards the child and his parents and how the child's mixed feelings about his parent, with whom he is unable to live, are handled. If the caseworker is experiencing some difficulty in handling any aspect of the situation, this is discussed with the psychiatrist with a view toward clarifying these feelings or attitudes. The psychiatrist then interviews the child and, if necessary, his parents, foster parents, teachers or cottage parents. Following this, he again consults with the caseworker and makes recommendations for treatment.

B. Treatment Services

Unfortunately, because of the large number of children needing service, the amount of time available for direct treatment by the psychiatrist is limited. However, in special situations a child may be seen regularly on a treatment basis. It is the goal of the clinic to assign the greater bulk of cases in need of intensive casework treatment to the psychiatric social worker. If a child is accepted for such services, the Child Welfare
Services worker continues to maintain responsibility for the total casework planning, but fulfills his function under the guidance of the psychiatrist.
CHAPTER III

REVIEW OF THE LITERATURE

The Theoretical Background of the Study

"Any child who is compelled for whatever reason to leave his own family and to live in foster placement lives through an experience pregnant with pain and terror for him and potentially damaging to his personality and normal growth. It is abnormal in our society for a child to be separated for any continuing length of time from his own parents and no one knows this so well as the child himself. For his placement is a shaking and bewildering calamity, the reasons for which he usually does not understand."²

Likewise, as stated by Draza Kline, "To the child's parents separation also has its evils. A parent who is unable to care for his own child is a failure. When he cannot meet this most basic requirement of our culture, the damage to his ego is inestimable. For some this can later be overcome; for others it leads to further damage and decreased capacity for interest in and responsibility for the child, despite the best efforts of the caseworker."³

³ Draza Kline, "Should Children be Separated from Their Parents?", The Child, 17:74, January, 1953.
Since these are the implications of child placement, Abraham Kostick writes, "It is axiomatic that the ultimate objective in child care is the return of the child to the most nearly normal environment into which he can fit.\(^4\) The needs of the child may vary from time to time, and each one may need different types of placements at different times, such as institutional care, foster home care, or return to parent or relative homes. The institution cannot duplicate family life, and its goal should be to return the child to normal communal living if and when he is ready. It must recognize that children who come to the institution have difficulty in relating to people because of personality problems or because a personal social situation precludes their living in a family group. If the purpose of the institution is to help the child return to the community, then it must help him in his relationship with people or resolve the social situation which prevents his return to his own family or the community. The mechanisms that can be used are mainly group living and the individual services made available through casework and related services. The common basic characteristics of all situations, no matter what they see as their purpose, is the fact that children live in a group.\(^4\)

Robinson points out that through group experience within an institution the child can arrive at a better understanding of his reactive patterns or tendencies.\(^5\) The group contributes to his increasing

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awareness of these reactions and exerts pressure for change. Pressure for change is both negative, in that certain kinds of behavior are discouraged, and positive as reactive tendencies are facilitated or encouraged. Various patterns of reaction are provided by the other members of the group and there is a medium of reacting. Group experience within an institution setting derives additional significance and importance from the purpose and program of the institution.

The atmosphere of belonging and acceptance can only grow in an institution where personnel squarely faces the fact that children do take root within its setting. Such acceptance of the child is never confused with acceptance of anti-social behavior.5

It is a basic assumption that foster home placement is a form of substitute care that best meets the needs of those children who can benefit from the relationships in a family unit.

"When properly used the foster home program deserves all the esteem it has won. The duration and self sacrifice of foster parents have made foster care a haven where many a child has been restored to physical and emotional health. The foster parents' kindness and hospitality to the child's own parents have frequently been significant factors in bolstering the parent's confidence in himself as a person as well as a parent - an enormously important force in the reestablishment of a parental home.

"No form of treatment is 100 per cent effective. Foster family  

care for an extended period, with little prospect of the reestablishment of the own-home or permanent care by adoption must be the lot of some children, for some with physical and emotional disabilities, some older children, some whose parents are sick or otherwise disabled, foster family care, remains the only feasible plan.

"The most serious criticism of the foster home program has been that too many children have spent too much of their childhood separated from parents who might well give them a home. Foster home care must not be viewed as an end in itself, as a means of rearing children. Rather it is an important service for treating certain situations in the hope that this treatment will make it possible for children to find themselves in a home where they can feel that they belong. It must, therefore, offer casework help to parents and children towards that end and that no child should be deprived of his own home any longer than is absolutely in his best interests."7

Regardless of where the child lives, in his own home, a foster home, or an institution, he needs adults with whom he can identify, and the more adequately this need is met in the earlier years, the more easily it can be met again during the strong ambivalent period of adolescence.

Often it is important to change the significant adults in the child's environment and to help him experiment with developing relationships with new adults. In a foster home only the foster parents are available and, if emotional deviations are indicated, a move to a new foster home is often the only alternative. In an institution contacts can often be changed with a shift of cottages, work assignment or classroom. These are accepted by the children as natural and are, therefore, rarely traumatic. A transfer in foster home, on the other hand, is almost always traumatic.

It is known that for some children the group may serve as a support or an ally in his fight with the adult world. It may give him a sense of security and a way of avoiding personal relations with adults and peers. The child's initial resistance to the group, his later attempt to take over the group and his eventual absorption and identification with it are steps that mark his progress and give indications of the level of his ego development.

**Psychiatric Consultation**

Psychiatric consultation in a social agency is a process in which the knowledge and skills of the psychiatrist and caseworker are focused on the individual who seeks casework help. The range of psychiatric consultation may be intensive and the methods used multiple. Such consultations always play a dual role.

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a. Focus on the individual client and how to understand and help him.

b. Emphasis on increasing the breadth and depth of the basic knowledge of the helper.

Van Ophuijsen defines psychiatric consultation as "the discussion with the psychiatrist of difficulties which the worker encounters in his professional contact with clients."^10

When an agency is free to use its psychiatric consultation in a flexible manner in conjunction with its casework process, the more frequently the client's needs will be met and recognized. Too, when psychiatric consultation can be used for multiple purpose, each purpose with its own definite characteristics, less consultation time will be wasted.

**Psychiatrist**

The psychiatrist is seen as the chief clinician with special skills in diagnosis and treatment and with special competence in direct psychiatric treatment of behavior disorders. Primarily he is responsible for the original diagnosis and will play an important part in setting the treatment plan. He is the one who decides whether the nature of the child's problem and degree of pathology make it appropriate for psychotherapy.

**Psychiatric Social Worker**

The caseworker is also a person with special skills based on social

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and psychological knowledge in helping people to a social adjustment. Traditionally his major competence lies in the field of environmental modification. Increasingly, however, his treatment responsibility has broadened to include the modification of personality as well as environmental betterment.

Kirkham and Thompson stress the point that the psychiatric social worker should be aware that he shares a responsibility for the patient's overall treatment plan, giving services primarily in the area of the patient's environment. He may, through discussion, assist in the release of the child's emotional tension, or he may try to develop with him and with his family, treatment and rehabilitation programs based on their understanding of the situation. But whatever he does, he follows the physician's role in his therapeutic plan. If the psychiatrist asks the worker to give merely supportive treatment to a relative or to assist in manipulation of the home situation, the worker does so in such a way that there is an integration of constructive movement between the worker with the family and the patient. At the same time he keeps the psychiatrist informed of important changes and utilizes the knowledge he gains in his conferences with him and in his ensuing casework with the relatives or with the dynamics in the situation.


"One school believes that psychiatric social work should remain within the traditional setup of the psychiatric clinic where the worker aids the work of the psychiatrist through help in environmental problems, relative contacts and follow up work.

"The functional school draws a line between the function of the psychiatrist and that of the social worker pointing out that while the psychiatrist, 'treats illness of the patients,' the purpose of all casework contact in the psychiatric clinic is to make more available to the patient the clinic services and, therefore, as a member of the therapeutic team, contribute to the therapeutic progress of the patient."\(^{13}\)

CHAPTER IV

ANALYSIS OF THE CASES STUDIED

The writer, in this chapter, will present a description of the children involved in the cases which will serve as background material of the study.

The following tables will be included in this discussion: sex of children referred; age at commitment; type of commitment; results of psychological testing; marital status of parents at time of commitment; number of times children were interviewed in 1953; number of interviews of these children prior to 1953; classification of services; number of persons interviewed other than child; place of residence of child when referred to the Mental Hygiene Clinic; types of problems referred; psychiatric recommendations.

At the beginning of the psychiatric conference, in all but four of the cases studied, the Child Welfare Services worker presented a psychiatric social history to the psychiatrist. From this the psychiatrist was then able to see more clearly the relationship of events in the child's life as possible causative factors for his present situation.

As stated previously, this study is based on a sample of twenty-five cases referred to the Mental Hygiene Clinic during the year 1953.
Table I gives a picture of the sex of the children referred. The fact that the distribution of referrals among the sexes was fairly even suggests that in the cases studied, sex was not a factor having a significant bearing on the psychiatric referral.

**TABLE II**

**AGE AT COMMITMENT**

<table>
<thead>
<tr>
<th>Age</th>
<th>Number of commitments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 1 year</td>
<td>5</td>
</tr>
<tr>
<td>1-3 years</td>
<td>4</td>
</tr>
<tr>
<td>4-6 years</td>
<td>5</td>
</tr>
<tr>
<td>7-9 years</td>
<td>5</td>
</tr>
<tr>
<td>10-12 years</td>
<td>2</td>
</tr>
<tr>
<td>13-15 years</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>25</strong></td>
</tr>
</tbody>
</table>
This table gives a picture of the age at commitment of the children studied. The majority of these children were in the age brackets from under one year up to nine years. This poses a question as to whether or not age at commitment has a bearing on future referrals to the Mental Hygiene Clinic.

**TABLE III**

**TYPE OF COMMITMENT**

<table>
<thead>
<tr>
<th>Classification</th>
<th>Number of commitments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dependency</td>
<td>17</td>
</tr>
<tr>
<td>Neglect</td>
<td>8</td>
</tr>
<tr>
<td>Total</td>
<td>25</td>
</tr>
</tbody>
</table>

The two types of commitments ordered by the court in the cases referred are shown above. Twice as many children were committed as dependent than as neglected. The distribution is indicative of the fact that in the overall picture the number of commitments for dependency is more frequent than those for neglect.
# TABLE IV

**INTELLIGENCE QUOTIENTS OF THE CHILDREN**

<table>
<thead>
<tr>
<th>Classification</th>
<th>Number of children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Defective (65 or below)</td>
<td>0</td>
</tr>
<tr>
<td>Borderline (66-79)</td>
<td>6</td>
</tr>
<tr>
<td>Dull normal (80-90)</td>
<td>10</td>
</tr>
<tr>
<td>Normal (91-110)</td>
<td>7</td>
</tr>
<tr>
<td>Bright normal (111-120)</td>
<td>1</td>
</tr>
<tr>
<td>Superior (121-127)</td>
<td>0</td>
</tr>
<tr>
<td>Untestable</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>25</strong></td>
</tr>
</tbody>
</table>

The majority of the children tested (40 per cent) were in the dull normal category, six others were borderline and one was untestable. In many of the cases it was felt that the results of the tests were not accurate, since at the time of testing severe emotional stress may have inhibited a child's performance. Further study of these children is needed to understand more clearly this factor.
### TABLE V

**MARRITAL STATUS OF PARENTS AT TIME OF COMMITMENT**

<table>
<thead>
<tr>
<th>Status</th>
<th>Number of parents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Separated</td>
<td>2</td>
</tr>
<tr>
<td>Divorced</td>
<td>4</td>
</tr>
<tr>
<td>Married (living together)</td>
<td>3</td>
</tr>
<tr>
<td>Single (mother not married)</td>
<td>13</td>
</tr>
<tr>
<td>Deserted</td>
<td></td>
</tr>
<tr>
<td>Father</td>
<td>1</td>
</tr>
<tr>
<td>Mother</td>
<td></td>
</tr>
<tr>
<td>Illness</td>
<td></td>
</tr>
<tr>
<td>Father</td>
<td>1</td>
</tr>
<tr>
<td>Mother</td>
<td></td>
</tr>
<tr>
<td>Deceased</td>
<td></td>
</tr>
<tr>
<td>Father</td>
<td>1</td>
</tr>
<tr>
<td>Mother</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>25</strong></td>
</tr>
</tbody>
</table>

The marital status of the parents of the children studied at the time of their commitment is demonstrated in this table. Over one-half of the children had been born out of wedlock.
TABLE VI  
NUMBER OF INTERVIEWS WITH CHILDREN IN 1953

<table>
<thead>
<tr>
<th>No. of interviews</th>
<th>No. of children</th>
<th>Total No. of interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>2</td>
<td>5</td>
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<td>3</td>
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<td>9</td>
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<tr>
<td>10</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Over 10</td>
<td>3</td>
<td>51</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>25</strong></td>
<td><strong>130</strong></td>
</tr>
</tbody>
</table>

This table gives a picture of the variation that exists in the number of times that children continue to be seen by the psychiatrist beyond the initial interview. Though the largest number of referrals were of the children seen up to three times, this does not indicate that there was no further need for service. On the contrary, because of the limited amount of available psychiatric time and the large number of children needing this area of service, it was not always possible to meet the needs of all these children.

The psychiatric social worker treated three children on a regular basis. He also conducted group therapy sessions with seven of the older boys on a weekly basis for twenty-three consecutive weeks.
TABLE VII

INTERVIEWS WITH CHILDREN PRIOR TO 1953

<table>
<thead>
<tr>
<th>Children interviewed</th>
<th>Total No. of interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>14</td>
<td>79</td>
</tr>
</tbody>
</table>

Total 14                               79

Of the twenty-five children studied, 56 per cent were experiencing a continuation or a renewal of contact with the psychiatrist. Some of the children had been seen from one to four years previously, while others were being seen on a continuing basis.

TABLE VIII

CATEGORIES OF MENTAL HYGIENE SERVICES

<table>
<thead>
<tr>
<th>Classification</th>
<th>No. of cases studied</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultation</td>
<td>16</td>
</tr>
<tr>
<td>Treatment</td>
<td>7</td>
</tr>
</tbody>
</table>

Total 25

The two areas of psychiatric services offered by the Mental Hygiene Clinic are presented in this table. Though treatment services represents only 28 per cent of the cases referred by the Child Welfare Services social
worker for study, this is not an accurate indication of its need as has been explained in Table VI.

**TABLE IX**

**OTHER PERSONS INTERVIEWED**

<table>
<thead>
<tr>
<th>Status</th>
<th>No. of cases</th>
<th>No. of times interviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Mother</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>Foster mother</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>Cottage personnel</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Teachers</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>12</strong></td>
<td><strong>21</strong></td>
</tr>
</tbody>
</table>

In the Mental Hygiene Clinic the psychiatrist frequently sees not only the child but other people who play an important role in his adjustment. Thus, the psychiatrist can get as complete a picture as possible of the child and reasons as to why he may be deviating from the norm, and also clarify such behavior to those in authoritative roles. The Child Welfare Services social worker also consults with the psychiatrist about the difficulties he has encountered in his contact with the child he has referred to the Clinic. In 1953 the social worker saw the psychiatrist in all twenty-five cases studied for a total of fifty-seven interviews. The psychiatrist also saw the mother of one of the children under treatment on a regular basis.
### TABLE X

**CHILD'S PLACE OF RESIDENCE AT TIME OF REFERRAL**

<table>
<thead>
<tr>
<th>Place of residence</th>
<th>No. of children referred</th>
</tr>
</thead>
<tbody>
<tr>
<td>Own home</td>
<td>3</td>
</tr>
<tr>
<td>Foster home</td>
<td>12</td>
</tr>
<tr>
<td>Children's Center</td>
<td>7</td>
</tr>
<tr>
<td>Other settings</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>25</strong></td>
</tr>
</tbody>
</table>

The place of residence of the children varied at the time of referral. Almost half of the referrals were of children living in foster homes. The next highest group were those of children living at the Center. Of the seven children who were living at the Center at the time of their referrals to the psychiatrist, five of them had had previous foster home experiences in which they were unable to adjust.
TABLE XI
ONLY PROBLEM PRESENTED

<table>
<thead>
<tr>
<th>Problem</th>
<th>Number of cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adoption</td>
<td>3</td>
</tr>
<tr>
<td>Behavior</td>
<td>4</td>
</tr>
<tr>
<td>Change of foster home</td>
<td>1</td>
</tr>
<tr>
<td>Commitment to School for Feebleminded</td>
<td>1</td>
</tr>
<tr>
<td>Fire setting</td>
<td>1</td>
</tr>
<tr>
<td>Hostility towards mother</td>
<td>1</td>
</tr>
<tr>
<td>Question of petit mal</td>
<td>1</td>
</tr>
<tr>
<td>Rejecting mother</td>
<td>1</td>
</tr>
<tr>
<td>Return to father's home</td>
<td>1</td>
</tr>
<tr>
<td>Return to mother's home</td>
<td>1</td>
</tr>
<tr>
<td>Runaway</td>
<td>1</td>
</tr>
<tr>
<td>Suicidal threats</td>
<td>1</td>
</tr>
<tr>
<td>Stealing</td>
<td>2</td>
</tr>
<tr>
<td>Temper tantrums</td>
<td>2</td>
</tr>
</tbody>
</table>

Total 21

This table represents the predominating factors in the referrals by the social workers for psychiatric help in 1953. It shows only those cases in which the reason for psychiatric referral was based on a single problem. In undertaking this study, the writer attempted to present as wide a variety of cases as possible in order to give a more comprehensive picture of the manifold problems that are presented to the clinic.
<table>
<thead>
<tr>
<th>Main problem</th>
<th>Other problems</th>
<th>Number of cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stealing</td>
<td>Enuresis</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Fire Setting</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Promiscuity</td>
<td></td>
</tr>
<tr>
<td>Soiling</td>
<td>Enuresis</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Nail biting</td>
<td></td>
</tr>
<tr>
<td>Truancy</td>
<td>Behavior</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Promiscuity</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Stealing</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>4</td>
</tr>
</tbody>
</table>

In this table four cases are shown in which the Child Welfare Services social worker referred a child to the psychiatrist for more than one problem. The main problems are presented in addition to the other problems which accompanied these behavior deviations.
TABLE XIII

PSYCHIATRIC RECOMMENDATIONS

<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Number of cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adoption approval</td>
<td>1</td>
</tr>
<tr>
<td>Adoption disapproval</td>
<td>1</td>
</tr>
<tr>
<td>Change in type of placement</td>
<td>5</td>
</tr>
<tr>
<td>Change in handling a child</td>
<td>2</td>
</tr>
<tr>
<td>Foster home placement</td>
<td>3</td>
</tr>
<tr>
<td>Medical examinations</td>
<td>3</td>
</tr>
<tr>
<td>Sex instruction</td>
<td>1</td>
</tr>
<tr>
<td>Supportive relationship</td>
<td>5</td>
</tr>
<tr>
<td>Treatment by psychiatric social worker</td>
<td>4</td>
</tr>
</tbody>
</table>

Total                                      25

This table represents those categories into which the recommendations of the psychiatrist were placed. It can be seen that the recommendations were varied and manifold.
CHAPTER V

PRESENTATION OF CASES

In this chapter the writer will present ten cases to show how the facilities of the Mental Hygiene Clinic are being used by the social workers of Child Welfare Services.

The cases that have been selected from a study of twenty-five cases referred during the year 1953 for psychiatric help will be divided into two areas of psychiatric help, namely, Consultation and Treatment.

Consultation:

Meeting with the psychiatrist to evaluate the problem from the point of view of psycho-social setting and other conditions, with the expressed purpose of working through the dynamics of the situation, to understand better the client and his problems and to help in planning for the adjustment of the client's personality structure.

In this category the writer studied eighteen cases. He will present seven in detail to illustrate some of the problems that the psychiatrist was asked to evaluate.
Case 1.

Ann, an attractive, white Catholic girl, with an I.Q. of 117, was committed, when fourteen years old, as a dependent child to Child Welfare Services because of habitual truancy, rejection of her home and a request by the child that she be placed in a foster home.

During Ann's childhood her parents had separated twice and she was placed in an institution. Her adjustment while there was described as good.

Two years ago, before commitment, she was first referred to the Mental Hygiene Clinic by a private agency upon request of the school authorities who had complained that she was frequently truant, ran away from home, indulged in petty stealing and had threatened suicide. When interviewed by the psychiatrist she refused to cooperate in any plan made for her. It was felt at that time that she was in need of psychiatric services.

When her behavior did not improve, Ann was committed to this agency. She was placed at the Children's Center while awaiting a foster home. There she displayed strong hostility towards everyone.

Six weeks after admission she was referred to the psychiatrist because of continued threats of suicide, assaults on several girls, lack of personal cleanliness, and threats of bodily harm to the cottage personnel.

The psychiatric impression was that Ann was a very rejected child who pretended she was disinterested in her surroundings, yet was yearning to be liked. He pointed out the importance of gaining for the child a genuinely warm association with as many people as possible. He recommended that the social worker continue to offer support to Ann and return to clinic after a few weeks with a report of the child's behavior.

After a threat of suicide, Ann again was referred to the clinic. She was seen on separate occasions, by two psychiatrists, to determine if she was committable. The impression was that Ann was decidedly hostile and preoccupied but was able to verbalize well. Also, she was depressed and hopeless, feeling that no one was genuinely interested in her, and that life held nothing for her. Commitment papers were signed to be used on an emergency basis.

Shortly after Ann threatened a cottage mother with a knife and was committed to a mental hospital. Three months after admission she was released with an opinion rendered that the girl was not mentally ill but was psychopathic. She returned to her parent's home, where she adjusted well.

Ann's social worker continued to visit her regularly and the girl developed a strong attachment for her. She was able to verbalize freely about her parents, sibling and past events in her life. However, when a new worker was assigned to supervise Ann, she rejected her. After
several attempts to establish a relationship with Ann failed, the Child Welfare Services social worker discussed the case with the psychiatrist. He expressed the feeling that a change in workers had been too hasty and that the wisest plan would be to develop a close relationship, if possible, with Ann before resuming psychiatric consultations. Also, he felt that the introduction of a new worker probably only served to remind Ann of her unpleasant self-evaluation of being a worthless person. In view of the good adjustment that Ann had seemingly made, it was suggested that termination of custody might have a beneficial effect.

The Child Welfare Services social worker has not yet been able to establish a relationship with Ann. Since she had been in custody but a few months, it was decided to watch her progress before asking the court to release her from the care of the agency.

Discussion:

In order to get a better dynamic understanding of Ann and for clarification as to whether or not she might attempt to commit suicide, the social worker presented this case for consultation to the Mental Hygiene Clinic.

The worker recorded her major interest in the interview as being the possibility of suicide. She related several incidents in which Ann verbalized a feeling of worthlessness and having nothing to live for. The meaning of the girl's behavior was discussed with the social worker and her supervisor by the psychiatrist. He recommended that the worker offer her support and help Ann gain strong relationships with many people.

The social worker followed through on these recommendations by seeing Ann regularly. However, she was only able to maintain a superficial relationship with her. The worker interpreted to adult figures in Ann's life the reasons for the girl's behavior. She continued this support while Ann was hospitalized by visiting her frequently. When the child was released, the worker, following through on a psychiatric recommendation,
was able to get Ann promoted at school. This contributed to her school adjustment and helped alleviate much conflict in an area which had once been a source of stress. In working with Ann's family, the worker was able to give them insight into why the girl was behaving in such a manner. Both parents were made more aware of their contributions to her past behavior and cooperated in being more tolerant and understanding of their daughter.

In this case the agency's policy of returning the case to the area worker had an unhealthy effect which resulted in complete rejection of the new worker by Ann. Upon psychiatric recommendation, the new worker was advised to proceed slowly. To date she has not made any progress in gaining the trust and confidence of this child.

This case points out how two agencies working in harmony and with the same goals in view, namely, the adjustment of a child to live and work within her limits and with a view towards her eventual return to her parent's home, were able to give this child the support she needed to maintain herself during stress periods.
Case 2.

Betty, a thirteen-year-old, well developed, white Protestant girl, was committed in 1951 along with her sister Jacqueline, on a charge of neglect because their mother could not plan for them.

Betty's parents had separated before her birth and had never lived together again. After her birth, Betty went to live with her grandmother.

When three years old she experienced her first foster home placement, and from then until the time of her commitment, at the age of eleven, she either lived in her mother's home or in foster homes.

Shortly after commitment Betty was placed in the A. home. At first her adjustment was good both at home and in school. She was an honor student and was said to be an avid reader. Her I.Q. was 91. Several months after placement she began to steal; was rude, abusive and purportedly wrote obscene notes to small boys at school. Because of this behavior, a referral was made to the Mental Hygiene Clinic to determine what factors in the child's personality were in conflict.

When Betty was interviewed by the psychiatrist, she was accompanied by Mrs. A., her foster mother. The latter was described as a "proper" matronly woman with high standards and good intentions. During the interview Betty was very brusque and displayed strong hostility toward her sister. She claimed that the A.'s preferred Jacqueline. She also denied having written obscene notes. It was the psychiatrist's impression that Betty was reacting to situations that were related to adolescence, and also that an intense sibling rivalry was a dominant factor in her behavior difficulties.

After this consultation, the social worker devoted a good deal of time to Betty in an effort to support her and help her work through her problems. However, the child's conduct did not improve. Another psychiatric referral was made when complaints were received by the social worker that Betty was staying out late at night and was failing in her school work.

During this interview Betty asked that she be removed from the A. home. Because of strong hostility towards Mrs. A., the psychiatrist recommended that Betty should be removed as soon as possible.

Betty was then placed in the R. home, but made a poor adjustment. She expressed a strong desire to return to live with her mother. Shortly after this placement she began to receive salacious notes from the boys at school and was suspected of sex play.

The social worker arranged another appointment with the psychiatrist. Betty was seen along with Mrs. R., her foster mother. The psychiatrist's impression of Betty was that she was "an unhappy, sad, and slightly
embarrassed child who hated school because the children talked about her. Betty admitted that she had received notes from boys but said that it was because they disliked her. When Mrs. R. was interviewed, the psychiatrist felt that she was a somewhat frustrated person who was unable to express any love for Betty. He pointed this out to Mrs. R. and she agreed to be more demonstrative with the child.

Betty continued to adjust poorly following this consultation. Her sexual interests continued uninhibited and she was criticized in the community because of her behavior. On account of her excessive interest in boys, it was felt that Betty should be placed in an institutional setting.

Her social worker is now planning this move.

Discussion:

In this case psychiatric consultation was requested by the Child Welfare Services social worker because she wished to receive a clarification of the dynamics of Betty's behavior.

For the consultation the social worker prepared a summary of Betty's total situation and the stresses she was undergoing. Emphasis was placed on those factors in the child's personality which seemingly were in conflict. The psychiatrist, social work supervisor and the social worker discussed Betty's behavior before the child was interviewed. Following the psychiatric interview with Betty, the psychiatrist talked with her social worker about his findings and recommendations.

The psychiatrist saw Betty and her social worker a total of four times. His initial recommendation was for the social worker to offer her support to Betty during what was seen as an adolescent upheaval. When Betty was seen again he suggested that she be removed as soon as possible from the A home. During the next consultation he suggested to her new foster mother, Mrs. R. that she should be more demonstrative with the child.
The fourth and last psychiatric recommendation was that Betty should be placed in a private school because of an excessive interest in boys.

The social worker offered support to Betty but she was unable to accept it. She complied with the recommendation of securing another foster home for the child. Now she is planning an institution placement for Betty where she will receive closer supervision because of an intense interest in boys.

In this case the Mental Hygiene Clinic was used to interpret to persons other than the client, namely, foster parents, what their roles should be in handling a child who apparently was experiencing the pull of adolescence. Through the use of this discipline these foster mothers were shown the importance of modifying their behavior in handling Betty in order that she could receive the affection and understanding so necessary during periods of stress.
Case 3.

Paul, age 9, a sturdily built, blue-eyed, blond, white Catholic boy, was born out of wedlock in June, 1944 with a clubbed right foot and internal strabismus. At birth he was rejected by his mother. He was placed in an infant asylum until committed, as a dependent child, to Child Welfare Services in 1950. At that time it was noted that Paul had a serious speech defect.

Immediately following commitment Paul experienced his only foster home placement. In this setting, the J. home, he was self-assertive and was considered to be a gregarious, pleasant child who made a good adjustment.

After a year and a half he had several temper tantrums. These took place in school. Unfortunately, it is not known if these episodes had been a part of his living when at the infant asylum. Because of the tantrums he was removed from the J. home and placed at the Children's Center. He attended school on the grounds. His tantrums increased in number and severity.

Because of these episodes, Paul's social worker referred him to the Mental Hygiene Clinic to determine, if possible, wherein they had their roots.

At the time of the initial psychiatric interview, the impression of the psychiatrist was that Paul was having considerable difficulty in adjusting and was reaching out for some person to show an interest in him and care for him. He felt that when frustrated Paul's feelings of not belonging led to displays of tantrums. It was felt that he was a feeble-minded child who had had a rather limited, restricted and rigid upbringing devoid of emotional warmth. Further, it was felt that he had the ability to make relationships and apparently was looking for someone to love him. The psychiatrist felt that there was a need for group living with an aim to place Paul in a foster home after a year of participating in the institution program.

Paul's social worker saw him infrequently and established a good relationship with him. However, the tantrums did not diminish.

The psychiatrist saw Paul again when the tantrums continued. He described him as a shy, insecure and anxious child who was looking for someone to love him. He recommended that Paul should receive more personal attention from his social worker and cottage personnel.

Following this recommendation, Paul was seen on a weekly basis by the Child Welfare Services social worker. He accepted his worker completely and without reservation. His behavior showed considerable improvement both in the cottage and in the classroom and he became a member of the group. However, he continued to be hyperactive but
the number of tantrums decreased.

Paul was seen by the psychiatrist several times after this. A continued improvement was noticed in his behavior. Although his tantrums still were in evidence, they were less frequent and milder. They occurred on those days when the worker was not in the agency.

Paul was able to accept a new worker without any difficulty. In the past months his behavior has improved and his tantrums have almost disappeared. He has been placed in a community school where he adjusted well. He is now being considered for another foster home placement.

Discussion

The Child Welfare Services social worker's original referral for psychiatric consultation was based on a desire to gain clarification of a specific behavior problem, namely, temper tantrums and also to discuss the general method of treatment.

Prior to consultation the case was discussed with his supervisor by the social worker. It was then suggested that a referral should be made to the psychiatrist.

At the psychiatric interview the psychiatrist, supervisor and social worker discussed some of the dynamics of children with temper tantrums. Then Paul was seen by the psychiatrist. Following this, the supervisor and social worker again talked with the psychiatrist about treatment methods. At that time it was decided that Paul should be seen on a consultation basis with the social worker scheduling appointments when he felt it necessary.

When the psychiatrist first saw Paul he had the impression that the child was having considerable difficulty in adjusting and was reaching out for some person to show an interest in him. He felt that these feelings of not belonging were responsible for the tantrums.
A recommendation was made that Paul should be given an opportunity for group experience.

When seen in a later interview a further recommendation was made that Paul should be given more personal attention by the social worker and cottage personnel.

Paul's social worker began to see him on a weekly basis and an improvement was noted in both his social and school adjustment. He began to participate in group activities and became more secure within his group. With considerable support from the worker, Paul's feelings of not being wanted diminished and his tantrums decreased noticeably. The social worker continued to consult the psychiatrist periodically to gain further insight into the dynamics of Paul's behavior. The psychiatrist pointed out to the worker those areas in which he should concentrate in his work with the child.

This case indicates how through close cooperation between the social worker and psychiatrist on a consultation basis, a child can be helped to release some of his tensions and anxieties and thus improve both in his social and school adjustments.
Case 4.

Claire, a five year old, white Catholic girl, was born out of wedlock in April, 1948. She was placed in an infant asylum when six weeks old because no plan could be made by her mother to care for her. At that time she was described as a "forlorn, apathetic, dull looking child with a Mongoloid appearance." She remained in this setting until committed when one and one half years of age as a dependent child to Child Welfare Services.

After court commitment Claire was placed in the L. home. There she seemingly adjusted well. A few months after placement she had what was thought to be an epileptic seizure, accompanied by loss of consciousness. This is the only incident of this nature that has occurred since placement. The environment of this home has been described as somewhat rigid. The social worker reported that Mrs. L. appeared to be a person devoid of warmth and affection. She besieged Claire with a series of commands which tended to confuse the child. When she placed Claire in kindergarten she encouraged the teacher to be strict with the child. The teacher did not comply with this request and Claire "ran wild," craving attention and affection. Mrs. L. resented this behavior and asked that the child be removed from her home. Later she relented. The social worker reported that Mrs. L., who keeps an immaculate home, is constantly in need of reassurance that she is doing a good job. She is always on the defensive and is hurt by what people might say or think about her.

The social worker was interested in learning what, if any, potential capacity Mrs. L. had for modifying her behavior to meet Claire's needs. Thus, she arranged for Claire and Mrs. L. to be seen by the psychiatrist.

In her Mental Hygiene summary and at the psychiatric interview the social worker reported that in her contacts with Mrs. L. she was compulsive, aggressive and somewhat suspicious and resentful of the worker and her role.

In talking with Mrs. L., the psychiatrist learned that she had come from a rigid and very strict family. His impression of this foster mother was that her early life affected her handling of Claire, and that it had made her a rather rigid person who apparently was trying to sublimate her accumulated frustrations.

Considering the type of child Claire was and her behavior patterns, which were those of a retarded child, the psychiatrist felt that such a rigid upbringing wasn't necessarily harmful but quite the opposite. To him it seemed that only a woman of Mrs. L.'s stamina could cope with Claire.

A recommendation was made that Claire should continue to live
in the L. home. Further, the social worker was asked to work more closely with Mrs. L. to clarify for her why she handled Claire as she did. This was felt to be the social worker's most important role in the case.

The social worker continues to see Mrs. L. frequently and has reported that she has been able to modify her behavior towards Claire somewhat.

Discussion

The outstanding reason for presenting this case to the psychiatrist was to evaluate the feasibility of removing Claire from her foster home. Also, the worker was interested in learning if Mrs. L. had the capacity to change her manner of handling the child.

The meaning of the foster mother's behavior was discussed both before and after the psychiatric interview with the social worker and her supervisor.

From this evaluation the psychiatrist deduced that Mrs. L.'s handling of Claire was not necessarily harmful. He recommended that Claire should remain with her foster mother. He further recommended that the Child Welfare Services social worker should form a close relationship with Mrs. L. and attempt to clarify with her the reasons why she handled Claire as she did.

The social worker accepted the recommendations of the psychiatrist and is currently working with Mrs. L. to help her to better understand Claire. The foster mother has responded to the worker's approach and is now better able to accept Claire, though much work remains to be done in this area.
This case is an example of how the psychiatric facilities of the clinic were used not only for the child, but also to help a foster parent better understand how her behavior may be affecting her foster child.
Case 5.

Carl, the youngest of three children born out of wedlock, is a twenty year old, well-built, white Catholic boy with an I.Q. of 50. Nothing is known of his early developmental history except that he showed signs of retardation when, as a dependent child, he came under the care of Child Welfare Services at the age of fourteen months.

From the time of commitment until he was eleven years old, Carl had four foster home placements. The first three were satisfactory but the last one was unsuccessful and he was returned to the Center. He remained there for a year and adjusted well. Again he was placed. This time with his brother. His school work was poor and he was described as being easily led, lazy and lacking ambition. A strong sibling rivalry sprang up between Carl and his brother during this time.

There were two brief periods during which he lived with his mother. She had married when he was ten years old. These stays were short lived and Carl returned to live in the H. home, where he had been placed as an infant and had lived during the first eight years of his life.

Meantime Carl quit school, spoke of becoming a religious, gave up that idea and went to work. His parents continually hounded him for money after he got a job. Twice he attempted to enlist in the Armed Forces but was rejected. This proved very discouraging, as his brother had been accepted.

In the H. home Carl’s behavior became very upsetting to his foster mother. She discussed it with his social worker and related that Carl was extremely jealous and suspicious of another foster child in the home, was careless about his personal appearance, had a poor memory, appeared confused frequently and rocked violently in his sleep. On the basis of this information, the social worker requested a psychiatric opinion as to whether or not Carl should be removed from the community and placed in a school for the feebleminded.

When interviewed by the psychiatrist, Carl was seen as an inoffensive boy who possessed a poor fund of information. It was the opinion of the clinic that Carl should be allowed to remain in the community until such time as he displayed signs of getting into trouble or totally failing to adjust.

Carl appears to have settled down and is again working. He returned to live with his parents but this move proved unsatisfactory. He again lives in the H. home, is adjusting well and now drives his own car.
Discussion

The basis of referral to the Mental Hygiene Clinic was to evaluate Carl's potentialities for remaining in the community. As in the other cases, the Child Welfare Services worker had a direct contact with the clinic.

The worker brought the case in for consultation in order to get a clearer understanding of the diagnosis and prognosis of this boy, to gain a better dynamic understanding of him, and for clarification as to the meaning of Carl's behavior.

The psychiatrist recommended that Carl should remain in the community until such time as his behavior deviated to a point where he became a menace. The social worker was asked to work within the boy's limits and to support him in such areas as securing employment and establishing closer family ties.

The worker accompanied Carl several times while he sought employment and gave him the support he needed so that later he was able to meet new situations alone. Also he worked with Carl's family to give them insight into his behavior so that they might be more tolerant of him.

This case demonstrates how often a plan other than that presented by the social worker can prove more satisfactory in aiding in the general adjustment of the child.
Case 6.

Jim, a fifteen year old, white Catholic boy, with an I.Q. of 98 was the only one of five children committed to Child Welfare Services in 1949 on a charge of neglect. This commitment was based on destruction of property, defying and refusing to obey his father, and staying away from home until the early morning hours.

Jim's mother died when he was three years old. His father never remarried. Jim and his sibling were then cared for by a paternal aunt. She was very strict but nonetheless the children took advantage of her.

When Jim was five years old he was placed in an institution where he remained for four years. His adjustment was fair but his need for family ties was very strong.

When committed as a neglected child Jim was transferred to the center. He ran away several times to his father's home. Because it was not possible to keep him in an institution, Jim was allowed to remain at home under the supervision of the agency. After several weeks he was removed because of truancy. Following this he had a series of foster home placements interspersed with stays in his own home, during which he was constantly rejected by his father. The relationship between Jim and his father is very unstable. Two months ago he returned to live with his father and though he is still there, his father has requested his removal several times.

Because Jim continually ran away, was involved in petty stealing, and had a strong desire to remain in his father's home, his social worker referred him to the Mental Hygiene Clinic.

The psychiatrist's impression of Jim was that he was emotionally insecure and was unable to find any positive identification with his father or other family member. Thus, he was displaying symptoms of maladjustment. It was felt that if Jim was to remain at home he might benefit if it were possible to establish some father figure in his life to whom he could become attached and in whom he could find security and happiness.

Jim is still living at home. His social worker believes that when he reaches his sixteenth birthday in June, he will leave home and go to work out of state.

Discussion

The focus in this case was for an evaluation of Jim's strong need to maintain family ties by remaining in his father's home.
The agency social worker consulted with the psychiatrist in order to clarify his function in working with Jim. He discussed Jim's guilt about having been committed to agency care and his interactions with his environment, specifically in the area of his relationship with his father. The psychiatrist read a summary prepared by the social worker in which Jim's early life history was described. From it he was able to gain a clearer picture of the nature of the boy's conflicts.

After interviewing Jim, the psychiatrist told the worker that he felt Jim could not find any positive identification with his father and suggested that if the boy remained in his father's home, someone should attempt to fill the role of father figure, so that Jim might find the security and happiness that he was seeking.

Though the psychiatrist did not specifically recommend that the social worker assume this role, the latter has offered Jim continued support and has been able to maintain him so that his adjustment since referral has been more stable.

In this case the clinic was used but once, on a consultation basis, with the idea of manipulating a child's environment if the move was felt necessary.
Case 7.

George, a well-developed, blue-eyed, redhead, Catholic infant was born out of wedlock to an eighteen year old girl, who, at the time, was under the custody of Child Welfare Services, but living in a foster home. According to the mother, he was an eight months old baby. During the first three months of life he slept a great deal. After that he became quite observant and alert. At no time did he present a feeding problem.

George was rejected at birth by his mother, who asked that he be placed for adoption. He has seen her but twice since birth. At the commitment hearing he was adjudged a dependent child and placed in a foster home.

When he was five months old his social worker referred him for an adoption evaluation, as it was felt that he should be placed as soon as possible in a home where he could have the security and love of a father and mother. At this time a psychometric test revealed that George's I.Q. was normal.

The psychiatric impression was that George was an alert, friendly, emotionally responsive child. He had no objection to placing the child provided the adoptive parents were not college graduates and would not expect him to perform beyond his capacity.

The social worker was able to find a home that met with the suggestion of the psychiatrist.

Discussion

This case is presented as an illustration of the social worker's role in the referral of a child to the psychiatrist for adoption evaluation.

The psychiatrist concurred with the social worker in the opinion that George should be placed for adoption, but he added that this should be in a setting where later life situations would not prove too much for either the child or his parents to cope with. The emphasis on this evaluation was on the child's potentialities rather than on the type of home he should be placed in.
The adoption social worker secured a home for George where the demands placed on him are not expected to be too much for him. The adoptive mother is a high school graduate, the adoptive father has had two years of college.

The importance of proper placement for children in adoptive settings, with a view towards obtaining the "right" child for the "right" home illustrates how the psychiatric facilities are used to assist the social worker in her choice of such a home.

Summary

In the eleven remaining cases in this category, two referrals were of girls who were having difficulty in their interpersonal relationships. After psychiatric consultation, in which recommendations were given that the Child Welfare Services social worker support these children in this area, one of the girls was able to form lasting relationships; the other continued to experience difficulty and was removed to another setting.

Three young boys were seen at the clinic because of episodes of stealing and fire settings. One of these boys exhibited strong feelings of needing to return to his mother's home. The psychiatrist recommended such a plan and after investigation by the social worker, the child was placed with his mother. This was short-lived and the boy is now at the Center where his adjustment has been good. The other two boys seemingly came from favorable foster home situations but were exhibiting symptoms of aggressive behavior because of difficulty in adjusting to their
settings. The social worker was asked to supervise more closely these children and the homes and report to the clinic any reoccurrence of this behavior. Both of these boys are apparently adjusting well at this time.

Two children, a three year old girl and a six year old boy, were referred to the clinic for adoption evaluation. The girl, it was felt, was retarded and a suggestion was made that she should be remanded to a school for feebleminded children. Another psychiatrist who examined this child concurred in this opinion, but felt that before that move should occur, an attempt could be made to place the child in a residential treatment study home for observation. This has not been done to date. The young boy was brought to the psychiatrist as part of a process of wishing to determine the advisability of allowing him to remove to another state with his mother, recently married, and his stepfather. The boy, his mother, step-father and foster mother were all interviewed during this interview. The psychiatrist felt the parents were not stable enough to be allowed custody of the child at that time. He also felt that the boy, though a poor adoption risk because of personality problems, would probably most benefit from remaining in his present foster home. He asked the social worker to report any new developments in the case to him.

Because of a question of the possibility of petit mal, a thirteen year old girl was referred to the clinic. An electroencephalogram recorded that the girl was functioning "just within normal limits." Her foster mother, who accompanied her, was also interviewed. She
was seen as a person who was unable to give the child the affection she needed. The psychiatric recommendation was that the girl should remain in her present home and that the social worker should help the foster mother by clarifying the reasons why she handled the girl as she did.

Two children, a fifteen year old girl and a twelve year old boy, were seen by the psychiatrist because of school problems. The older, a fifteen year old girl, was acting up in the classroom because she did not feel that she was an integral part of her foster home. The boy's difficulty centered around his inability to concentrate in the classroom, daydreaming and poor school work. The psychiatrist felt that in both of these cases there was evidence of a great deal of unrest in the children because of separation from their families. He suggested that the workers' roles should be supportive in the area of helping the children in their school adjustments.

A six year old boy, living with his mother, was presented to the psychiatrist because of the social worker's observations that the child appeared to be rejected by his mother. The child and his mother were interviewed by the psychiatrist. He noted no evidence of anxiety in the boy during the conference. However, he felt that the boy's mother was a rather depressed and self-deprecating person who was extremely narcissistic and dependent, with limited ability as regards the care of herself or her children. The psychiatrist recommended in this case that the social worker should continue to observe the home conditions and the behavior of the child and if there was no improvement, she was to report back to him.
Treatment

The psychotherapeutic process of purposeful planning designed to modify attitudes or behavior patterns, remove precipitating stresses, eliminate unhealthy personality traits, and assist the patient to solve his conflicts and live comfortably within his limitations.

The writer studied seven cases in this category. Three will be presented in detail to illustrate the roles of the psychiatrist, psychiatric social worker, and the Child Welfare Services social worker.

Case 8.

Mary, age 13, a rather pale, dark-haired, white Catholic girl, was born out of wedlock in November, 1944 to a mother having a mental age of ten years and a medical history of epileptic seizures.

When three years old, Mary was placed in a nursery because of maltreatment and neglect. After several months she was returned to her mother but was rejected. In order to protect the child it was decided to place her out for adoption. She was committed, along with her brother two years younger than she, to the custody of Child Welfare Services.

After commitment she had several unsuccessful foster home placements. She fought, bit, indulged in sex play, stared into space and was disobedient. After three years in various foster homes, she was returned to the Children's Center. There she regressed and became a severe behavior problem.

Mary was then referred to the psychiatrist because she presented a picture of emotional despair. Also, the worker wished to learn if there was any medical basis for the child's behavior because of an early history of epilepsy. Too, there was a question of sex play which consisted in the writing of obscene notes in very coarse language.

The psychiatrist recommended that a foster home should be found for Mary where she would be the only girl, as she seemed to have difficulty in her relationships with peer groups. Another recommendation was that the Child Welfare Services social worker should explain the fundamentals of pregnancy and child-bearing to the child.
When Mary's adjustment continued to be poor, she was seen on a regular basis by the psychiatrist. She impressed him in succeeding interviews as having a great desire to be loved.

An electroencephalogram disclosed some focal brain damage.

To date a foster home has not been found for Mary. Her social worker sees Mary frequently. She has made remarkable strides in her interpersonal relationships.

**Discussion**

Mary was referred for psychiatric evaluation by the Child Welfare Services social worker in order that she could gain a better understanding of the girl and to discuss methods of meeting the child's needs.

During the initial interview the psychiatrist, social work supervisor and social worker discussed the dynamics of the child's behavior. Various methods and techniques of treatment were suggested. Following this conference the psychiatrist talked with Mary and then recommended she should continue to come to the clinic on a treatment basis.

The following recommendations were made at this time; that Mary should be placed in a foster home where she would be the only girl, as she seemed to have difficulty in her relationship with peer groups; that she be given sex instructions by her social worker; and that an electroencephalogram be taken to detect, if possible, the presence of epilepsy.

The social worker followed through on these recommendations and attempted to find a home for Mary, but the girl's pre-placement behavior was so erratic on two occasions that the prospective foster parents refused to take her. The worker gave Mary sex instructions and the girl's conflicts in this area diminished. The worker had an electroencephalogram done and the results showed focal brain damage. In
addition the worker helped Mary to extend her relationships beyond the Center by approving wholeheartedly of her efforts to reach out to people outside the institution.

This case is an example of how the social worker was able to use the psychiatrist in helping a girl who, at one time, was being considered for commitment to a school for feebleminded children, and who was having difficulty in establishing personal relationships, gain the support and confidence she needed so that she could establish healthy relationships and function at a truer level free from tension.
Case 9.

Tom, a fourteen year old, white Protestant boy, with an I.Q. of 106, was committed in 1948 to Child Welfare Services on a charge of neglect. He is the third oldest in a family of four children.

In 1941, a few months prior to his mother's death, Tom and his sibling were placed in a foster home because of neglect. The year following his mother's death, Tom's father remarried and took the children into his home. Four months later he joined the U.S. Navy. Tom and his sibling remained with their stepmother for about two years before again being placed in a foster home.

Tom had several foster home placements in the next two years. His last one prior to commitment was with his maternal step-grandmother. After living in her home for about a year, he began to steal, was truant, resented discipline, and attempted to set fire to the house.

This conduct led to his commitment to Child Welfare Services. He lived at the Center several months but ran away many times to his grandmother's home. He then experienced two foster home placements but adjusted poorly and was returned to the Center.

His stealing continued and Tom was referred to the psychiatrist, who recommended that the boy should be seen regularly by the psychiatric social worker. After months of treatment Tom was again placed in a foster home. His early adjustment was good but after several months his pattern of stealing resumed. He was removed to the Center again, where he became a leader of the group in his cottage. His adjustment was poor and he was involved in acts of vandalism, stole from the cottage personnel and ran away several times.

Upon his return to the Center, Tom again was referred to the psychiatrist who undertook to treat him. He realized that people were interested in him and wanted to help him. He did not give up stealing. Once when plans were made to remove him to a correction institution, Tom inferred that his only way of staying at the Center was by cooperating with the psychiatrist.

During his interviews with the psychiatrist Tom related dreams which evolved around being chased and sometimes ended up in falls from a cliff or of being pushed into a fire. Also, he had pleasant dreams that did not awaken him, such as operating a ranch and protecting the cattle from rustlers. Tom was able to verbalize his feelings about his parents and other adults. He also had mixed feelings whether to remain a child or grow up.

Early this year he was transferred to a private boarding school where he is making a satisfactory adjustment. His social worker has formed a good relationship with him and through support has helped Tom to become more stable in his behavior.
Discussion

The decision to bring this case to the psychiatrist for evaluation of Tom's need for treatment resulted from continual acts of aggressive behavior. The meaning of this behavior was discussed with the supervisor, psychiatric social worker, and Child Welfare Services social worker by the psychiatrist. Various aspects of the situation were explored and specific ways in which to handle such behavior were suggested.

At the initial interview a recommendation was made that Tom should be seen by the psychiatric social worker on a regular basis. The results of this recommendation were fruitful and Tom's adjustment reached a point where he again was placed in a foster home. He was returned to the psychiatrist when he again began to steal. This time the psychiatrist undertook treatment. The worker was asked to devote more time to Tom and give him the necessary support to carry him through periods of stress and conflict.

The worker and the psychiatrist saw Tom regularly and helped him to feel that people were interested in him and wanted to help him.

The services of the psychiatric social worker were made use of in this case so that a seriously disturbed boy might benefit from an extended period of contact with someone who could give him a feeling of worth and of being cared for.
Case 10.

Ted, a twelve year old, attractive, dark-eyed, dark-haired boy, was born out of wedlock in February, 1942. When he was four months old he was committed on a dependency charge to the Child Welfare Services because his mother was unable to care for him.

He was placed in the H. home immediately following commitment. His development was normal and he adjusted well. His foster parents were very accepting of him. His natural mother visited him regularly until he was seven years old, then her visits became very infrequent.

Two years ago Ted began to visit his mother in her home. Since then he developed the idea that she had been treated unjustly. He fantasized her as a fairy godmother and his foster mother as a "witch". Prior to these visits Ted had been a cheerful boy who seemed to be at ease socially. Then he began to be frequently unhappy and depressed, stole and had long crying spells. Because of this behavior, Ted was referred to the Mental Hygiene Clinic.

Ted's foster mother, Mrs. H., accompanied him during this visit. She was a middle-aged, rather thin, modestly dressed woman. Without waiting to be questioned, she began to speak about Ted's problems. She spoke factually and to the point. Her attitude towards the boy's problem was a healthy one and she displayed a great deal of sympathy and understanding.

When interviewed by the psychiatrist, Ted gave the impression of seemingly being quite intelligent with an understanding of his problem. His I.Q. at the time was 101.

The psychiatrist felt that Ted lacked a sense of reality but that he was strong enough to be able to adjust himself to situations. He recommended that the psychiatric social worker treat Ted and that the Child Welfare Services social worker should continue to work with the foster parents.

On his first visit to the psychiatric social worker, it was pointed out to Ted that the doctor had asked the worker to help him. Ted was able to talk at that time and during succeeding interviews about his feelings concerning separation from his mother. He seemed to lack understanding as to the reasons why he was not living with her. He talked freely of his feelings towards his mother and showed strong hostile feelings towards his foster mother.

During the interviews the psychiatric social worker conferred frequently with the Child Welfare Services social worker concerning Ted's behavior in the H. home.

Ted's behavior improved considerably and after fourteen sessions
it was felt that the objective had been obtained. The psychiatrist was satisfied with the treatment results. After interviewing Ted again, the psychiatrist recommended that treatment should be discontinued. He suggested that the Child Welfare Services social worker should keep in touch with Ted's foster parents to check on his behavior.

Discussion

The worker brought this case to consultation in order to get a better understanding of Ted's behavior and to receive clarification of the boy's feelings relative to separation from his mother.

The psychiatrist, social work supervisor and social worker reviewed the mental hygiene summary which had been presented prior to the conference. They discussed Ted's early life and events that seemed to lead up to his problems.

Following an interview with Ted and his foster mother, separately and together, the psychiatrist recommended that Ted should be seen by the psychiatric social worker and Mrs. H. by the Child Welfare Services worker.

These recommendations were carried out successfully by both workers. When considerable improvement was noticed in Ted's behavior, the social workers returned to the clinic and reviewed the case.

The psychiatrist felt that the objective had been obtained and that treatment should be discontinued. However, he asked the Child Welfare Services worker to continue a close supervision of the home.

This case demonstrates how a social service agency and a mental hygiene clinic used their facilities to help both a child and foster mother gain insight into their problems.
Summary

Of the four remaining cases studied in this category, one referral was of a fifteen year old boy who was experiencing difficulty in interpersonal relationships. When frustrated, he developed serious temper tantrums during which he became hysterical. During his period of treatment by the psychiatrist he expressed feelings of inadequacy when with his peers. The psychiatrist recommended foster home placement for this boy when it was felt he was ready. This boy has been in a foster home setting for four months and is making a good adjustment. He is seen occasionally by the psychiatrist. Two children were referred for aggressive behavior. One, a sixteen year old retarded girl was referred because she was adjusting poorly at the Center. She was seen on a treatment basis by the psychiatric social worker on recommendation by the psychiatrist. During this time she gained a great deal of poise and matured to a point where she was better able to approach problems more realistically. The other child, a ten year old boy, was also referred for aggressive behavior. He impressed the psychiatrist as being a subdued, overwhelmed youngster. A recommendation was made that this child should be placed in a foster home where there would be but one other child. This has not been accomplished. Because of continual hostility against her mother, an eleven year old girl was seen on a treatment basis. After the initial interview, in which the mother was also interviewed, it was recommended that both should be seen on a regular basis. After several interviews both mother and daughter were able to more clearly see wherein the source of their differences rested. Unfortunately, the mother did not continue to follow through with her appointments.
Despite this she changed her methods in handling her child. The child continues to be seen occasionally at the clinic.
CHAPTER VI

SUMMARY AND CONCLUSIONS

In this study the writer will endeavor to analyze and evaluate the use of the psychiatric facilities of the Rhode Island Mental Hygiene Clinic by the Child Welfare Services social worker during the calendar year 1953.

The general questions to be answered in this thesis are as follows:

1. What were some of the reasons on which referrals were based?

2. What were some of the treatment recommendations?

3. How did the Child Welfare Services social worker follow through on these recommendations?

One of the basic assumptions of this thesis is that the most potent environmental factors in the life of the child appear to be those connected with the quality of his interpersonal relationships. Thus, the broken home, of which the majority of the children studied represent, quarrels between parents, poverty, neglect and malnutrition are of significance only in their effect on the child to form relationships that in turn will effect his outward behavior.

A primary problem of the child concomitant with parent-child separation is that such a trauma is symptomatic of a continuous unstable family situation which has ill effects on both parties. Thus, it would be safe to assume that most of the children studied, though effected by the separation process, showed symptoms of emotional maladjustment
prior to and after separation. The court commitment which effected the separation served as a means of manipulating the environment of the child in order to prevent further emotional or physical damage to him.

In the twenty five cases which were studied, two types of psychiatric services were used – Consultation and Treatment.

Eighteen cases were studied in the area of consultation. Of these, three children were referred because the worker wished to receive clarification of their behavior; three children were seen by the psychiatrist for opinions as to their potentialities for adoption; two children with difficulties in establishing interpersonal relationships were brought to the clinic for evaluation; two others who were experiencing difficulties in their school adjustment were interviewed by the psychiatrist; because of aggressive behavior three other children were seen by the psychiatrist; social workers also sought opinions in the following situations; the capacity of a foster mother to change her method of handling a child; to gain a clearer understanding of a child; a question of petit mal; how to work with a rejecting mother; and for clarification of a worker's role relative to dealing with a child in need of a father figure. These children were seen a total of forty two times in the clinic by the psychiatrist.

There were seven cases in which the children were seen on a regular treatment basis. Four of the children referred to the clinic were seen by the psychiatrist and three by the psychiatric social worker for a total of eighty eight interviews. Three of the presented
problems dealt with aggressive behavior, two children were treated because of difficulties in their interpersonal relationships, one child was referred because he was reacting to separation from his mother; the seventh child was seen along with her mother because of continued hostility towards one another.

In all of these cases progress was noted. After several interviews all but one of the children were released from treatment. Their adjustments have continued to be favorable.

The writer will attempt to answer the general questions listed below.

1. What were some of the reasons on which referrals were based?

From a study of the cases, the reasons that the social worker referred children for psychiatric help seems to be for the following; in order to gain a more dynamic understanding of the psycho-social factors pertaining to the child; to receive clarification and understanding of the child's behavior as it is affecting his personality development; to formulate recommendations for treatment.

2. What were some of the treatment recommendations?

Psychiatric recommendations varied according to the problem and its severity. In the main the child was given supportive treatment. Through acceptance and strength of relationship the child was encouraged to verbalize his feelings about separation, foster home placement, institutional living, school adjustment, or whatever change was taking place in his life. The recommendations were as follows: that the type of placement be changed; that supportive treatment be offered; that the psychiatric social worker treat some of the children; that foster
homes be secured for several children; that medical examinations be
given; that sex instruction be given a child; that two foster mothers
should be helped to change their methods of handling children; and
in two adoption evaluations one child was approved, the other not
approved.

3. How did the Child Welfare Services social worker follow
through on these recommendations?

It is difficult to learn from the case records how active the
worker and her supervisor were in sharing the thinking of the psychia-
trist which led to his plan of treatment for the children. It is known
that in most of the records the psychiatrist was furnished by the case-
worker with a psycho-social history containing the following; personal
history with particular attention to the developmental data, illness
and educational achievement. However, it would seem from the recordings
that the worker accepted the recommendations of the psychiatrist as
final and acted with the conviction that his treatment recommendation
was the only one to be carried out in the best interests of the child.

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In concluding this study, the writer cannot urge too strongly that
the Child Welfare Services social worker use the mental hygiene summary
to advantage in preparing a pre-referral history for the clinic so that
the psychiatrist may be able to discern more quickly the nature of the
problem. This will enable him to obtain a more comprehensive picture
of the child, thus saving valuable psychiatric time which could then
be used more profitably in the treatment of the child.

This thesis seems to point up the need of further clarification within the agency's structure as to whether the psychiatrist should be used solely in a consultive role, or to provide a plan or treatment which the Child Welfare Services worker should follow.

The writer is of the opinion that further examination of the clinic is indicated in order to determine how full use of available psychiatric time may be achieved.

Approved:

[Signature]
Richard K. Conant
Dean
APPENDIX

Schedule

1. Name
2. Date of birth
3. Religion
4. Age at commitment
5. Type of commitment
6. I. Q.
7. Personal history
   a. Developmental
   b. Early deprivations
   c. Specific traumatic experiences
   d. School adjustment
   e. Social adjustment
   f. Health (any physical or mental defect or limitation)
   g. Interpersonal relationships
8. Family history
   a. Parents
      1. Ages
      2. Marital status
      3. Religion
      4. Education
      5. Work history
      6. General statement about lives
      7. Economic situation
      8. History of medical or mental illness
      9. Attitude of parents toward child and/or children
   b. Sibling
      1. Number
      2. Ages
      3. Child's position
      4. Present whereabouts (contact)
      5. Past relationships with subject
      6. Subject's knowledge of and attitude toward them
9. Family atmosphere
   a. Intrafamily relationships
   b. Any preference of child for either parent
   c. Method of discipline used by parents and by whom administered
   d. Was either parent alcoholic?
   e. Physical abuse of each other or child
   f. Reason for parental separation

10. Subject's attitudes
    a. Knowledge of parentage
    b. Does he feel parents do not love him?
    c. Child's feelings about separation
    d. How has he been handling his hostility toward them?
    e. Is he ashamed of parents because of their inadequacy?

11. Present situation
    a. Description of the problem and circumstances that result in child being referred to the Mental Hygiene Clinic
    b. Interpretation given to child
    c. Interpretation given to parents
    d. Interpretation given to foster parents
    e. Interpretation given to social worker
    f. Attitude of these toward problem and/or child.
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