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A study of Massachusetts Society for the Prevention of Cruelty to Children referrals to the Judge Baker Guidance Center, 1938-1939

BOSTON UNIVERSITY
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A STUDY OF MASSACHUSETTS SOCIETY FOR THE PREVENTION OF CRUELTY TO CHILDREN REFERRALS TO THE JUDGE BAKER GUIDANCE CENTER 1938-1939

A Thesis

submitted by

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INTRODUCTION

Purpose

The protective agency and the child guidance clinic offer specialized services in the field of child welfare. Their functions and procedures are quite different, but their long range objectives are identical - the optimal growth of children.

Occasionally the child guidance clinic may request the services of the protective agency, at other times the protective agency asks for the clinic's services - depending upon the need of the individual situation.

This paper will be concerned wholly with the serviees rendered by the clinic to the child while under the supervision of the protective society.

An attempt will be made to analyze the methods of procedure and the principles inherent in the use of the child guidance clinic by the protective agency. We shall try to discover the conditions precipitating referral to the clinic, and the services requested of the clinic. We shall find out whether the referring agency carries out the clinic recommendation or the reasons for not doing so. Thus, why did the protective agency refer the cases to clinic? And to what extent was the agency able to benefit from the clinic's service? It is hoped that the study will derive what factors made for progress and what factors handicapped treatment of

the children.

Finally, it is desired that this study will reveal some of the basic factors that underlie the effective use of a child guidance clinic by the protective agency.

Scope

This paper is limited to a study of the cases referred by the Society for the Prevention of Cruelty to Children to the Judge Baker Ghidance Center over a two-year period, 1938 and 1939. For purposes of clarification and understanding, a brief summary of each agency's history, function, procedures, and policies will be given. This is not mainly a study of clinical treatment and an evaluation of its results. It is a study of the selection of the Judge Baker Guidance Center as a community resource by the Society for the Prevention of Cruelty to Children, and the cooperative efforts of the two agencies.

Method

The background material for this study was obtained from annual reports, articles, and studies. Additional information was received through interviews with the supervisor in the Boston office of the Society for the Prevention of Cruelty to Children, with the directors of the Judge Baker Guidance Center and with several other workers on the staffs of the two agencies.

The analysis of diagnostic services is based on 50 cases

referred by the Society for the Prevention of Cruelty to Children to the Judge Baker Guidance Clinic from January 1, 1938 to January 1, 1940 by the Society. The two-year period provided enough cases for the purposes of the study, and sufficient time has elapsed for the Society for the Prevention of Cruelty to Children to act upon the cases since the clinic findings were made.

During the two-year period, 1938 - 1939, 52 cases were referred by the Society for the Prevention of Cruelty to Children and received diagnostic service. Other cases may have been referred during this period but they, for some reason, did not go through the routine procedure. Of the 52 cases, 2 were dropped from the study because the material available was inadequate for the purposes of this study.

A schedule was drawn up to aid in the transcription of data from the records.[1] This schedule was the guide in obtaining the information pertinent to this study. After the schedule was tested and proved satisfactory, the 50 case records at both agencies were studied and the pertinent material was recorded on charts. The case material up to the time of clinic referral was taken from the Society for the Prevention of Cruelty to Children's records. The material acquired from the clinic included: psychological and medical findings, psychiatrists' and social workers' interviews, and

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[1] See Appendix

conference recommendation. Material concerning the referring agency's action on the cases after the diagnostic study at the clinic was taken from the Society's records. In some cases, other agencies were consulted to find out the present location of the children.

Throughout this study the Society refers to the Massachusetts Society for the Prevention of Cruelty to Children and the Clinic refers to the Judge Baker Guidance Center.

CHAPTER II

THE PROTECTIVE AGENCY

The Massachusetts Society for the Prevention of Cruelty to Children

The Massachusetts Society for the Prevention of Cruelty to Children is the second oldest chld protective agency in the United States. It received its charter from the state of Massachusetts in 1878. This occurred 4 years after Mary Ellen, the first child to be brought into any court as neglected, was found neglected under "cruelty to animals" act in a New York courtroom. The Society was organized by a group of influential citizens

> for the purposes of awakening interest in the abuses to which children are exposed by the intemperance, cruelty, or cupidity of parents and guardians, and to help the enforcement of existing laws on the subject, to procure needed legislation, and for kindred work.[1]

For the first 25 years, emphasis was placed upon the legalistic aspects of the cases. The Society concerned itself with the discovery of neglect and abuse, prosecution in court, securing laws for the protection of children and enforcing those laws. However, this agency never had policy power.

In 1907, with C. C. Carstens as general secretary, the Society expanded into a state-wide agency with branch offices

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[1] Society for the Prevention of Cruelty to Children Annual Report, Boston, page 33, 1938

throughout the state. At the same time emphasis was shifted from prosecution of the parents to prevention of neglect and abuse of children. The annual reports of the Society during the last 30 years consistently emphasized the proportionately small number of cases in which it resorted to court action. This occurred in approximately one-fifth of the total number of cases coming to the attention of the Society.

The purposes of the Society are the prevention of suffering by children from want of proper physical care and of physical abuse or injury, the protection of children from moral corruption, and from non-support and desertion by the parents. It aims to find suitable guardians for children of unfit parents, and prosecutes offenses against children. It is continually shaping legislation and organizing public opinion to the end that child neglect and abuse may be eliminated.

Child protection is a highly specialized service in the general field of child welfare. In Massachusetts it has been left exclusively to the Society. In Providence, Buffalo, Minneapolis, and Los Angeles the child protective agencies combined with other children's organizations in the interest of more effective coordination of effort. The responsibility for the protection of children not receiving the minimum amount of care in the home rests finally upon the State. Children's protective service, however, has been left to private initiative and support. No matter what organization

takes the responsibility,

> the protective service must seek to assure to every child within its territory at least the minimum of opportunity for normal growth and development which the common opinion of the territory regards as essential. In this effort it must strive to discover and eliminate all obstacles to such development, whether within the child or around him.[1]

In keeping with the above policy, the Society investigates all complaints concerning neglect, cruelty or abuse of children. These complaints come from police, courts, schools, relatives, neighbors, other agencies; or they may be anonymous. The agent visits the families for the purpose of alleviating the conditions that contribute to the neglect or abuse of the children. If the problem involves medical neglect, the agent usually has the child's medical needs taken care of at one of Boston's hospitals. The Society office in Boston employs a physician who examines the child when there is a question of possible medical neglect or when the child is to be admitted to the Temporary Home.

The Society maintains a home to provide temporary shelter and care for children. It takes care of children whose immediate removal from their own homes is necessary because of neglect and abuse. It also houses children from outlying territories who need study or treatment at local clinics or hospitals.

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[1] Child Welfare League of America, Standards for Child Protective Organizations, (New York: 1937), p. 7.

In carrying out its function, the Society uses the court only as a treatment measure when other efforts have failed and not as a punitive instrument. It is vested with the power to recommend removal of a child from its home, but recognizes the need for careful deliberation before action.

Before the Society decides what course of action to take regarding the children, it may consult specialists for advice so that they may better understand the children and have a guide for treatment. We shall concern ourselves with the Society's use of the Judge Baker Guidance Center as such a resource.

CHAPTER III

THE CHILD GUIDANCE CLINIC

Judge Baker Guidance Center

In terms of years the child guidance clinic is a youthful organization. When the juvenile courts were established they were primarily concerned with finding solutions for the problems of children. A new methodology for the treatment of neglected and delinquent children was introduced - the psychiatric approach. The individual child was to be studied with reference to his physical, emotional, mental, and environmental life. Thus, in 1909 the Juvenile Court of Cook County, Illinois, established the Juvenile Psychopathic Institute, later the Institute for Juvenile Research, with Dr. William Healy as Director. From that nucleus, because of community demand, and with the impetus of the Commonwealth Fund, more than 250 child guidance clinics have been established to date. In 1917 Dr. Healy became the director of the Judge Baker Foundation, now the Judge Baker Guidance Center. For the first 5 years the aim was solely to study juvenile delinquents who would not respond to ordinary probationary treatment. In 1922, however, it offered its services to other social agencies including the Society for the Prevention of Cruelty to Children. Gradually, with increased funds, it expanded its activities to include psychiatric treatment facilities, a research program and training for

workers in the child guidance field. Now, the majority of referrals come from private families and the schools, while the others come from social agencies.

The Clinic helps children who present conduct, personality, behavior, educational, and vocational problems, by studying them and their life situations, by giving advice and offering treatment.

> It attempts to marshal the resources of the community in behalf of children who are in distress because of unsatisfied inner needs, or are seriously at outs with their environment - children whose development is thrown out of balance by difficulties which reveal themselves in unhealthy traits, unacceptable behavior, or inability to cope with social and scholastic expectations.[1]

The Clinic is set up to accept the following types of cases:

> Those involving personality difficulties, e. g. excessive timidity, unhappiness, over-activity, unpopularity, etc., or undesirable habits such as enuresis, masturbation, temper tantrums, etc., behavior problems, e. g. truancy, lying, stealing, etc., vocational maladjustments... The clinic does not accept those where the major problems seem to be mental defect, mental or physical disease; those where parents are unwilling for study to be made, unless the child is already under the care of the agency referring.[2]

These services are carried out by a team including the psychologist, psychiatrist, and psychiatric social worker, who follow a fourfold plan of study for each child. It includes a psychological examination - which measures intellectual

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[1] George Stevenson and Geddes Smith, Child Guidance Clinics - A Quarter Century of Development (New York The Commonwealth Fund, 1934), p. 1.

[2] Judge Baker Guidance Center Policy Book,(Boston)

development, educational achievement and possibilities, and special abilities and disabilities - a careful physical examination, and interviews with a psychiatrist to find out the child's own point of view toward his difficulties. At the same time, the social worker obtains a social history from the parents which constitutes a setting for the problem which the child presents. In some cases referred by social agencies, circumstances make it impossible for the parent to come to the clinic. At such time a summary from the agency must suffice as the social setting.[3] In those cases it is of prime importance for the referrer to obtain the attitudes of the parents or guardians towards the child. Each member of the staff who studies the case then comes to a conference at which time the information is pooled, causative factors are analyzed, and recommendations for treatment possibilities are made. These recommendations depend entirely upon the individual situation. Some of them are: medical or psychiatric treatment, modifying family attitudes, change in school program, new recreational opportunities, foster-home or school placement.

The Clinic offers 3 types of service: diagnostic, treatment, and cooperative. The diagnostic study consists of physical, psychological, and psychiatric examination of the child, and a social investigation, followed by a staff conference at which the referring agency participates. Recommendations for immediate steps in treatment are formulated,

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[3] See Appendix

the treatment itself to be carried out by the referring agency. The Society receives this service. The treatment service, in which the clinic assumes the main responsibility for both psychiatric and social treatment, applies primarily to cases referred directly from parents or schools. However, a few cases referred by non case-working agencies may come under this group. The cooperative service contemplates joint responsibility for treatment program after the original study of the case. The history may be secured entirely by the social agency or may be supplemented by the Clinic workers by individual arrangement. After the study, a conference is arranged with the agency worker and members of the clinic staff who have studied the child, for an exchange of opinions as to the significant factors operating in the case. At that time specific plans for treatment are made, including determination of the part the clinic and the social agency shall play. Subsequent conferences on the same case may occur at the initiation of the referring agency worker or at the request of the Clinic. When the Clinic study definitely recommends seeing the child again, it is the agency worker's responsibility to arrange this appointment.

CHAPTER IV

RELATIONSHIP BETWEEN THE TWO AGENCIES

The Society was among the first social agencies to take advantage of the services offered by the Clinic. Each consecutive year it has referred more cases to the Clinic for study than the previous year. The Society, like the court, is given diagnostic service whenever it is requested. A suggested outline for referral to the Clinic is filled out by the Society agent and sent to the Clinic social worker previous to their contact with the child or family. This outline follows closely the summary used by the Clinic for its staff conferences. The Society agent explains the Clinic set-up to the child and family so that each may have an understanding of its function and procedure. If the child has been known to the court in any way, the Society agent explains to the family that any information disclosed in the Clinic will not be used as evidence in court. The Society agent attends the staff conference and discusses the treatment recommendations with the Clinic staff. If the recommendation for any reason cannot be carried out, the workers meet again to discuss further plans.

CHAPTER V

THE CHILDREN AND THEIR FAMILIES AS KNOWN TO THE SOCIETY

Presenting Problems

In general, the Society is concerned with abused and neglected children where this is culpability on the part of those legally responsible for their welfare. The families and children may come to the attention of the agency on varied complaints. Although the presenting problem , that is, the problem at the time of referral to the Society, varies with each case, certain factors naturally predominate. The main elements contributing to the initial complaint are tabulated at the top of the next page. Occasionally more than one element is present in a case. This table reveals that physical neglect and intemperance on the part of the parents occurred most frequently. Those classified under delinquency included boys and girls who ran away from home, truanted from school, or were brought into court on a stubborn charge. Fourteen percent of the children were morally neglected in some way; the parents sometimes operated disorderly houses, or they were living lewdly with other people. Forty-four percent of the cases came to the attention of the agency because one or both of the parents left the home and the children failed to get the proper care. Mental illness, death, separation or desertion on the part of one or both parents were the reasons for that condition. The main deduction to be made from the presenting problems, in the

TABLE I

MAIN ELEMENTS IN INITIAL

COMPLAINT TO SOCIETY OF CHILDREN

Order of Frequency	Elements Studied	Times Occurring	Percent
1.	Physical Neglect	24	48
2.	Intemperance	16	32
3.	Delinquency	10	20
4.	Separation of Parents	9	18
5.	Moral Neglect	7	14
6.	Illegitimacy	6	12
7.	Insanity	6	12
8.	Desertion	4	8
9.	Physical Cruelty	4	8
10.	Indecent Assault	4	8
11.	Semi-orphanage	3	6

light of the fact that the cases were later referred to the Clinic, is that only 28% of the cases initially involved specific problems on the part of the children. The others were environmental or family situations and the major problem was not that of any particular child.

The elements in these cases correspond closely to the elements in neglect of 5,530 families coming to the attention of the Society in 1939.[1] In the cases later referred to the Clinic, intemperance, delinquency, separation of parents, insanity, and indecent assault rated slightly higher. Physical neglect, moral neglect, and semi-orphanage rated slightly lower than in the bulk of the cases referred to the Society during 1939. In our 50 cases one or both parents were out of the home in 44% of the families, while in the larger group at least one of the parents was out of the home in 40% of the families. One can say that our cases are representative of the bulk of the cases coming to the attention of the Society.

Since many cases were referred to the Society because of the environmental situations, one might ask: How long was the family known to the agency before the worker thought it advisable to refer the child to the Clinic? The following table shows the length of time that elapsed between the Society's initial contact and referral to the Clinic.

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1 Massachusetts Society for the Prevention of Cruelty to Children Case Studies, 1939.

TABLE II

LENGTH OF TIME CHILDREN WERE KNOWN TO

SOCIETY BEFORE CLINIC REFERRAL

Length of Time	Boys	Girls	Total	Percent
Under one week	0	2	2	4
1 week to 1 month	3	4	7	14
1 month to 2 months	2	2	4	8
2 months to 6 months	2	3	5	10
6 months to 2 years	2	5	7	14
2 years to 5 years	1	6	7	14
5 years to 8 years	3	4	7	14
8 years to 11 years	1	2	3	6
11 years to 14 years	2	3	5	10
14 years to 17 years	2	1	3	6
Totals	18	32	50	100

The cases were known to the Society before Clinic referral anywhere from less than a week to 17 years. The distribution was fairly even throughout that period of time. Fifty percent of these cases were known to the Society over 2 years, 36% of them were known over 5 years and 20% of them were known more than 8 years. Of the cases referred less than 6 months after the initial contact, 6 were "run away" adolescent girls, 2 were "run away" boys. One girl was referred because of indecent assault by a neighbor; one boy came to the attention of the Society because of physical cruelty on the part of his mother. The 8 other cases referred within 6 months involved physical or moral neglect and necessitated immediate placement. In those cases where the Society had more than 6 months' contact before referral, the child was not referred until some crisis situation developed at home, until the child got into some sort of difficulty in school, or until the Society agent had enough evidence to bring a neglect charge against the parents in court.

Family Background of Children

A study of the economic status of these families revealed that the majority of the families were of the economically dependent group.

For purposes of classification, the dependent group included those who were receiving help from public or private agencies. The marginal group included those who were "getting along" without aid from any agency but who had a difficult

TABLE III

ECONOMIC STATUS OF CHILDREN'S PARENTS

Status	Boys	Girls	Total
Dependent	10	21	31
Marginal	3	7	10
Moderate	5	4	9
Totals	18	32	50

time maintaining themselves. The moderate group were economically secure and had no threat of dependence. These facts were taken directly from the Society referral sheet. Thirty-one of the families were dependent, 10 of them came within the marginal group, and 9 families had moderate incomes.

In every case where the family came within the moderate group, the source of the difficulty was stated to be with the parents. In 2 cases the mother was sent to a mental hospital and the father left the children alone most of the time; in 2 cases the step-mother rejected the child; in 1 case the mother was dead and the father was a heavy drinker. In the other 3 cases the parents were living together, but there was much discord between them.

More important than the economic status of the families is the marital status and compatibility of the parents.

TABLE IV

MARITAL STATUS AND COMPATIBILITY OF PARENTS

Status of Parents	Boys	Girls	Total
No Marked Incompatibility	1	8	9
Parents Divorced	5	4	9
Parents Legally Separated	3	5	8
Marked Incompatibility	4	2	6
Mother Dead	3	3	6
Father Dead	0	3	3
Mother Not Married	1	2	3
Mother in Mental Hospital	0	3	3
Separated - Not Legally	1	2	3
Totals	18	32	50

These facts were noted at the time of the child's referral to the clinic. In 41 of the 50 cases the family structure was markedly distorted. At this time at least one of the parents was permanently out of the home in 70% of the cases. In 7 cases the child had a step-father and in 4 cases the child had a step-mother. Three of the children had adopted parents. Since it was often difficult for the Society agent to determine the marital status of the parents from interviews with them, the agents made it a policy to check the marriage records of all parents and the birth records of

the children.

Although there was no marked incompatibility in 9 cases, in only one case was the family relationship harmonious. In that case the adopted child went to the Home for Distitute Catholic Children and wanted to stay there. She was looking for her siblings. Where there was marked incompatibility the child often sided with one parent against the other; sometimes the child felt ashamed of both parents. In 3 cases the child rebelled against the father's harsh treatment and continual drunkenness by running away. When the mother or father was dead, or when the mother was sent to a mental hospital, the other parent often neglected the child - at a time when the child needed security and affection all the more. Most of the family relationships were negative for the wholesome upbringing of the child.

Consideration of the parents' physical health shows that in 8 families one or both parents were frequently ill. However, mental illness seemed to occur more often than physical illness. As stated before, 6 of the mothers were in mental hospitals; in another case the mother was diagnosed as "psychopathic personality." In 3 cases one of the parents was diagnosed as "alcoholic psychosis." In 6 other cases the Society agent described one of the parents as being "peculiar" or "very nervous" or"neurotic."

In so far as physical or mental fitness of the parents may reflect the general atmosphere of the home, the above

facts are illustrative of the possibilities for the occurences of friction in the homes of these children.

Where do these families reside? A study of their residences reveals that approximately half of them live in Boston and the others live in communities near Boston.

The following table reveals that 21 cases came from Boston and that 23 communities were represented in the cases that came from the surrounding area. Seven cases were referred from district offices of the Society. They included: Attleboro, Brockton, Dedham, Hyannis, Lawrence, and Lowell. Three of these were placement problems; the others were personality or conduct problems. Twenty percent of the families resided in the South End and Roxbury districts of Boston.

TABLE V

RESIDENCES OF CHILDREN AT TIME OF REFERRAL TO CLINIC

Place	Boys	Girls	Total
South End	3	3	6
Roxbury	2	2	4
East Boston	0	4	4
Back Bay	1	1	2
Dorchester	1	1	2
Allston	0	1	1
West End	0	1	1
South Boston	0	1	1
Boston	7	14	21
Somerville	2	3	5
Attleboro	0	2	2
Dedham	0	2	2
Everett	0	2	2
Lexington	1	1	2
Medford	1	1	2
Misc. Places (one each)	7	7	14
Totals	18	32	50

CHAPTER VI

THE CHILDREN AT THE TIME OF REFERRAL TO THE CLINIC

Referral Process

Before the Clinic workers see the child, the Society agent fills out the suggested outline and sends it to them. This summary is particularly important to the Clinic staff, since the Society receives the diagnostic service. A study of these outlines revealed that the Society agents consistently failed to answer the "Explanation about Clinic to Parents and Children." No mention of any explanation was found in 40 cases; in the other 10 cases there was merely a statement that an explanation was made. The Clinic finds it very helpful, in working with the children, to know what impressions the parentsand children have of the Clinic. It is important for the parents and children to know that 3 or 4 interviews are usually necessary for a diagnostic study, that the Clinic is not connected with the court, and that no information the children might give while at the Clinic will be used as evidence in the courts.

Age and Sex of Children

How old were these children when they were referred to the Clinic? The following table lists the children according to their age and sex.

TABLE VI

DISTRIBUTION OF CHILDREN ACCORDING TO AGE AND SEX

Age	Boys	Percent of Total Number	Girls	Percent of Total Number	Total Number	Percent of Total Number
Under 9	2	4	0	0	2	4
9 to 11	5	10	1	2	6	12
11 to 13	3	6	6	12	9	18
13 to 15	2	4	10	20	12	24
15 to 17	5	10	13	26	18	36
17 or over	1	2	2	4	3	6
Totals	18	36	32	64	50	100

This table shows that 64% of those referred were girls and 36% of them were boys. This large number of girls is not what one would expect to find. The case load of the Clinic always shows a preponderance of boys. A study based on the total intake at the Clinic during the last quarter of 1938 indicated that there were twice as many boys as girls in that group. Of the 32 girls, 25 of them were adolescents. In fact, 50% of all the cases were adolescent girls.

There was no predominance of boys at any age level. Ten of them were younger than 13 and 8 of them were 13 years of age or over. Probably the boy is more likely to show his problems at an earlier age than the girl shows her problems. It is

reported in several studies that the adolescent stage produces more problems in girls, while the boys are more apt to show their problems much earlier. The definite lack of small children referred to the Clinic may indicate that the Society agent works with the family on a case-work basis for several years before consulting the Clinic for advice on treatment.

The Problems at the Time of Referral

The problems at the time of referral to the Clinic were classified into 5 main groups with sub-headings where necessary. The main classifications were: Placement problems, Neglect - Child-plan, Conduct problems, Personality problems, Educational problems. In several cases it was difficult to group the problems under the above headings as they could be classified into more than one group; therefore, the classifications were made on the basis of what the Society stated as the main reason for referring the case. Table VII shows the numerical distribution of the various problems.

Those figures indicate that in 22 cases the main problem was that of placement. In 10 of these 22 cases the Society wanted advice on disposition of neglect case in court. It is interesting to note that in 48 out of the 50 cases the Society was considering possible placement.

None of the girls was referred as a personality problem and there were only 4 personality problems amoung the boys.

For purposes of clarification each classification of

TABLE VII

MAIN PROBLEMS OF CHILDREN AT TIME OF REFERRAL TO CLINIC

Problems	Boys	Girls	Total
Placement Problems	4	8	12
Neglected, Child-plan	2	8	10
Conduct Problems			22
Running away	1	7	
Stealing and Lying	6	1	
Sex Misconduct	0	1	
Out Late at Night	0	3	
Personality Problems			4
Temper Tantrums	2	0	
Stubbornness	2	0	
Educational Problems			2
Inability to Learn	1	0	
Educational Advice	0	1	
Totals	18	32	50

problems will be illustrated.

Placement Problem

Betty is 14 years old. The family have been known to various agencies for many years. Frequent complaints were made by neighbors about the care of the children and they were reported as neglected. Mother paid little attention to children and was careless about the housework. Father was away from home a great deal of the time and drank excessively. Betty had been in Pomeroy Home from the age of 6 until 2 months ago. She now finds conditions in the home intolerable, complains about the dirt, the over-crowded conditions, and her mother's behavior and attitudes.

Neglected, Child-plan

John is 9 years old. He was referred for study pending a plan for disposition of neglect case in court. Boy came to the attention of the Society a month ago. The landlady, with whom mother and boy were living, complained that mother was drinking a great deal, was frequently out of the home and neglected the boy. At this particular time she was gone for 2 days. Father was out of the home 4 months. John was placed in temporary home. He does not appear to be a behavior problem. His body was filthy when taken by the Society.

Runaway

Helen is 14 years old. She ran away from home and is now in temporary home. Mother has recently developed epileptic seizures and Helen was recently awakened from sleep, in the same bed with mother, by mother's having an attack. She became frightened and said she would never live with mother again. She ran away with 75¢ in her pocket. She thumbed a ride to Providence and there gave herself up to the police. Mother thought that Helen might have started to find her father. When the girl was questioned, she commented that mother had told her father was dead; but it was only another one of mother's lies, to which she was accustomed. Mother served sentence for prostitution and has a court record for larceny.

Stealing and Lying

Edward is 10 years old. He was referred by the Society when his mother burned his hand, supposedly to punish him for setting a fire. Mother complained that boy steals articles from members of the family, but not from outsiders, and then is untruthful about it. He set fires in his bed room and in the woods. Boy's parents are middle-aged and he has two siblings both are more than 10 years older than he is.

Out Late at Night

Mary is 16 years old. She stays out late at night with a girl friend. Mother shifts responsibility for her conduct upon father, who in turn refuses to do anything other than threaten to put her out of the home. Mary refuses to work around the house and mother considers her unmanageable. She stole some of older sister's clothing and gave them to her girl friend. She is retarded in school, does fair work. Society referred case for assistance in making a plan.

Sex Misconduct

Anna is 11 years old. She was brought to police station by mother who said Anna was assaulted by a 64 year old man about a month ago. Anna stated she went to this man's house about 6 times and he gave her 10¢ each time. Anna has had a series of sexual experiences beginning at the age of 6 when she was assaulted by 2 boys of her own age. Two years ago she had relations with an old man 2 or 3 times; her cousin tried to have relations with her several times. Mother has known about girl's sex experiences but apart from scolding her has done little to protect her.

Temper Tantrums

Paul is 17 years old. He was referred by the Society because of sudden, unprovoked temper tantrums, and abuse of other members of the family. The case has been known to the Society since 1932 when it was reported to them by the school authorities because boy was truanting, had been violent

toward his mother, and was a general neighborhood nuisance. Complaints came to the Society annually, mostly in regard to his violent behavior. Recently the boy threw books, chairs, and a coffee pot on the floor. Complaint was made to court on stubbornness charge 4 months ago and he was placed on probation for one year. Mother says that Paul has an insane temper and thinks it started when he was 13. There has always been much marital friction; father is frequently out of the home and mother favors a younger brother.

Educational Advice

Jean is 14 years old. The case was known to the Society since 1934 when Jean's older sister was the victim of criminal assault by the stepfather. About a year ago when mother was about to have her second illegitimate child, Jean was kept in Society temporary home because mother feared Jean might be subject to advances from her stepfather. Since then she has been at home. Society would like advice about possible plans for further education since girl seems bright. She is shy and retiring. It is believed she has been troubled by her older sister's experiences. Her sister has since died. Mother feels she has never been able to gain Jean's confidence because she keeps her troubles to herself. The younger children are under court order as neglected.

The above cases illustrate the varied nature of the problems at the time of referral. Many of these children had some contact with the courts. In order to show further implications of the problems at the time of referral to the Clinic, it would be well to know in how many cases the children had been known to a court before referral.

These cases fall into 4 categories: Neglect, Stubbornness, Runaway, Truanting, and Stealing. Ten of the neglect cases were referred to the Clinic with the cooperation of the court; final disposition was postponed until recommendations

from the Clinic were received. All the other children, previously known to the court, were referred after disposition had been made. The time interval before referral to the Clinic ranged from 2 months to 5 years.

TABLE VIII

CHILDREN KNOWN TO THE COURT

BEFORE REFERRAL TO CLINIC

Charge	Boys	Girls	Total
Neglect	6	16	22
Stubbornness	3	1	4
Running Away	0	4	4
Truanting	3	0	3
Stealing	1	0	1
Totals	13	21	34

Eight of the children were found delinquent. One boy stole blankets from parked automobiles; 3 boys truanted; 4 girls were found delinquent - 2 with runaway. In all the neglect cases known to the court, one of the parents was frequently out of the home; in 13 neglect cases either the mother or the father was permanently out of the home.

Since 60% of the problems at the time of referral to the Clinic consisted of placement problems, neglect cases in court

and runaway problems, it was necessary for the Society to supply temporary shelter for many of the children. The following table shows the distribution of children according to age and sex in a temporary home during the Clinic study.

TABLE IX

CHILDREN TEMPORARILY SHELTERED BY SOCIETY DURING CLINIC STUDY

Age	Boys	Girls	Total
Under 9	1	0	1
9 to 11	3	1	4
11 to 13	1	5	6
13 to 15	1	7	8
15 to 17	2	9	11
17 or over	0	1	1
Totals	8	23	31

Most of these children were cared for at the Society for the Prevention of Cruelty to Children Temporary Home. The adolescent boys and several girls were temporarily placed in foster homes because they did not fit into the other group.

CHAPTER VII

THE DIAGNOSTIC STUDY AT THE CLINIC

Psychological Findings

During the first visit to the Clinic, the child was given a battery of psychological tests. The distribution of the intelligence quotients reveals marked differences between the sexes. Of the 32 girls, 20 had less than average intelligence while 11 of the 18 boys had average or better intelligence. Twenty-two percent of the boys were of superior intelligence and 12% of the girls showed superior ability. The following table indicates the distribution of the intelligence quotients.

TABLE X

COMPARISON OF INTELLIGENCE OF BOYS AND GIRLS

Class	Boys	Girls	Total	Percent of Total Number
Superior (I. Q. 110-129)	4	4	8	16
Average (I. Q. 90-109)	7	8	15	30
Dull Normal (I. Q. 80-89)	6	8	14	28
Borderline Zone (I. Q. 70-79)	1	10	11	22
Defective (I. Q. 60-69)	0	2	2	4
Totals	18	32	50	100

It appears from this data that the majority of girls had dull normal or borderline intelligence; a large majority of the boys came within the average and dull normal group. The fact that the boys as a whole had higher intelligence than the girls might be explained by turning back to the problems as referred to the Clinic. The 7 girls classified as "sex misconduct" and "out late at night" had less than average intelligence; 5 out of the 7 girls who ran away had borderline intelligence. Eight of the 11 boys with average or better intelligence were conduct or personality problems. The girls referred as conduct problems had relatively low intelligence while the boys in the same group had relatively high intelligence.

Physical Findings

Since most of the children came to the attention of the Society because there were some elements of neglect in the home, consideration should be given to the physical findings at the Clinic. Table XI indicates the findings in the order of their frequency. Some of the children had more than one physical ailment.

This data shows that in 12 out of the 50 cases the physical findings were negative. In 22 cases the children needed medical attention because of their teeth, eyes or tonsils - in every one of these cases the Society took care of the necessary physical attention. Forty-two percent of the children needed dental care and 16% needed glasses. This

TABLE XI

PHYSICAL FINDINGS OF CHILDREN

AT TIME OF CLINIC STUDY

Order of Frequency	Findings	Times Occuring Boys	Girls	Total
1.	Carious teeth	8	13	21
2.	Good health	6	6	12
3.	Defective vision	2	6	8
4.	Underweight	1	4	5
5.	Acne	0	3	3
6.	Infected tonsils	2	0	2
7.	Fair nutrition	2	0	2
8.	Overweight	1	0	1
9.	Syphilis	0	1	1
10.	Old osteomyelitis	1	0	1
11.	Psoriasis	0	1	1
12.	Tenderness around appendix	0	1	1

would indicate some laxity on the part of the schools as well as on the part of the parents. It may be assumed from these findings that the majority of the children were healthy in spite of their deprived background.

Psychiatric Findings

For diagnostic service the psychiatrist usually sees the

child three times. In 29 cases the children were seen once by the psychiatrist. In seven cases the children had more than five interviews with him. The following table shows the distribution of contacts with the psychiatrist.

TABLE XII

NUMBER OF TIMES CHILDREN WERE SEEN BY PSYCHIATRIST

Number of Times	Boys	Girls	Total
1	10	19	29
2	2	5	7
3	1	3	4
5	1	2	3
6	0	1	1
7	1	1	2
13	2	0	2
17	0	1	1
28	1	0	1
Total	18	32	50

A surprisingly large number of the children were seen only once by the psychiatrist. This may be partially explained by the fact that 62 percent of the children were temperorarily sheltered by the Society during the study and they requested an immediate recommendation for placement. Some

of the cases were also studied at the Clinic pending a plan for disposition in court. At times the psychiatrists' calendars were filled for a week or so ahead of time and immediate service could not be given. In some cases where the problem was solely environmental there was no need for the psychiatrist to see the child more than once.

The Clinic desires to have interviews with the parents or guardians as well as with the children so it may obtain a setting for the problems, so that it can work cooperatively with the family, and so that it can have a better understanding of the situation. In 52 percent of the cases no member of the family came to the Clinic; a parent was seen once in 28 percent of the cases. The parents of two boys and two girls came to the Clinic more than four times. Table XIII indicates the number of times the parents or guardians came to the Clinic.

This table reveals that in 80 percent of the cases the parents were seen only once - if at all. A study of the cases reveals that these parents were usually the ones who neglected their children the most, and were the most difficult ones during the Society contact. The parents of the boys referred did not come to the Clinic more often than the parents of the girls, although the boys were more often referred because of personality problems.

Problems as Seen at Clinic Conference

The problems at the time of initial contact with the

TABLE XIII

NUMBER OF TIMES PARENTS OR GUARDIANS WERE SEEN BY SOCIAL WORKER AT CLINIC

Number of Times	Boys	Girls	Total
0	8	18	26
1	5	9	14
2	3	1	4
4	0	2	2
6	0	1	1
7	1	0	1
10	1	0	1
17	0	1	1
Total	18	32	50

Society and the problems at the time of referral to the Clinic have been discussed. Now the problems as seen at the Clinic conference shall be considered. In 27 cases the child presented no problem other than that he was living in a poor home situation. In 13 cases the child showed some emotional disturbances about the poor home environment. Five of the girls were dull and suggestible, while in three cases the child's main difficulty was poor school adjustment. Table XIV reveals the problems as seen at the Clinic conference.

TABLE XIV

MAIN PROBLEMS AS SEEN AT CLINIC CONFERENCE

Problem	Boys	Girls	Total
Poor Home Situation	10	17	27
Child Emotionally Disturbed about Home Conditions	5	8	13
Child Dull and Suggestible	0	5	5
Poor School Adjustment	2	1	3
Lack of Sex Information	0	1	1
Community Problem	1	0	1
Total	18	32	50

The majority of the children presented no behavior or personality problems. In 18 out of the 22 cases referred by the Society for placement recommendations or for advice while the neglect case was pending in court, there were no problems other than a poor home situation. The other four children showed some emotional disturbance about the home conditions.

Of the 11 boys referred because of conduct or personality problems, eight showed some emotional disturbances about the family situation. Two rebelled against their parents; two felt rejected by the family; another was sensitive about the poor physical conditions in the home. Four of the girls who were dull and suggestible got themselves involved

in some sex misconduct.

Two of the boys had reading disabilities and one girl was attending Latin School. The standards there were too high for her intellectual capacity. The boy who was diagnosed as a community problem came from a town where there were few wholesome recreational outlets.

In all but three cases in which the child showed some emotional disturbance, the psychiatrist was able to see the child more than once. The reasons for not seeing the child more than once in the three cases were: recommendation for placement needed immediately, in another the child lived too far away from the Clinic, and in the third case the child failed to keep appointments.

In many cases the conference staff concluded that the children were doing remarkably well in the light of their environmental conditions.

CHAPTER VIII

THE CLINIC'S RECOMMENDATIONS

In order to know what benefit the Society derived from having the children studied at the Clinic, the recommendations at the time of the Clinic conference must first be considered. All the Society cases receive diagnostic service: thus the responsibility for carrying out the recommendations rests upon the Society agent. Since most of the cases originally came to the attention of the Society because of some elements of neglect in the home, and since 44% of the problems at the time of referral to the Clinic were clearly neglect and placement problems, one would expect a large number of school and foster-home placement recommendations. And that was definitely what happened. In 35 cases, 11 boys and 16 girls, the recommendation was either school or foster-home placement. In most cases the Clinic specified through what agency the child should be placed, or to what school or home the child should go. In four cases the Clinic suggested two alternative agencies. In no case was the family able to pay for the support of the child outside the home. The Clinic usually asked the referring agency to return for further consultation and revision of recommendations if the original plan did not work out.

In 14 cases it was thought best for the child to remain in his own home, or to return to it if in the Temporary Home.

Living with relatives was advised for one child. In four of the cases in which the child was advised to remain in his own home, the Family Welfare Society was asked to follow the family on a case-work basis, and in two cases the Clinic suggested that the Children's Aid Association supervise the home.

In seven cases the Clinic desired to see the child more often before recommendations should be carried out. This could not be done in one case because the child failed to keep any appointments. The Clinic realized that it would be possible to see these children more often before it suggested more interviews. Since these were the cases seen by the psychiatrist more often than is usual for diagnostic service, they should be given special consideration here. The following is a brief summary of each child's problems at the time of conference, including the reasons for continued contacts and the accomplishments.

Erratic Parents

Alfred was 10 years old when referred to the Clinic. He stole goods from the ten cent store, set fires, and was disobedient in school. There were several conflicting stories told by mother and step-father. The step-father had deserted the family for a time, then returned. Mother gives impression of being a peculiar personality. At conference it was decided to have boy and mother continue contacts at Clinic in order to get a better picture of the situation. Mother and boy kept appointments irregularly, friction between parents continued, and both wanted the boy out of the home. Alfred felt excluded from advantages given his siblings, and had no pattern of identification with anyone in the home. The case was rediscussed and school placement recommended. Alfred is now in Stevens School for Boys.

Disturbed About Home Situation

Betty, age 17, was sent to the Clinic as a runaway problem. Her mother is in a mental hospital and her father is a fireman. On each occasion she is said to have run away after being out late, and claims she was afraid of her father. There is some element of rebellion against father's restraints. She has no close friends, but picks up acquaintances rather easily. The Clinic felt they knew all too little about the girl. Betty was put on suspended sentence to Lancaster and came to the Clinic. Prognosis was poor. Psychiatrist saw girl five times after conference, and social worker saw father. No good working relationships were established. The girl ran away again and was sent to Lancaster.

Rejected by Parents

Edward was a 10 year old boy who came to the attention of the Society because his mother had burned his hand as a punishment. He was referred to the Clinic for stealing from his parents, lying, and fire-setting. It was felt best to allow the boy to remain at home for an experimental period and to continue his contacts at the Clinic. The attention and satisfaction he received from the contact, it was hoped, might affect his school situation. The parents are middle-aged, and neglect the boy. Edward was seen eight times after conference. He was sent to Clinic summer camp. He now seems to be getting along well at home, but still has some difficulty in school.

Poor Home - No Behavior Problem

Jack is nine years old, and was referred for study pending a plan for disposition of a neglect case. The boy is very sensitive, makes a definite bid for affection. He was placed in a Catholic Charitable Bureau foster home and saw the psychiatrist thirteen times while he was adjusting to the foster home. He became occupied with day to day living instead of brooding over the past. After a year's placement he was returned home, where he is doing well, according to the Catholic Charitable Bureau.

Worried About Mother

June, aged 12, was referred for study and placement recommendations. Mother is in a mental hospital and girl was staying with father and brother. She was unhappy, and threatened to run away several times. She is very attractive, immature, childish, but had taken the role of woman of the household. Continuation of Clinic contacts was recommended, and placement in a supervised foster home, provided that the father's consent could be obtained. She stayed at a cousin's home and was seen at the Clinic. She ran away from that home, and the father would not consider the Children's Aid Association. He placed her with friends in Springfield. She was seen nine times. During her Clinic contacts her school work improved, she went to summer-camp, took more interest in her appearance, and got some understanding of her mother's condition.

Personality Problem

Ralph, 13 years old, was referred by the Society because he was expelled from English High School for obscene drawings. On investigation of home situation, it was felt he should be placed in Temporary Home pending study. The father deserted and was an alcoholic. Mother considered boy a personality problem of long standing. Ralph showed much resentment against his father and not much of an emotional tie with his mother. The Clinic wished to see him more often, to get a better understanding of him. They felt he should later be sent to a private school. Boy was seen 25 times and mother ten times after conference. He was temporarily placed in a Children's Aid Association foster home. The mother did not want him at home. He was sent to a caddy camp and then went to Fessenden School. He is being supported there jointly by the Children's Aid Association and the Society. His behavior and grades there are fair.

CHAPTER XI

SOCIETY TREATMENT AFTER CLINIC CONFERENCE

The Clinic made specific recommendations in most of the cases at the time of the conference. In six cases the Clinic made further recommendations after the psychiatrist had seen the child several more times.

Seventy percent of the recommendations were foster home or school placements. In 27 of these 35 cases the Society carried out the specific recommendation. Eleven boys and 16 girls were included in this group. The agencies assisting in the foster home placements were: Children's Aid Association - 6; State Division of Child Guardianship - 5; Catholic Charitable Bureau - 3; New England Home for Little Wanderers - 2; Children's Friend Society - 1; One boy went to each of the following schools: Fessenden, Stevens School for Boys, and Chelmsford. Six girls went to Welcome House. One boy went to the National Youth Administration Camp. In 10 of the 27 cases the court suggested the Clinic recommendation as a plan for disposition of the neglect case in court.

Why weren't the other eight placement recommendations carried out? Practical difficulties hindered Society treatment of these cases. For one girl, the Clinic recommended a private school. The family would not consider such a move; the Society has seen the child in her home several times and reports no neglect. The Children's Aid Association offered

to place one girl in a foster home but the girl refused to go. She went to a maternal aunt instead, and the Society reports no neglect. In one case the court granted custody of the child to the maternal grandmother. In three cases the Clinic recommended foster home placement through a private agency and the agency refused to accept the child; one boy is not in Chelmsford, a girl is in a Convent, another girl is at home.

In one case the parents went back together so the child was sent home and the Society states the whole family is doing well. In another case, a private school in the south was recommended for a colored girl. The Society agent wrote to eight schools, but none would accept her. The Society closed the case. Since then the mother made a stubborn complaing against the child but the court refused to issue a complaint because of insufficient evidence.

The Society attempted to carry out the Clinic recommendation in every case. Because the placing agency or the school did not take the child or because the child went to live with relatives, the Society was occasionally unable to carry out the recommendations. In no case did the Society return to the Clinic for further advice after the original plan had failed.

What happened to the 15 cases in which neither foster home nor school placement was advised? In two cases the child moved to relatives as the Clinic had suggested. In the other 13 cases the Clinic recommended that the child stay

with the family. Whenever the Clinic thought the family needed intensive case work it recommended that either the Family Welfare Society or the Children's Aid Association supervise the home. The Children's Aid Association dropped both their cases within six months because that agency felt its services were no longer needed. Of the four cases in which the Family Welfare Society was asked to supervise, two are still active with them. In the other two cases, one girl was later placed in a Children's Aid Association foster home, and one boy was committed to Lyman School for stealing. In all the other cases the Society agent visited the home occasionally to check for possible neglect of the children. In one case the Society was instrumental in having a girl placed in a Convent after the placement agency recommended by the Clinic refused to take her.

Present Location of Children

It was no aim of this study to make any detailed follow-up study of these cases. However, by taking the latest information from the Society and Clinic records and by writing to several other agencies or schools, we were able to find where the children were located on January 1, 1941. Table XV indicates with whom or in what place the children were living at that time.

These figures show that 36% of the children were living with their parents or guardians at the beginning of 1941. At the time of the Clinic conference 30% of the children were

TABLE XV

THE PLACES WHERE THE CHILDREN WERE LIVING

ON JANUARY 1, 1941

Place	Boys	Girls	Total	Percent of Total
At home	5	12	17	34
In placement Recommendation	8	8	16	32
With Relatives	0	4	4	8
State Training School	3	1	4	8
Working for Family	0	3	3	6
At C.C.C. Camp	2	0	2	4
In Convent	0	1	1	2
In C.A.A. Foster Home	0	1	1	2
With Friends	0	1	1	2
Listed as Missing Person	0	1	1	2
Totals	18	32	50	100

recommended to remain in or return to their own homes. In three cases where the girls had been placed at Welcome House, that place got them jobs with families. Of the children who were later sent to a training school, one boy was in a state foster home, another was supervised by the Family Welfare Society, when each was sent to Lyman School for stealing. One boy was sent to Chelmsford for truanting; a girl was sent to Lancaster on a runaway charge while she was being seen at the Clinic. One girl disappeared from her home in September, 1940 and was not located by the police on January 1, 1941. It can be assumed that most of the children made satisfactory adjustments subsequent to Clinic conference.

CHAPTER XII

SUMMARY AND CONCLUSIONS

During the two-year period, 1938-39, the Society referred 52 children to the Clinic who received routine diagnostic service. An undetermined additional number of children were seen once, but for some reason did not receive the full study. In the 50 cases studied there were 18 boys and 32 girls ranging in age from 8 to 17 at the time of Clinic service. Half of the whole group consisted of adolescent girls. No preponderance of boys at any age level was noted. The majority of the children had less than average intelligence, eight of them had superior intelligence, while two were defective intellectually. On the whole, the boys had slightly higher intelligence than the girls. Most of the children were in good physical condition. The Society provided for dental care, tonsillectomies, and glasses wherever necessary.

These children first came to the attention of the Society for protective reasons. In 10 cases the child came to the attention of the Society because of some delinquent act; in the other cases factors in the home situation made referral to the Society necessary. Parental neglect or broken homes accounted for most of these referrals. The Society agent usually knew the family for several years before Clinic referral. During this period of time the worker tried to prevent the child's being brought into court as neglected. Most of the families were dependent economically. Physical or men-

tal illness on the part of parents occurred frequently. Some crisis situation in the family prompted the agent to refer the child to the Clinic for placement recommendations in 22 cases. The main precipitating factors were: death of either parent, mother sent to a mental hospital, separation of parents, desertion of both parents, neglect to the extent that court procedure against parents was necessary. The other children were referred to the Clinic because of: conduct problems - running away, stealing and lying, sex misconduct, out late at night; personality problems - temper tantrums or stubbornness; school problems - inability to learn, educational advice. Most of these problems were definitely associated with the unstable home conditions. In almost every case the Society agent was considering possible placement of children. Thirty-one children were sheltered temporarily by the Society at the time they were being studied at the Clinic. This was necessary because the children were either neglected in their own homes or they ran away from home. Only rarely did the Society refer a case because they wanted to continue case work with the child in the family setting.

In most cases the Society agent gave an inadequate interpretation of the Clinic to the child. Sometimes, for instance, the children thought they were coming for vocational advice or because the court sent them when neither was the case.

The parents did not come to the Clinic in the majority

of cases; when they did come, they were usually not cooperative. Most of the parents did not seem deeply concerned about their children.

The problems as seen at the conference corroborated on the whole with the problems as referred by the Society. The child's home environment was found to be poor in all cases. In 35 cases it was thought advisable for the child to be placed in some other home. The number of times the child saw the psychiatrist did not corrolate with the success of outcome. All the cases received diagnostic service and the psychiatrist saw some children more often than others to better understand the situation.

The recommendations for placement with agencies or in schools were carried out in all except eight cases. In these cases the Society made a definite attempt at placement, but were unable to carry out the Clinic suggestions. In two cases the Clinic recommendations were placement in some private school - these were probably ideal solutions to the problems but they were very difficult to carry out. However, the Clinic might have worked out an alternative plan if the Society had come back for further advice.

When the Clinic advised the child's returning to the home, the Society usually kept the case active and visited the home occasionally to make sure that the child wasn't being neglected. The Society agents have from 60-125 families on their case load and they find it difficult to carry on

long time, intensive case work with any one family. In those cases where there was sufficient neglect to bring the cases into court, the Society was able to carry out the Clinic recommendations quite easily. Where the treatment depended upon family cooperation, the task was much more difficult.

In drawing conclusions from this study one must keep in mind that the Society has a definite responsibility to the community - the protection of children. In carrying out that function the Society agent must often act quickly and frequently does not receive the full cooperation of the parents.

This study revealed that the majority of referrals to the Clinic were in regard to placement recommendations. Frequently the Society agent had a definite plan in mind but desired the recommendation of a specialist. In those cases, the agent usually requested quick service. The Clinic is not set up to handle emergency cases. Appointments are made weeks and even months ahead of time.

This study also shows, however, that the Society can utilize the findings and recommendations of the Clinic in placement problems very effectively. If the Clinic recommended that the child remain at home and be seen by a case worker, little is usually done; but, if the recommendation was placement, the Society agent does a highly satisfactory job.

It is certain, from the results of this study, that the child guidance clinic can be of valuable service to the protective agency. The fact that the majority of children have

made satisfactory adjustments subsequent to diagnostic study at the Clinic is ample proof of that. Probably the main factor which will insure a greater cooperative effort between the two agencies will be a clearer understanding, on the part of each agency staff, of each other's functions and methods of procedure.

APPENDIX

SCHEDULE

I. Identifying data:

No: Address: Birthdate: Sex: Race: Nationality strain: Religion: Position amoung siblings: Legitimacy: Economic status: Grade in school: Is child known to court? On what charge? With whom was child living at time of referral to Clinic?

II. Society contact:

A. Date first known to agency:

B. Presenting problem:

C. Home conditions:

(1) Physical factors -

(2) Psychological factors -

(3) Marital status of parents -

(4) Health of parents -

D. What action was taken by Society worker?

III. Referral to Clinic:

A. Services desired of Clinic:

B. Problems at time of referral:

C. Worker's description of Clinic to parents and children:

IV. Clinic contact:

A. Psychological:

(1) Date of test -

(2) Intelligence quotient -

B. Psychiatric:

(1) How often did child see Psychiatrist?

(2) Psychiatrist's physical findings:

(3) Problems as described by child:

(4) Family attitudes as described by child:

(5) School history as described by child:

C. Social service:

(1) Did parents come to Clinic? How often?

(2) Attitudes expressed to social worker:

D. Conference:

(1) Problems as seen at conference:

(2) Recommendations:

(3) How often did Psychiatrist see child after conference?

V. Society contact after conference:

A. Was recommendation carried out?

B. Reasons for not carrying it out:

C. Did other agencies assist in carring out recommendations?

D. Present status of person:

SUGGESTED OUTLINE FOR REFERRAL TO JUDGE BAKER GUIDANCE CENTER

The following outline follows closely the summary used by JBCC for staff conference. We realize that often this detailed material about the child and relatives may not be available in your records. This outline is only a suggestion and there are times when it may not be possible or desirable to obtain all the information. The clinic is interested in seeing the parents and, if the agency is willing, to obtain details about the child's history. This is often helpful in giving the parents an understanding of the clinic, and a feeling of the purpose. There are instances, we recognize, when an interview at the clinic might interfere with the treatment relationship of the referring agency, but if it is possible it adds to the clinic's picture of the family. The information from the referring agency that is most valuable to the clinic is that which gives the worker's impression of the feeling qualities (so indicated) and best possible sketch of the family situation as seen by the agency and certain factual data that is available in the agency record.

IDENTIFYING DATA

Name and address of child, parents' name, names and ages of siblings, date and place of birth of child referred, nationality, religion, color, sex, school and grade.

NATURE OF CONTACT OF REFERRING AGENCY

Length of time, type of service, member of family with whom agency has had most contact, and present status, including brief evaluation of agency treatment.

PARENTS' UNDERSTANDING OF CLINIC FUNCTION

Their attitude toward referral, including child's preparation for coming to the clinic.

CHILD IN THE FAMILY SETTING

Present family group, child's ordinal position; relatives or others living in the home.

PROBLEM

Running account of child's difficulties, including speci-

fic facts regarding onset, agency's estimate of problems and method of handling by parents and agency, reason for referral at this time.

BACKGROUND

(a) Heredity. Mental illness, disease or deficiency. (Court records may be included here.)
(b) Sketch of each parent's life experiences (up to marriage) from the standpoint of health, education, occupation, attitude toward their parents, toward their own siblings, etc, with special emphasis on underlying feeling tones.
(c) Brief Sketch of each sibling.
(d) Home Conditions. Sketch living conditions of family up to the present, periods out of the home of any member, types of neighborhoods lived in, financial situations past and present, and sleeping arrangements.
(e) Family Attitudes. Trace from the marriage of the parents to the present, including attitude toward grandparents and parents' sibs., parents' attitude toward each other and toward chrn; sibling attitude toward parents and toward each other, including referred.

THE CHILD

(a) Developmental. Condition of mother during pregnancy and delivery; condition at birth, whether full term baby, presence of cyanosis or other irregularity; a detailed feeding history, including length of time, breast fed, attitude toward nursing period and reaction to weaning; establishment of toilet habits, age begun and method used; time of teething, talking and walking; chrn's diseases, operations, accidents and other illnesses, with special emphasis on severity and child's reactions. (Include copy of any medical report.)
(b) Habits. Eating, sleeping, thumb sucking, nail biting, enuresis, nocturnal and diurnal, soiling, masturbation, or any other outstanding habits.
(c) Personality. Include child's attitude toward referral to clinic, his understanding of reason, his attitude toward parents and sibs., his general personality trends as indicated by his contacts outside of the home, the impression he makes on people, his interests, as well as family's description of him.
(d) School History. Age entered, grades repeated,

present adjustment as to behavior and academic standing.

SERVICES DESIRED OF JBGC

State whether this is a case in which referring agency wishes to carry full case work responsibility or wishes JBGC to carry case to include treatment of parents, or whether this responsibility is to be shared by the two agencies.

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