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The use of the school visit in a child guidance clinic.

BOSTON UNIVERSITY
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THE USE OF THE SCHOOL VISIT IN A CHILD GUIDANCE CLINIC

A Thesis

Submitted by

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CHAPTER I

INTRODUCTION

A. Reasons for the Study

The child guidance movement, since its inception in the early 1900's by Dr. Healy, has long been aware of the various forces impinging upon the individual. With the advent of psychoanalytic theory these forces have been brought to the fore, and as a result their interrelationships have come to be seen in the dynamic whole. The individual was no longer viewed as an agent having an innate moral concept of what is supposedly good or bad. The individual was now to be understood as a dynamic being living in a dynamic environment. As a result of these new theories, the individual, if he was to be understood, had to be viewed as a total being receiving stimuli, acting upon these and in turn setting up further stimulants. Therefore, it was only natural to view the child as one in whom primary behavior patterns were of necessity to be molded by his parents or parental figures. Arising from this was the apparent requirement for the child guidance clinic not only to work with the child, but as essential, or perhaps even more so, was the need for an understanding of and working with the home environment. Namely, the parents.

In the present industrialized economy, the child's life has become so enmeshed between the home and the school, it is of interest to discuss and understand how the children's clinic has been working with these aspects of the child's environment. Firstly, to relieve

the stresses in the child's life from these sources. Secondly, to make available new and more healthful experiences to assist in helping him thrive in the new phases of his maturation, as well as, in the eradication of less mature levels of adjustment.

The child guidance clinic has long realized the need to understand as well as work with the child's home environment through the parents. Thus it has been found that at times the child could be helped to a better adjustment by working with the parents alone. Another aspect of the child's environment, the school, which composes approximately one third of the child's waking hours, must also be considered in the total treatment plan of the child guidance clinic. The school presents a great challenge to the child guidance clinic as a resource for the treatment of the disturbed child. The challenge lies not only in the administrative aspects peculiar to the school but also in so far as the potentialities of the school as a curative agent as well as a resource for the prevention of emotional disabilities in children.

B. Aims of the Study.

It is the intention of this study to present the use the child guidance clinic makes of the school, namely, through a face to face relationship. The face to face relationship is found to exist in the sc ool visit bby the child guidance clinic. Therefore, the topic under study will be, the use of school visits by the child guidance clinic.

Two complimentary declarations of purpose are to be found in this study. Cases from the Massachusetts Memorial Hospitals

Children's Psychiatric Division, in which there has been contact with the school through a school visit will be analyzed. The function of this type of investigation will be to study the utilization of the school in the total treatment plan of the disturbed child. Through this will be established what has been don in this area.

The material will then be considered as to the possibilities indicated to further help the child. Therefore, from the material in this study the following questions have been posed.

1. What is the value of the school visit?

2. How and to what extent did the school and clinic collaborate in the treatment of the child?

3. What possibilities are indicated for more positive cooperation between school and clinic?

C. Methods and Scope.

Cases that are to be examined represent the total population of those children who were seen at the clinic from September 1949 until January 1953, in which at least one school visit was made by a social worker. Visits by social workers have been chosen. In the main, the psychiatrists' visits were not written in the manner to afford suitable material for a study such as this. The school visit was mainly reported in such terms as "school visit made", "school visit; recommendations to the school are to be taken under advisement by the authorities". Psychiatric residents make school visits as part of their learning experience.

In obtaining the material the case study method has been used. The social worker's records have been read as well as the psychiatric chart. Pertinent information was abstracted and collated so as to shed light on the reason for the school visit; the course of the school visit; the course of treatment in light of the school visit.

The relationship between the reason for the school visit and the child's problem as well as changes in the school's treatment of the child will be explored.

In all, twelve cases were found to meet the requirements for the study. These cases will be analyzed as a group and from this group a number of cases will be presented to illustrate the particular categories.

There are many limitations to this study. Perhaps the most obvious limitation being the small number of cases utilized. Of the cases utilized many of the school visits were not written in process form and much of the dynamics of the visit are left to inference or clarification from a secondary source. In short the records were not written for research purposes. Any conclusions are applicable only to this group.

CHAPTER II

THE CHILDREN'S PSYCHIATRIC CLINIC OF THE MASSACHUSSETTS MEMORIAL HOSPITALS

The Children's Psychiatric clinic of the Massachussetts Memorial Hospitals is one of the divisions of the Psychosomatic Clinic. The Psychosomatic Clinic is the psychiatric outpatient clinic of the hospital and also serves a consultative role for the hospitals' in-patients. The Psychosomatic Clinic has three divisions, the Adult Psychosomatic Clinic; the Seizure Clinic; and the Children's Psychiatric Clinic.

The Psychosomatic Clinic was established in August 1946, to evaluate and treat adults with psychosomatic symptoms. The clinic at that time also started a program to train fourth year medical students of the Boston University School of Medicine in clinical psychiatry.

In October, 1947, the Seizure Clinic was established as part of the clinic program. The aim of this clinic is to provide an opportunity for epileptics to receive treatment of their maladies through medicine, psychiatry and social work.

The Children's Psychiatric Clinic has been in operation since September, 1948. The Clinic was founded primarily for the purpose of evaluating and treating acute emotional problems in children and somatic symptoms that may develop on the basis of emotional disturbances. The basic unit of the clinic staff, as in other

psychiatric clinics, is the psychiatrist, psychologist and the psychiatric social worker.[1]

The Children's Psychiatric Clinic accepts for treatment patients with recent onset of symptoms, and for evaluation patients referred from the hospital staff. There is a twofold purpose to an intake policy such as this.

1. To ensure rapid psychiatric care for those children whose symptoms, if they were obliged to wait the usual six to nine months period, might become much more fixed and difficult to modify.

2. To procure good teaching cases for the residents and medical students.[2]

It was felt that because the Children's Psychiatric Clinic is part of a general hospital, it would be possible to institute treatment early enough to most likely to succeed. The clinic can at the same time establish easy access to consultations with general medical and surgical facilities of the hospital. It was further felt that the clinic could provide opportunities for the training of professional personnel; psychiatrists, nurses, social workers and psychologists in the field of child psychiatry.

At the present time the staff consists of psychiatrists who act as therapists and also instructors to the eight resident

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1. French, Lois Psychiatric Social Work, The Commonwealth Fund, Oxford University Press, New York, 1940, p. 154.

2. Pavenstedt, Eleanor, M.D., Letter to Dr. A. Z. Barhash, American Association of Psychiatric Clinics for Children, 1950.

psychiatrists as well as the fourth year medical students and internes. There are three full time psychiatric social workers who see patients and also serve in a teaching capacity both to the residents as well as the eight social work students. Of these students seven are second year students and one a third year student. All of the student social workers, medical students, psychiatrists and residents carry cases from the three divisions of the Psychosomatic Clinic.

Usually the child is seen in approximately three weeks for evaluation. During the evaluation the child is seen by a psychiatrist and the parent by a social worker. During this period other agencies or physicians having known the patient are usually contacted with the patients' permission. Permission is also granted at the time of intake to contact the school. After the evaluative period the patient is either kept in treatment or put on the waiting list for a regular therapist. The waiting period is usually three or four weeks, but during the summer months this may be somewhat longer.

The Clinic provides an evaluative period for all cases referred by the hospital staff and diagnostic services for various other community agencies.

After a child has been accepted for treatment, the child is usually seen by a psychiatrist and the parent, in most instances, the mother, is seen by a social worker. During past years student social workers and student psychologists have also seen children as part of their learning experience. The residents also see parents

as part of their training.

To better understand the treatment plan in child guidance and especially at the Children's Psychiatric Clinic the three disciplines of treatment will be reviewed.

In the Children's Psychiatric Clinic the psychiatrist sees one child, generally, once a week for an hour session. Most of the young children are seen in the play room, while usually the adolescents are seen in the interviewing room. Although child psychiatrists vary in the way they put their precepts into practice there are some common elements involved.

Helen Witmer says:[3]

> The therapist strives to have the child sense that he is appreciated and that his feelings in the present situation are understood. The psychiatrist seeks to develop the child's trust in him, so that he will not be afraid to work out his problem before him, in speech or in symbolic play.

The social worker at the Children's Psychiatric Clinic, as in most other child guidance clinics, Has as his chief role the therapy with the mother while the child is seeing the doctor. It is usually a desired practice for the social worker and psychiatrist to meet, to discuss the progress of treatment or any new material, for a few months after each session.

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3. Witmer, Helen L., Psychiatric Interviews with Children, (New York: The Commonwealth Fund, 1946) P. 42-43

Helen Witmer says:[4]

> Most child guidance social workers now take as their task the fostering and enhancing of the strength that a parent displays when he decides to do something about an unpleasantsituation. The social worker tries to prepare the child for psychotherapy by discussing with the parent how he will present to the child the plan of coming to the clinic. They seek to maintain the parent's interest in the child's treatment by accepting the ambivalence of the parent's desires, by helping him to decide what he most wants to do about the child's problems, and discussing with him what the psychiatrist is discovering about the child's difficulties.

The social worker, therefore, is striving to help the parent support the growth the child may be receiving through psychotherapy. As a result of this process some of the parents own emotional conflicts may be discussed mainly about the parent-child relationship or about the family situation. This can result in the parent's own mental health being improved. "The primary aim is to help the parent work out a problem in social relationships and thus to provide an environment in which the child can continue the change he initiates in treatment interview."[4]

The psychologist is used not only for testing purposes, but also for tutoring some of the children at the clinic. The tests

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4. Ibid p. 14

the psychologist may give depends upon the recommendation of the doctor as does the testing itself. The child may be given one of the generally accepted intelligence scales, a projective test or both.

CHAPTER III

TREATMENT IN CHILD GUIDANCE

The philosophy behind the child guidance movement today has as its prime motivating factor the principle, that emotional problems found in children are resultants having at their core the relationship of the child to his parents.[1] Growing out of this philosophy is a treatment plan based upon a combined type of therapy with the child and his parent. The child is usually seen by a psychiatrist. In this relationship he is allowed to express and work through his conflicts in a nonthreatening and accepting environment.

The parent, usually the mother, is seen by a social worker. Work with the mother is concerned with trying to utilize and mobilize the strengths in the family situation. Thus it is hoped the family will be able to assist and support the child in those changes that his participation in therapy are attempting.[2]

Perhaps the main tool in therapy with the child is the transference relationship. Through this type of relationship the child's fears of desertion and not being lowed are slowly worked through.[3]

The medium for this type of a relationship is found in the play room of the clinic. Through play therapy it is possible to

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1. Allen, Frederick, "Combined Psychotherapy with Children and Parents," Modern Trends in Child Psychiatry, edited by Lewis and others, p. 257-258

2. Ibid, p. 258

3. Hamilton, Gordon, Psychotherapy in Child Guidance, pp. 320.

understand the child's problems. Therapy of this nature is extremely important in child psychiatry as acting out of conflict's is the natural process for a child. Play is the child's method for communication as his verbial communicatory responses are not fully matured. Play also provides a safe opportunity for the child's expression of feelings and attitudes which in turn provide a release of tension.

> Living out an experience together within the relationship is much more a part of child than of adult therapy, although it is a part of all psychotherapy. Little children must be gratified in order to postpone gratification. The worker's understanding and acceptance of the wishes is translated through appropriate play and comment. The attitude of unfailing friendliness, and concrete offers of help give the opportunity, to release tension, and relieve a badly assimulated or non-assimulated growth experience. Because an important factor in assimulating the experience is time, therapy must proceed at the child's pace, which may be slow.[4]

However, play cannot be the sole source of understanding the psychodynamics of the child's problems. There must of necessity be an integration of all material received about the child. Material brought out in play, information secured from the parents, other sources, such as the school, and the awareness of emotional attitudes gained by both parents and child must all be collated if we are to arrive at an adequate diagnosis and treatment plan.[5]

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4. Ibid 209

5. Despert, Louise J.,"Play analysis," edited by Lewis and others, op.cit., p. 252

It has been found that as the child enters latency the repressive forces of his ego take on new impetus and his activity begins to take him away from his parents. Phantasies focused about the parents are displaced upon more remote figures, such as teachers. As a result of socialization new experiences give rise to new types of defenses.[6] It is during this period that parents often consign to the teacher major responsibility for the child's development and training. In the school situation the child is further assisted to seek the company of his own sex, to seek chums, form gangs and secret societies. It is also through this means of supervised activity that the child is able to work off much of his aggression and hostility. It is also at this time that the child is testing the world and gaining useful knowledge and molding his theories about the world in general.[7]

In treatment of the latency child these new defenses cannot be approached directly. Therapy therefore, becomes more difficult because there is usually greater damage to this child than found in earlier age levels. The play is more complicated and of a more defensive type. Therefore, the child should be encouraged to verbalize, as it is appropriate for his stage of growth. Deep interpretations are not effective. The therapist's understanding

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6. Hamilton, op. cit. p. 245

7. English, Spurgeon O., and Pearson, Gerald H. J., Emotional Problems of Living W. W. Norton and Company Inc., New York 1945, pp. 133-134

acceptance of the child's responses is the real tool which relieves the child's tensions.[8]

In the adolescent it is found that this is his last period of dependence and also the last period when environmental forces alone can help him. It is during this period the adolescent must:

1. Decide upon a vocation and do some work in preparation for it.
2. Effect an emancipation from his parents and family,
3. Bring about a satisfactory relation with the opposite sex and at least begin to make some resolution of his love life, and
4. Effect an integration in his personality for mature responsibility.[9]

It is also during this period that the individual is striving for independence. Trying to shed his parental yoke by identifying with his peer group and seeming to be governed more by their expectations and codes than those of his parents. This type of striving sets up a conflict within the adolescent. It is during this period we find him one moment acting in a mature manner and another moment in a childlike fashion. As a result of the adjustments of this period the child can be helped to work through his feelings through an understanding parental surrogate. This can be any adult such as a teacher, or clergyman.[10]

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8. Hamilton, op. cit. p. 246

9. English & Pearson op. cit. p. 278

10. Ibid 270-291

Therefore, therapy during adolescence involves still another focus and goal. As has been said, the adolescent is helped to grow toward independence. This can be assisted through a strong identification with the therapist who works with constructive defenses, offers an ideal and approves of the adolescent's efforts to be himself.

> Emancipation plus a workable interpretation of the drives through ego building achievements and sublimation are the goals...Through being understood he comes better to understand himself and to be "on his own." Understanding is not only expressed through the transference relationship itself but also in activity used to help the young person into experiences and opportunities which will give him skill and strength to take his leave of the worker, as of the parents.[11]

From this statement it would appear that the word and worker can be substituted to read teacher. This type of activity on the part of the teacher can therefore be extremely helpful in the treatment of the adolescent as a supplement to the treatment he may be receiving at a clinic.

Although child guidance workers have developed a fairly definite body of principles and practices there is considerable diversity among clinics.

Helen Witmer's survey of current treatment practices reveals four general types of approach.[12]

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11. Hamilton op.cit. 273-274

12. Witmer, Psychiatric Clinics for Children, p. 56

1. Attempting to make the environment an easier or pleasanter place for the patient to live in.
2. Attempting to find new outlets for the patient's energies or capacities... the building up of new recreational interests, the fostering of undeveloped talents, the encouragement of activities in which he is likely to find success.
3. Removing certain specific internal obstacles so that the patient is put more on a par with his fellows...
4. Direct dealing with the patient's psychic problems, the methods varying with the different therapists.

Usually a combination of these four approaches is found to exist in practice. The divergences are found to exist in the philosophies of the various clinics as well as related to individual treatment goals. There appears to be a fundamental difference between at least the first and the last one. From the latter the clinic would consider as its specific task understanding the child's feelings and desires and would limit the extent of its work with other agencies. However, this seems to contradict the basic philosophy of approaching the total person, as stated previously. Therefore, it does not appear that a dichotomy does exist for if we are to understand and work with the child we must also understand and work with his environment. Here it is felt the school can play a very important role. Not to make the school a treatment institution but rather an understanding and happy environment for the child. One in which the child's maturing processes can develop. Looking to the general philosophy of education we can see that the philosophies of both settings

have at their core the same purposes.

The classical ideal of education was derived from Plato's definition of justice.

"Justice is the harmonious relation of man to society and the chief instrument of justice is free education....education freely pursued to a satisfying conclusion for the individual and for society."

In this statement we find our present philosophy of education and perhaps even more fully of a democratic social order. This statement implies that each man shall be helped to realize his abilities and in turn this man shall find a place in the social system according to his abilities. We see that in a democratic educational system we are attempting to give the child the needed learning experiences to enhance the realization of his native abilities.

The caseworker working with the school should help the teacher to become aware of the causative factors behind the child's defensive mechanisms. The reasons for this are to elicit the teacher's help and cooperation in assisting the child to overcome his difficulties or at least in lessening the pressures placed on the child at school.

Social work with the school aims at the removal of obstacles to the child's education and to the improvement of his behavior in groups.[13]

13. Louis Veo, and Luther Woodward, "Planned Social Work in the School,"American Journal of Orthopsychiatry, VolXl, 1941 pp 2-10.

However, the social worker must never lose sight of the fact that while her focus is on the individual child, the teacher's focus is on the individual also, but through the use of the group. The case worker must not make demands or offer recommendations that are deleterious to the growth and development of the group as a whole.

To bring about a better working relationship between the teaching profession and social work, the social worker must go into the schools more often to provide the school with a knowledge of what the social worker can and cannot do. There should be a respect for school personnel and an acceptance of the fact that the school does not have the responsibility for one child alone, but has equal responsibility for the group. Only by a closer working relationship between teacher and social worker can the maladjusted school child be more effectively helped.

CHAPTER IV

THE GROUP AS A WHOLE

The following section will be devoted to a discussion of some significant material of the group as a whole.

The group studied consisted of twelve cases representing the total population in which a school visit was made by a social worker from September 1949 to January 1953. Of these four are boys and eight are girls. Their ages are from five and one half to sixteen years.

The following table shows the ages of the group and their grades at the time the school visit was made.

TABLE I.

AGE OF CHILDREN AT TIME OF SCHOOL VISIT

AGE	NUMBER OF CHILDREN
5-5.9	1
6-6.9	2
7-7.9	2
8-8.9	1
10-10.9	2
11-11.9	0
12-12.9	0
13-13.9	0
14-14.9	3
15-15.9	0
16-16.9	1
Total	12

TABLE II.

GRADES OF CHILDREN AT TIME OF SCHOOL VISIT

Grade	Number Of Children
Kindergarten	1
1	2
2	2
3	1
4	2
5	0
6	0
7	0
8	2
9	1
10	1
Total	12

The presenting problems of this group are quite varied. However, it is interesting to note that the problems in the main also had some bearing upon the child's school adjustment, although none of the children were referred to the clinic by the school.

The following table indicates the problem of the child at the time of referral and associated problems that appeared as treatment progressed.

TABLE III.

PRESENTING AND ASSOCIATED PROBLEMS

Type of Problem	Number of Cases
Retardation	2
Food phobia	1
School phobia	3
Nightmares	1
School failure	2
Temper Tantrums	1
Fire setting	1
Fainting spells	1
Seizures	1
Nervousness in school	1
Enuresis	1
Sexual Curiosity	1
Atypical behavior	1
Truancy	2
Running away from school	1

Table III shows that of the twelve cases, eight were directly related to the school situation. Of these all showed an emotional component except the cases of retardation. Even in these cases, there was found to be a difficult social situation. In the case of seizures, this problem also affected the child's school adjustment. In relation to the parental attitudes it was found, the parents were either outwardly rejecting or overprotecting. The mothers were usually the dominant figure in the family. The fathers in many cases were passive. In some cases the father was not in the home.

In all the cases except two, only one school visit was made. In the cases of Allan and Dorothy there was more than one visit. In the former case there were three visits and in the latter four visits.

The reasons for the visit to the school were mainly in two categories. The main reason was to give the school information about the child's difficulties and the needs of the child that might be met in the school. This meant giving an understanding of dynamics, intellectual development as well as an explanation regarding the handling of problems such as an epileptic attack during a class. The second reason for the visit was to get information about the child's school adjustment. The workers were usually interested in how the child was getting on with his classmates, his academic achievement and also how the school saw the child's problems.

The following table will present the various reasons for the school visit in each of the cases studied.

TABLE IV.

REASON FOR THE SCHOOL VISIT

Reason For Visit	Number of Cases
Give the school information	7
Receive information from the school	5
Parental insistence	2
Attend classes with the child	2
Work out a tutoring plan	1
Total number of visits	17

The preceding table shows that there were, a total of seventeen visits. Of these seventeen visits, seven were to give the school information. Five of these were concerned with interpreting the dynamics of the children's behavior. The visits in two cases were to give the school information regarding the children's mental retardation.

In the five cases in which the main purpose was to receive information from the school, the visits were mainly aimed toward understanding the children's social adjustments in the school setting.

In the two cases in which the visits were made due to parental insistence, the visits were also intended to clarify the children's school adjustments.

In the case of Dorothy, the second and third visits found the social worker participating in the classroom procedures along with the child and the other students.

An interesting observation is in the cases of Dorothy and Allan. The first visits in each case were to give information and the last visits were devoted to the receiving of information from the schools.

Although the table might imply that a school visit was devoted either to giving information or receiving information, this was not the case. There was a definite sharing of information in all of the cases, with a constant giving and receiving of material. However, the visits were classified in this fashion,

as to present the major emphasis of the clinic's reasons for visiting the schools.

It was noted that of those cases in which there was a direct relationship of the children's problems to the school situations, six of the visits were to give the school information. Three of the visits in this group were for the purpose of receiving information. In one of the cases the visit was also aimed toward receiving information. The seven other visits all had bearing upon the children's problems, but any patterns coming forth to suggest any relationship between the problems and the reasons are not apparent.

Table V will present the information given to the school.

TABLE V.

INFORMATION GIVEN TO THE SCHOOL

Information Given	Number of Cases
Handling of epilepsy	1
Interests of the child	1
Suggested recognition by the teacher	7
Dynamics	5
Allow the child to be promoted	1
Home situation	1
Mental deficiency of patient	2
Parental wishes or attitudes	2
Suggested special classes	2

Table V, although indicating that in only five cases were dynamics discussed during the visits, must not be misinterpreted to mean that dynamics were not discussed in the other cases. It is to be understood that in all cases there was of necessity some discussion of the children's problems and the dynamics behind them. However, the visits in the seven cases associated in this group were intended to give the schools a better understanding in the dynamic areas. That is the main purpose of the visit was to impart dynamic understanding of the child to the school.

As is also evident, the information related had many components. The point is again emphasized in this table that a school visit has many facets to be discussed. Table V shows that in ten cases direct suggestions were given to the school authorities for the handling of the child in question. These suggestions were indicated both by the clinical treatment as well as the evaluation of the school settings.

In all of the cases the workers saw the principals as well as the children's home room teachers. In one case the worker also saw the child's guidance teacher. In two of the adolescent cases the workers had contact with a number of the children's departmental instructors. One worker also made it a point to talk with the child's previous teacher. The workers all evaluated the school setting considering the following, the teachers' warmth or lack of warmth; the teachers' understanding of the children and their problems; their desire to enter into and carry through planning for the children. As each of these were not mutually

exclusive and not discussed fully in the workers' records it is impossible to evaluate the school settings in this regard.

As a result of the school visits some plan was worked out for the children in relation to the school setting. This plan was in accord with the treatment plan for the individual child. It was also in keeping with the limitations of the school settings. Except for one case no definite treatment plan could be worked out, due to administrative difficulties within the educational system of the particular town. A plan was reached between the clinic and the schools in all cases, however, this does not necessarily imply the plans were fulfilled.

The following table will present the plans arrived at between the clinic and the schools for each or the twelve cases. The table will show how the school utilized the information.

TABLE VI.

UTILIZATION OF PLANNING BY THE SCHOOL

Plan to be Enforced	Number of Cases
Special classes	1
More recognition	6
Mother attended child's classes	1
Indefinite plans	1
Teacher visited the child at home	1
Social worker attended the child's classes	1
Child promoted	1
Child taken back to school	1

Table VI shows that in six of the cases, the school plan was to provide more recognition for the child. This was to be employed as the school saw fit. More recognition of the child was to be undertaken in various ways. In some of the cases it was to be praise for achievements no matter how slight the accomplishment. The accomplishment could be even an attempt at hitherto unattempted activities on the part of the child. More recognition of the child's interests was also to be considered in this plan.

In the cases of Michelle and Dorothy, the school made innovations in usual policy. The schools allowed non-school personnel to attend classes along with the patients. It was seen how these plans were part of the treatment process of getting these children back to school. In the case of Laura there is a reversal of this pattern, whereby the teacher visits the child in an attempt to build a relationship which might then allow the child to return to school. Max was put into a special class as a result of the school becoming aware of his mental retardation. In the case of Rebecca, however, no definite plans for special classes could be made as the school did not have any classes for children who were mentally. Millie and Allan presented special problems to the schools and as a result of the visits the plans worked out were also part of the general treatment goals of the clinic. It is also of interest that here too, the schools made special administrative provisions to implement these plans.

In all of the cases studied, the material received in the

school visit helped to confirm the clinic's impressions of the children or else to shed further light upon the children's activities. The school visits in none of the cases basically changed the treatment plans at the clinic. However, the visits did give the therapists of both the children and their parents a better understanding of the reality of the school settings. In two of these cases the reality of the settings as perceived by the schools were almost completely contradictory with the information received from the parents and the children involved.

Table VII will present an evaluation of the success of the school visit. In order to measure the success of the visit it was necessary to determine to what degree the plan was carried through. The following criteria were used;

1. If the plan was carried through to its ultimate, i.e., helped to relieve the child's problem as presented in the school or allowed the child, as a result of the school's activity, to function more adequately in the other spheres of environment, this was called a "good" visit.

2. If the plan was carried through only in part, but in the major areas of the plan, this was called a "fair" visit.

3. If the plan was not carried through at all, or only in very minor ways, the school visit was called "poor".

There can be much said about the value of criteria such as these. However, as there is no way to measure success or failure of any type of behavior other than in terms of achievement,

the criteria measuring the degree to which the plan was carried through is employed in this study.

TABLE VII.

SUCCESS OF THE SCHOOL VISITS

Degree of Success	Number of Cases
Good	6
Fair	4
Poor	2
Total Number of Cases	12

Table VII shows that six cases proved to have successful visits. This is fifty per cent to the entire group. Thirty three per cent or four cases were evaluated as having "fair" visits. The two cases in which the visits were considered "poor" represent seventeen per cent of the cases.

The following material is derived when Tables III and VII are compared: In those eight cases in which the presenting problem was related to the school situation, four of the cases were considered to have "good" visits. This is fifty per cent of this group of cases. Twenty-five per cent of this subgrouping had "fair" visits and the other twenty-five per cent were considered to have "poor" visits.

The relationship of this subgroup broken down into the

success categories, to the success categories of the total population is as follows. The visits evaluated as "good" in this group, represents sixty seven per cent of the total "good" category. The visits evaluated as "fair" are fifty per cent of the "fair" category. The "poor" visits of this group are the total population of the "poor" category.

Comparing table IV and table VII the following information is derived. Of the seven visits made to give the school information or forty one per cent of the total number of visits, the four cases representing these visits were considered to be successful visits or fifty percent of the total in this category. One of the visits to give information was considered "fair". This represents twenty five percent of the "fair" category. There were two "poor" evaluations in the group in which the visits were intended to give information. This is the total population of the "poor" category and represents twelve per cent of the total number of school visits.

The comparision between the cases in table III which were designated to receive information and table VI shows the following. Five visits fall into this group and are twenty nine per cent of the total number of visits. There were two cases in which the visits were considered to be successful. This is thirty three per cent of the cases in this category and twelve per cent of the total number of visits. Three cases in this group of visits were considered to have had "fair" visits. The visits in this "fair" group are eighteen per cent of the total number of

visits and represents seventy five per cent of the cases which were considered to have had "fair" visits. (The remaining five visits or twenty nine per cent were found in the four cases in which the school visits were considered to be successful. These cases represent sixty seven per cent of the cases that were evaluated as successful visits to the schools.)

CHAPTER V

CASE PRESENTATIONS

This chapter is devoted to the presentation of case material aimed toweard highlighting the material found in the discussion of the group as a whole. It was felt, that as the cases fell into three categories of "good", "fair" and "poor" visits, the presentation of cases from these categories would be most helpful to further the understanding of the material. Of the twelve cases used six fell into the "good" category, four into the "fair" category, and two into the "poor" category. Two cases from each category will be presented and a discussion will follow each case. The first two cases to be presented will represent those in the category "good". These will be followed by two cases from the "fair" category. Finally two cases from the "poor" category will be presented.

THE "GOOD" CATEGORY

THE CASE OF DOROTHY

Dorothy was an eight-year-old, rather obese child who was referred to the clinic by the County Hospital because of withdrawn behavior, strange hand movements, sleep disturbances and refusal to go to school. Dorothy was just starting the fourth grade at the time she started treatment at the clinic. She seemed out of contact with her surroundings, lived in a fantasy world, following a ritual of strange steps and hand movements. She would often sing and talk to herself, oblivious of others in the home even when interrupted by her parents or sisters.

Dorothy was living with her parents, her paternal grandmother who was aged and crippled, and her three sisters, Eileen, twenty, Olga, eighteen, and Sue, thirteen.

D. Dorothy's mother had rejected her since birth. Actually she did not want any more children but since she had become pregnant, she hoped that she might have a son. Her preference for a male child stemmed in part from a cultural factor. The male child would always remain with his parents even after marriage, and would assume responsibility for his mother as long as she lived. A girl's independence meant going out into the world which was a threat to mother. As a result mother kept all of her girls very close to her, especially Dorothy. The only time Dorothy would go out would be when she was with her mother or her oldest sister. Her mother expressed a great deal of hostility of a verbal nature toward Dorothy. She could not discipline her and seemed to project this inability on the fact that Dorothy would never again be a normal child. Her mother catered to her every dependency wish and even allowed Dorothy to sleep in the same room with her and father. As a result Dorothy was extremely dependent on her mother and could not dress herself. Mother would call her a baby, and Dorothy would frequently ask her mother if she loved her.

Dorothy seemed quite close to her sisters and also showed great dependency on them. Dorothy seemed to her father than to her mother. Father was somewhat outgoing. He never disciplined Dorothy and her mother resented this. Father and mother would frequently quarrel in the home. This was a matched marriage. Father was in this country and returned to his homeland to pick a wife. There was no period of courtship and mother did not know father previous to the marriage.

Dorothy was the first child mother had to assume responsibility for and thus, mother felt completely helpless in caring for her. Mother would frequently tell Dorothy that because she was a "bad" girl, she would become old and sick like her grandmother. As a result Dorothy feared old age and illness.

Dorothy had no outside contacts with children her own age. She feared leaving the house to go out and could not associate well with other children, withdrawing from any friendly gestures made by them.

Dorothy was hospitalized at the County Hospital for eighteen days becasue of her with-

drawn behavior. During her hospitalization she was freightened, resorted to her world of fantasy, and could not relate on the ward.

Although Dorothy demonstrated a withdrawal from the outside world, she did not develop her school phobia to the point of complete refusal to attend, until after her hospitalization. Dorothy attended kindergarten. There too she seemed isolated. Mother would have to wait with her until the teacher arrived. She did not present any behavior problems in school. Mother attempted to handle Dorothy's fear of school by spanking and urging her to attend at first, than by accompanying her.

There were four visits to the school. The worker interpreted to the school some of the dynamics of Dorothy's behavior and the principal's cooperation was elicited. It was the decision at a conference with the psychiatrist that Dorothy's mother and therapist should attend school and sit in the classroom with her until she was able, to sit alone. At first the principal showed a reluctance to this plan since he stated that the first grade was difficult for most children, and if Dorothy's mother was allowed to attend the class, the other children would want their mothers. The therapist could understand this, and a compromise was reached whereby only the therapist would sit in the class. The therapist attended school with Dorothy for two days. This proved to be a strong supportive therapeutic measure. She sat by Dorothy, recited the lessons with the other children, and Dorothy would follow the therapist's example. The fourth visit was to check on Dorothy's school adjustment. As a result of this collaboration Dorothy continued to attend school.

Dorothy's referral centered around withdrawal from reality and an escape into a world of fantasy which was further intensified after an eighteen day hospitalization which proved traumatic to her. Her major defense of withdrawal, was expressed by school phobia which lasted for a year.

After the worker's help through her support around school, Dorothy was able to conquer her fear of attending school and had no difficulty since that time. It was the worker's impression that Dorothy would have never been able to go to school if the former were not able to sit in the classroom with her.

It was the worker's feeling, that the cooperative working relationship was vital to the resolution of this aspect of Dorothy's problem. Although the clinic initiated this plan, the school accepted it very sinsitively. The school was also grateful for the help the clinic offered them in handling Dorothy's school phobia. This cooperative relationship was like a catalytic agent that helped Dorothy get over this hurdle, namely her school phobia.

THE CASE OF MAX

Max, five and one half years old, was referred through the Home Medical Service of the hospital, as the mother was concerned about the patient and his younger brother being retarded. A note was also received at this time from the nursery school that the patient had attended and which at the present time his brother was attending.

At the time of referral the patient was in kindergarten. He did not talk until the age of four, and walked at two. The mother attributes the patient's difficulties in speech to his being "tongue tied". After the mother had prevailed upon doctors the patient finally had an operation at the age of two, but this did not seem to help. The patient can not coordinate his hands and feet well and is slow in running. He is a good eater and sleeper, but is "nervouw" and can't keep still. The patient is quiet when by himself but wild and stubborn with other children.

Father is described as being illiterate, alcoholic and showing little or no attention to the children. Mother is overconcerned about the patient feeling very strongly about his possible retardation and not able to accept it. She has a warm feeling for the child but forces him into activities which he is unable to cope with.

The child was taken from the nursery school against the school's recommendations. Mother placed the child in kindergarten. At first the patient refused to cooperate in school, but mother "paddled him" a number of times and said after this he did well. The patient was slow in learning to color and mother taught him at home.

Treatment with the child lasted one year. The child would find it difficult to take the therapist into his play and related on an infantile level. Psychological tests found the patient to be operating on a definitely retarded level. Casework with the mother consisted in helping her to accept the child's limitations and also with her marital difficulties.

A school visit was made when the patient was due to be put into the first grade. The reason for this was to acquaint the school with the patient's limitations and to discover the possibilities for special classes. The school was very cooperative and understanding of the patient having planned to place him in special classes. The mother did not wish the patient to continue in special classes at this school, but in one outside of the district. The mother's feelings about this were also discussed at this time, and the school principal made arrangements according to the mother's desires.

At this time the case was refered to a family society as the patient was not in need of treatment, but the mother needed further assistance with her marital difficulties.

In this case it appears the problem focused about the child's apparent mental retardation and treatment was concerned with having the mother accept this and not make too many demands upon the child.

The school visit was made when treatment was to be discontinued, to arrange for special classes for the child. The school was cooperative and willing to make the necessary arrangements, taking into consideration the mother's feelings. It was also learned that the school had independently also decided at that time to arrance for special classes.

THE FAIR CATEGORY

THE CASE OF BRUCE

This is the case of Bruce, a nine year old boy at the time of referral. The patient's mother brought him to the clinic on the advice of a neighbor. The patient was described by mother as having an awful temper, often going into tantrums if his wishes were in any way frustrated. The patient was in the fourth grade.

The patient was an only child living with his parents in the home of his maternal grandmother and a maternal aunt. There was a great deal of friction in the home between father and maternal grandmother. Father felt maternal grandmother made mother too dependent upon her as well as demanding too much work from her. Maternal grandmother was a dominating woman, interfering with the parents in their handling of the child. Maternal grandmother was not in favor of treatment for the child, feeling that he needed more controls and was constantly admonishing him for his hyperactivity.

Mother demonstrated warmth for Bruce but was unable to cope with his behavior due to her own dependency and being an ineffectual person. She was emotionally unstable, having had a "nervous breakdown" when Bruce was three. This condition lasted for one year. Mother was annoyed by the patient's acting out, and would continually reprimand and castigate the boy for his actions especially when his behavior was quite appropriate for his age. It was felt that mother unconsciously provoked Bruce to act out what she would have liked to do but was unable to. Mother also showed

irritation and embarrassment over the boy's sexual advances toward her and his curiousity about the differences between the sexes. Bruce frequently would rub up against mother's legs asking if she had a penis. To queries and actions such as this mother would become embarrassed and state she did have a phallus, fearing Bruce might want to see the differences between the sexes.

Father was described as liking Bruce but would become extremely hostile and verbally aggressive if his wishes were thwarted. Father felt that Bruce had a great deal of energy like himself. He also felt the child's problems were not acute as he also had behaved in the same fashion as a child.

Bruce's relationships with his parents and adults was characterized by aggression on the one hand and a striving for attention and affection on the other. His best relationships were with younger childfen, whom he would affectionately embrace. Bruce would also attach himself to most any adult as a means of seeking love.

Treatment with the child was aimed at allowing him to express his anxieties. A warm accepting atmosphere was provided on then it was attempted to place limits on the boy.

Work with mother was focused on giving her a supportive relationship. The worker reassured mother and also offered suggestions on how to handle his questions and outbursts.

There was one school visit by the clinic to get an objective report on how the child was acting in school, although mother had not reported difficulties in this area. It was learned that Bruce was quite restless and his attention span was quite short. Bruce tried very hard to do what was expected of him in the classroom, but his efforts were not in any way organized. It was also learned that while in kindergarten Bruce had outbursts during which time he would hurl chairs against the walls and indulge in other types of destructive behavior. The present teacher had not seen any temper outburst during her four months of contact with the child. However, teacher said she did not allow him to act out as she was quite firm with him. The boy's dynamics motivations were explained to the teacher and his need for recognition and warmth were interpreted. The plan evolved was to have the teacher give the boy more praene and recognition and allow him to form a closer relationship with her. This plan was in operation

> for about a month when teacher telephoned the clinic perturbed over Bruce's questions in the area of sex. Her anxieties were allayed, but she felt she could not allow the relationship with the boy to remain as close as it had become, but would continue to give him an adequate degree of recognition. There was no follow with the school.

This is a case in which the child's problems were manifested through destructive and uncontrolled behavior. He could not handle frustrations and would resort to temper tantrums upon these occasions.

The school visit in this case was aimed toward getting an objective evaluation of the child's behavior in that setting. A plan was worked out with the school, but the teacher's anxiety did not allow her to follow through completely. However, the teacher did follow the plan in the main and this visit was considered to be fairly successful according to our criteria. However, if another visit had been made at the time of the teacher's phone call perhaps further interpretation could have been given the teacher and a greater use made of the resources in the school.

THE CASE OF SANDRA

> Sandra was a sixteen year old girl and in the first year of high school at the time of referral. She was referred to the seizure clinic by her family doctor. Sandra had had epilepsy since the age of nine. At the time of referral the patient was having seizures about once a month. When speaking to the psychiatrist at the seizure clinic she told of having difficulty with her parents and did not have any friends. The only activity she had outside of the home was attendance at school. She felt she was not getting

along well at school and was uncomfortable in the classroom. Sandra was referred to social service for help in these areas.

The patient was born in the South when the mother was seventeen. The patient never knew her father. Mother was married to patient's stepfather when Sandra was six years old. The parents moved to the North, the patient remaining with her maternal grandparents. The mother later sent the patient's brother, Benjamin, to live with his maternal grandparents. The patient stated she was quite happy with the grandparents until the age of nine or ten, when an aunt and her children moved in. She then felt rejected and at one time when she was eleven, she ran away from home, carrying Benjamin with her.

The patient returned to her parents' home but was very unhappy. Sandra had to take care of the home, the cleaning, the cooking, and caring for her younger brothers. The patient was always having difficulty with her mother and stepfather who did not allow her to have any friends, either male or female. Sandra was almost seduced by her stepfather and felt she would have been, had not her mother returned before the act could be consummated.

The patient states she had always done well in school but from the time she began school in the North she has been finding the work rather difficult. The patient stated she liked school, especially art and English. The patient spent much of her spare time writing poetry or painting. The patient was also concerned about the possibility of being forced to leave school due to her seizures.

The worker wanted to learn if Sandra was going to have to leave school, the extra curricular activities she was partaking in her academic progress, and whether or not she had related to the rest of the students.

The home room teacher and the principal were spoken with and the following information received. Sandra got along quite well with her school mates, usually being with a group of boys and girls during free time periods. Sandra was doing only C work academically and due to this low average could not partake in extracurricular activities. The patient was described as being slow in temperment and hard to talk with. She had a number of seizures while in school which was disturbing to the teacher. The handling of seizures was e xplained to the

teacher, and also some of the personality manifestations of epilepsy as found in Sandra.

The patient's interests in art, poetry, singing and physical training were explained to the teacher. Her difficult home situation was also discussed. The school had been aware of that situation.

A plan was worked out with the school whereby the patient would receive more recognition of her interests and would receive some extra attention in her academic subjects. The school would also try to have the patient enter into some extra-curricular activities.

The patient did receive extra attention and more recognition of her interests which were quite helpful in making her feel happier in the school. However, she was still not allowed to enter into extra-curricular activities.

This is the case of an adolescent who has felt rejected from birth. She has been finding it difficult to have any social outlets due to pressures from home. The patient had been unhappy in school and a visit to the school was made to receive information about the patient's school adjustment. The school visit was only fairly successful, in that, only part of the plan decided upon between school and clinic was implemented. However, the patient did feel more comfortable in school after receiving extra attention and more recognition of her interests. The patient was still not allowed to participate in extra-curricular activities. It would also appear that another school visit might have been utilized to check on the patient's progress and also to try to have the rest of the plan implemented.

THE POOR CATEGORY

THE CASE OF REBECCA

This is the case of Rebecca, a seven and one half year old girl at the time of referral. The patient was referred through the pediatric clinic of the hospital where the mother had taken her for the problem of stuttering.

Rebecca lives with her mother a thirty-six year old woman, her sister Lauretta, two and one half years older, maternal grandmother and mother's second husband. Father is thirty-six years old and has been separated from mother since Rebecca was two and one half years old.

There is little developmental history other than the fact of the patient having been enuretic diurnally until the age of five. During further contacts it was learned that Rebecca had been failing in school and was high strung and irritable at home. She was shy, preferring to be by herself. Sister Lauretta is still enuretic and sporadically breaks out with rashes. Mother feels that sister presents a picture of a good obedient girl often comparing the two children.

Father was an unstable person. Mother married him to get away from home. Father drank heavily, would not work and had numerous extra-marital relations. Father was accused of attempting to attack a fifteen year old girl, living next door to the family and also once attempting to commit suicide. Father filed for divorce which became final four months after treatment began.

Mother is emotionally tied to her parents having a hostile dependent relationship with her mother. The environmental situation is extremely difficult for mother. She displaces her feelings upon the children especially the patient, who is rejected.

Treatment with the child was focused around her problems mainly to develop a warm accepting atmosphere. The patient reacted well to therapy, her symptoms receded to some degree. It was found that patient was dull normal. Mother was helped to be more independent. Through this she was able to react more warmly to patient. Treatment was discontinued

> after a year and mother was referred to a family society for further help with her own problems. This was done as it was felt the child's difficulties arose out of the mother's own inner turmoil.
>
> A school visit was made as mother was complaining of the patient's failing in school. The visit was made two months before treatment ended. It was hoped to discover how the patient was doing academically. The school was helpful, telling of patient's failing work and explaining the difficulty in giving her extra attentions. It was also found that the patient had falsely been accused of stealing, by the teacher and that the teacher was also rejecting the patient. A plan was decided upon whereby the patient would be transferred upon the school's recommendation if they felt it necessary. The transfer would be to the only other school in the city which tried to divide the children into groups of slower and more adept children. However, here too the patient could not receive extra attention. The recommendations were not implemented.

The patient was having difficulty in her speech as well as her school and social life. The school difficulties were found to be the result of the patient's dull normal intelligence. The other problems centered about the mother's displacing her own neurotic conflict onto the child and rejecting the patient. The focus would be on the mother's difficulties and she was referred to a family agency for help with these. It was felt that the patient would improve in her social adjustment as mother became more accepting.

A school visit was made to discuss the patient's school failure and to see about the possibilities for special attention and special classes for the child. Although, the school seemed

cooperative and understanding the recommendations were not acted upon. It was also found the teacher was rejecting the child and that there was little possibility for the child to receive the needed special attention as the school system did not have any provisions for the retarded child.

THE CASE OF MICHELE

This is the case of Michele, a six and one half year old child at the time treatment began. Treatment lasted for thirteen months, and was never able to leave her mother to enter the playroom with her therapist. However, when mother would go to see the social worker, Michele was able to leave her mother although she would enter the interviewing room once or twice during the hour. The patient was referred for the problem of school phobia.

The patient is one of three children, her twin Laura and her sister Barbara, twelve. Mother is forty and Father thirty three. He is a produce manager. The parents are of different ethnic and religious backgrounds. The parents were married against their families wishes describing the marriage as one of "spite."

The patient was referred to the children's psychiatric clinic by the X clinic. The presenting problem was that the patient could not go to school. The patient had started kindergarten a year before starting treatment, and was doing well, but at the end of the year the family moved, and the twins were put into different classrooms. The patient got along well until teacher reprimanded her, threatening to send her back to kindergarten. The child became upset and refused to go to school. The mother felt the patient would go to school if in her sister's class. This was arranged and Michele returned to school until the previous teacher entered the room. At this time she became hysterical and would not return to school. The mother talks of both teachers as being "old battle axes," and not giving Michele enough attention.

The twins were born with "upside down stomachs" and had pneumonia and rheumatic fever within the first two years of life. The mother describes herself as feeding them with eye droppers and staying up all night with them. Mother claims she received no help from father other than his bringing her a sandwich when he came home from work.

The twins are still sleeping in cribs and have to curl up in order to fit. Mother states she cannot afford to buy beds. However, it was suggested that mother visit a number of philanthropic organizations but she was unable to follow through on this.

Mother is quite ambivalent about Michele, one moment feeling how good the child is and telling how dependent the child is on her, seeming to enjoy this. She then projects her own feelings onto the teachers, she claiming they are rejecting the child and not giving her enough attention.

The mother had gone to school with Michele a number of times but was unable to allow the child to separate. The child, however, seemed eager to separate but when the mother saw this refused to take the child to school any longer. She stated she felt uncomfortable in the school and that the teachers did not like her just as they did not like the child.

The child had a good relationship with her therapist and enjoyed her visits, but was not free to act in an uninhibited way. She would continually look from therapist to mother before attempting anything.

One school visit was made after the first few sessions. The reason for the visit was to gain information as to the child's activity in school and also to try to give them insight into the dynamics of the situation. The school seemed willing to cooperate and they were very understanding of the problem. The child's teacher was very warm with her children and seemed to have a strong relationship with them. The child's former teacher was also spoken with and although she seemed to be less warm to the child, stated she never used corporal punishment. With the principal a plan was worked out whereby the mother was allowed to go to classes with the patient.

> This was done for a number of weeks until teacher and principal felt this was too disturbing to the other students. At this time the principal started blaming the mother for the child's problem. The principal also recommended the patient's commitment to the state hospital. It was also discovered that although the child would make efforts to enter the school by herself, mother would not allow this.
>
> During the school year a number of phone contacts were made with the principal who felt the child was not being helped and was disturbing to the other students. She recommended a home teacher but was made to understand that this would not have the child in school. At the beginning of the second school year the superintendent of schools heard of the case and made an appointment for the child to be seen at the state hospital as he felt they worked better with the out-patient department. At this time the mother refused further treatment at this clinic as the therapist and social worker she had known had left. The referral to the state hospital was carried through.

This case shows a child who is not allowed to free herself from her mother due to the mother's overprotective attitude and close identification with the child. The problem focused around the mother's inability to let the child go, due to her rivalry with teachers and therapists for the child's affection and also for the affection they were giving the child.

At the beginning of the school contacts a close cooperation with the school in sharing of information and for a plan to help the mother separate from the child was achieved. However, the school could not go along with the plan due to administrative difficulties and became hostile toward the mother. Frequent telephone conversations did not seem to be effective in helping the school

understand the problem or to work out a new plan. Finally the school made a referral to another clinic without consulting the clinic in which the child was being seen and played into the mother's resistance to treatment.

In short the reason for the visit was to help in planning a method to allow the mother to let the child go to school. At first this was helpful and a greater understanding was achieved, but eventually the school became antagonistic toward the clinic. If further visits were made to discuss these differences perhaps a harmonious plan could have been developed.

CHAPTER VI.

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

The author attempted to study the use of the school visit by the child guidance clinic. Twelve cases from the Massachusetts Memorial Hospitals, Children's Psychiatric Clinic were employed as the study group. The cases represent the total population of school visits by a social worker at this clinic, during the period from September 1949 to December 1953. The author set for himself the purpose of trying to understand how the school visits were employed as part of the treatment process. From this purpose he attempted to evaluate the value and extent of the school visits as well as possibilities for further cooperation in this area.

Of the twelve cases studied four are boys and eight are girls. The ages of the group ranged from five and one half to sixteen years. Their school grades ranged from kindergarten to grade ten. The presenting problems were quite varied. However, eight of the presenting or associated problems had direct bearing upon the school situation.

It is interesting to note that in all cases the parents were either overtly rejecting or overprotective. The mothers were mainly dominant figures in the family. In those cases in which the father was in the home he was usually quite passive.

There was a total of seventeen visits. Except for two cases there was only one visit made for each child. The reasons

for the visits, for the most part, were either to give information to, or receive information from the schools. This was true in twelve visits; seven to give and five to receive information. Two visits were made due to parental insistence arising from concern over the children's school adjustments. In two visits the worker sat in classes with the child, partaking in the learning activities with the child. The remaining visit found the social worker working out a tutoring plan with the school. When the reasons for the visits in those cases with problems, having direct bearing upon the children's school adjustment, were analyzed, the visits to give information were twice those to receive information. However, in all the visits it must be kept in mind that there was a definite sharing of information between the two institutions. The distinction was made on the basis of the main reason behind the clinic visit to the school.

The information given to the school was quite varied. However, in all cases whether the visits were intended to give dynamics or not, dynamics of the child's behavior and the child's needs were discussed. The visits in which information was received focused mainly about the child's social adjustments and behavior in the school. This implies that the information shared in the school visits had many aspects.

The school visits were made as part of the treatment plan. Therefore, some sort of plan with the school for the handling of the individual child's problems, in the school setting, was

sought. In all cases except one, a definite plan was achieved. The plan arrived at was as to how the school was to utilize the information shared. However, the implementation and responsibility for carrying through the plan was to be decided by the school. More recognition of the child through praise for achievement, was the plan worked out in half the cases studied. The accomplishments to be praised were quite varied.

In two of the cases the plans achieved were innovations in usual school policy. These plans were to allow non-school personnel to attend classes with the patients. In one case of school phobia the teacher visited the child in a successful attempt to have the child return to school. In another case a special class was arranged for the youngster. Another case did not have any definite plans worked out due to administrative difficulties within the school.

The school visits helped to confirm the impressions of the clinic, or shed further light on the children's problems. The visit did not in any way basically change the treatment plans at the clinic. However, the visits did give the therapists of the children as well as the mothers' workers a better understanding of the reality in the school settings.

It was decided to measure the degree of success of a school visit according to what degree the plans established by the clinic and schools were carried through. The criteria for so doing were:

1. If the plan was carried through to its ultimate, i.e.,

helped to relieve the child's problems as presented in the school or allowed the child, as a result of the school's activity, to function more adequately in the other spheres of his environment, this was called a "good" visit.

2. If the plan was only carried through in part, but in the major areas of the plan, this was called a "fair" visit.

3. If the plan was not carried through at all, or in only very minor ways, the school visit was called "poor".

Six or fifty per cent of the cases had successful or "good" visits. Thirty three per cent, or four cases, were found to have had "fair" visits. There were two cases in which the visits were considered to have been "poor", representing seventeen per cent of the total number of cases.

In the eight cases having problems directly associated with the school fifty per cent were considered to have had "good" visits. Twenty five per cent had "fair" visits. The "poor" visits also constituted twenty five per cent or this group.

Seven visits made to give information to the school were found in seven cases. Of these seven cases, four cases were found to have "good" visits, one case had a "fair" visit and two cases had "poor" visits.

Twenty nine percent of the school visits made were to give the school information. Comparing these cases with the degree of success of the visits it is found that thirty three per cent of the visits in this group were to be considered "good"; sixty

seven percent having "fair" visits.

The author will now answer the questions he set for himself and also make some recommendations.

1. What is the value of the school visit?

As the study group showed there were but two cases in which satisfactory school visits were not had. This leaves one to assume that in the other cases the visits were successful in that they did give to the child more of a treatment area than had before been available. This alone is of value to the clinic as well as the school as each is devoted to helping children to grow. The school is made aware of the child's needs and problems and a plan is worked out which is in line with treatment goals of the clinic. This further value definitely highlights the general value of the school visit.

2. How and to what extent did the school and clinic collaborate in the treatment of the child?

In all but two cases there was a definite collaboration between school and clinic to work out a plan within the school setting to help further the treatment area for the child. There was a definite sharing of information and in ten of the cases studied, the plan derived was carried through. For the most part, this type of collaboration in a face to face relationship is essential if the clinic is to help the child in his total environment.

3. What possibilities are indicated for more positive cooperation between schools and clinic?

It appears to the author that in all of the cases studied there existed a need on the part of both the school and the clinic for further contacts. These contacts would be to give the school information about the child's progress at the clinic and for the clinic to receive information about the child's progress in school, as a result of the plan worked out between the two. This would allow for a nutual reconsideration of progress and any changes that might be indicated as regarding future actions of both concerned.

There is one major recommendation that seems to come from this study. In none of the cases did the author feel that the worker and the school were working in a team approach to the child. Therefore, it appears to the author that if the clinic were to make its services known to the school in the form of lectures, case presentations, and case conferences on a larger scale a team approach might be had. It would also set in motion the establihsment of a mutual vocabulary which would break down the present barriers to communication.

In line with this recommendation it also appears to the writer that school visits should be made in all cases in which children are concerned even if no definite changes in procedure are warranted. A step such as this would insure the child all possibilities of help.

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Appendix

SCHEDULE

1. Age:

2. Sex:

3. Grade:

4. Referral:
   a: By whom:
   b: Presenting problem:
   c: Associated problem:
   d: When referred:
   e: Age at referral:

5. Face sheet information:
   a: Mother: Age: Religion:
   b: Father: Age: Religion:
   c: Marital status of parents:
   d: Siblings:
      Name: Age:
   e: Other people in household:

6. Developmental History:
   Including relationship to parents, siblings, school, and friends.

7. Relationship to treatment:
   a: Mother:
   b: Patient:

8. Any other pertinent information found in the record:

9: Treatment methods and goals:

10: Reason for the school visit:

11: Number of visits:

12: Information given to the school:

13: Information received from the schpol:

14: Impressions of school visit:

15: How was the information utilized:
   a: School:
   b: Clinic:

16. Relation of school visit to total treatment plan:

17. Possibilities for further work between school and clinic:

18. Evaluation of the school visit: