

1953

The value of a diagnostic study as a limited service

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BOSTON UNIVERSITY
SCHOOL OF SOCIAL WORK

THE VALUE OF A DIAGNOSTIC STUDY
AS A LIMITED SERVICE

A Thesis

Submitted by

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(B.S., Boston University, 1950)

In Partial Fulfillment of Requirements for
the Degree of Master of Science in Social Work

1953

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CHAPTER I

INTRODUCTION

Diagnosis without means for meeting the needs and problems of the client is without value.¹ This is the general view present in the literature which deals with diagnosis and its meaning to the client. As Harms sees it,

Without adequate provisions for diagnosis of the child and his potentialities and problems, and the use of these findings in the guidance of children the value of guidance efforts are very limited.²

This philosophy prompted the Worcester Youth Guidance Center³ to question its policy in regard to the use of the diagnostic study as a limited service, and the value of such a study when not followed by treatment or other help. The writer has examined the current literature relating to diagnostic studies and has been unable to find the diagnostic study treated as a limited service. All writers assume that the diagnostic study precedes something else. It is a prelude to treatment.

1 Ernest Harms, editor, A Handbook of Child Guidance, p. 340.

2 Ibid., p. 339.

3 Hereafter referred to as the "Center."

Purpose.

The purpose of this study is to examine the diagnostic studies offered by the Center to determine the value of the diagnostic study used as a limited service. The writer will compare the diagnostic studies given to applicants to the Center who are eligible for treatment, Group A, and those who are not, Group B, but who had been accepted by the Center for a diagnostic study.

Diagnostic studies are offered as a limited service to those individuals who do not meet certain eligibility requirements, viz., those applicants who reside outside a certain geographical area. Are these clients helped by a diagnostic study as a limited service, and is this in keeping with the aims of the Center, which is to extend psychiatric help to children who have problems? In attempting to answer this general question several other questions arise in relation to the factors which might have influenced the outcome of the diagnostic studies. What were the reasons for the diagnostic studies and who made the requests? Were there any differences in the number of interviews and psychological testing procedures in the two groups? What was the final outcome of the diagnostic study in each case?

This study is not intended to be a critical appraisal of the work of the Center as a whole, but an examination of diagnostic studies to see if they do provide a limited service.

A service is helpful only when it fulfills the functioning of the person or agency giving it and the needs of the individual receiving it.

Selection of Cases.

This study will consist of a comparison of thirty-two cases, Group A, with five cases, Group B. The cases for Group B were selected by the Center on the following criteria:

(1) They came from outside the geographical area served by the Worcester Community Chest and Council area;⁴ (2) the referral material on the application indicated that treatment was necessary; (3) the applicants were informed that only a diagnostic study could be given; (4) the applications were after the change of the Center's policy in the summer of 1950. Prior to this there was no geographical limit to eligibility. It was planned to obtain at least ten cases meeting this criteria, but only five cases met the above criteria.

The Group A cases were selected on the basis of:

(1) the diagnostic study had to be done following intake; (2) at least one parent had to be present; (3) the case was current, i.e., since the summer of 1950. Thus, diagnostic studies on children from the Division of Child Guardianship, in adoptions and situations where a diagnostic study was begun after the client had been in treatment were eliminated.

All cases were from the current active files of the Center. The five cases of Group B and the thirty-two cases of

Group A represents about twenty per cent of the total current cases of the Center.

Scope of Study and Method of Procedure.

This study is limited to a comparison of five cases to thirty-two cases in the Center. With this limited number of cases, therefore, the study is valid only for these cases in this particular agency. There has been no attempt to consider the variable of time, except that the cases are current. Some of the diagnostic studies of Group A were done some time ago by workers, clinical psychologists and psychiatrists who are no longer at the Center.

The two groups of cases will be analyzed and grouped in order to more readily compare the similarities and differences. These groupings are such areas as age and sex of the children; the reasons and outcomes of the diagnostic studies; the number of interviews and testing procedures and the recommendations made to the clients.

The case presentations will consist of cases selected from each group on the basis of clarity and completeness of recording, and to represent an overall picture of the diagnostic studies.

CHAPTER II

DESCRIPTION OF THE WORCESTER YOUTH GUIDANCE CENTER AND THE SERVICES OFFERED

The Center began in 1921 as an out-patient service of the Worcester State Hospital and was known as the Worcester Child Guidance Clinic. In consideration of the public's feeling about mental institutions the Clinic was held at the Memorial Hospital and later was moved to separate quarters in a residential section of the city.

In 1929 the Clinic's first full time psychiatrist and director was appointed. He stressed the treatment of delinquent children, and the Clinic expanded and became well established during this period.

The Clinic continued later in a more generalized manner and on a high level during this time up to the war when a shortage of personnel hampered its functioning and efficiency.

In 1948 the name of the Clinic was changed to Worcester Youth Guidance Center. This was an attempt to define the role of the agency to the community in terms of preventative services. It was felt that the word "Clinic" had too many associations with the treatment of mental illness. It was also hoped to attract the older child by offering services to children up to the age of seventeen.

The center obtains its financial support from different sources; the Community Chest, the State Department of Mental Hygiene, the United States Public Health Service, and a fee system for clients based on a graduated scale ranging from ten cents to fifteen dollars according to the family budget. The fee is paid on a weekly basis for the combined services to the parent or parents and child. The fees are the same regardless of the type of service; intake, diagnosis, or treatment.

In that the Center is partially supported by State funds the Center is in reality a state-wide agency and accepts clients from the entire state. However, because of the increased demands of the community for the services of the Center the services have been limited by a change of policy, a joint board and staff decision, in the summer of 1950. It was felt that the Center could give its full services most efficiently to a limited geographical area. The area chosen was Greater Worcester which includes the towns that contribute to the Community Chest and Council of Worcester. All applicants from outside this area can be eligible only for limited services.

The Center's limited services are diagnostic studies and consultation services. The number of clients who shall be eligible for this limited service can comprise only five per cent of the total case load.

The Center also operates the State Travelling School Clinic for the Greater Worcester area. It has not been functioning since 1951 because of personnel shortage. It is expected to be re-established and operating by the end of 1953.

The aim of the Center is to offer psychiatric treatment to children and social casework services to the parents simultaneously to help them solve the problem of living together. All aspects of the child's situation are studied. This involves the parents as the parents attitudes and feelings are regarded as the chief determinants of the child's problems. Parents are accepted, not as mere informants or sources of information, but as individuals who are involved in the complex and troubled relationship with the child. Their own emotional conflicts, especially those having to do with the relationship, are worked with an attempt to change the environment of the child in order to have lasting changes which begin in the therapy situation.

Trained workers are on the Center staff and work as a team in diagnosing and treating; they include psychiatrists who have special training in adult and child psychiatry; social workers who have advanced degrees and experience in psychiatric casework treatment with emphasis on the problems of children and psychologists who have special training and experience in psychological testing to determine intelligence,

special abilities and disabilities and personality factors in children. They are also trained in the treatment of children.

Treatment of the child's problem is based on diagnosis by the clinical team. The members of the various disciplines follow their general functioning, but the Center allows a great deal of flexibility in the assignment of either a child or adult client to any member of the team.

Intake begins with the initial telephone call, letter or visit by the applicant. Self referrals are encouraged though some referrals come from some other source than the parent or child himself. At intake clarification about the kind of service that can be offered andt seems to be in the best interests of the clients is undertaken.

Services of the Center Include:

Diagnostic Studies.¹

Although there may be some overlapping purposes in the individual studies, diagnostic studies fall into the following major categories:

1. Determination of intellectual ability.
2. Establishing diagnosis.
 - a. Whether mental retardation due to emotional or organic factors.

¹ Worcester Youth Guidance Center Policy and Procedure Manual.

- b. Clarifying mother-child relationship.
 - c. Area and/or basis of problem.
 - d. Basis of treatment.
3. Court referrals.
 4. Determination of treatability.
 - a. Evaluation of child and determination of mother's accessibility.
 5. Determination of need of treatment.
 - a. To see if client meets eligibility requirements.
 6. Adoption service.

There are other uses of the diagnostic study not shown above. One of these is as a tool in which an attempt is made to involve or make the parent aware of his role in the child's difficulty. The diagnostic studies done in adoption services are of a consultative nature being done for other agencies.

When the diagnostic study is being done for any of the first three purposes the intake worker continues with the parent. After the study has been completed, the parent is seen by the worker for an interpretation of the results and recommendations.

When the diagnostic study is planned with future treatment in mind, assignment is made to the therapist prior to the study. However, this policy is not always followed because of the pressures on the staff, but for the most part

every effort is made to have the therapist start and finish with the child.

A diagnostic study at the Center consists of casework interviews with the mother by the social worker, and psychological testing of the child by a psychologist. If the child is untestable, as is sometimes the case, then play observation is used and this can be done by either a psychologist or a psychiatrist. Occasionally the child may be seen for testing and observation by the psychologist and observation only by the psychiatrist. The study is then written up in a standard form² and presented at a conference which is presided over by the Chief Psychiatrist, assisted by the Chief Social Worker and the Chief Psychologist. Both the worker and psychologist who worked with the clients present the case from their point of view.

Treatment.

Treatment of the child's problem is based on diagnosis by the clinical team. Since the problems of no two children are identical, each treatment program is carefully worked out to fit the child. The type and length of treatment is varied. All children up to the age of seventeen years can be accepted for treatment except those whose primary problem is one of mental deficiency.

Consultation Services.

Services of the Center staff are available on an advisory basis to social agencies when they are dealing with children's problems. On an educational basis a portion of the time of the Center is available to community groups studying the behavior of children.

CHAPTER III

DIAGNOSIS

The writer wishes to examine some of the current thinking relative to diagnosis in the field of social work and particularly in the field of child guidance.

The diagnostic procedure is a basic necessity;¹ when change in a person is the chief aim diagnosis must be the focal point of the whole process.² A diagnostic study should entail comprehensive psychiatric study, adequate testing, and medical consultation. Psychiatric diagnosis means the current symptom picture, a view of the total personality gained through direct observation of the client and family situation and understanding the genetic development of the client's personality and symptoms. This includes an awareness of the significant character traits, and an appropriate definition of the processes of retardation, fixation, distortion or regression in growth.³ This appears to be an ideal diagnostic situation where the total individual is studied to the fullest extent. Such a complete and extensive study is unusual as

1 Nathan W. Ackerman, "Psychotherapy in Child Guidance Clinics," American Journal of Orthopsychiatry, 15:716, October, 1945.

2 Gordon Hamilton, Psychotherapy in Child Guidance, p. 19

3 Ackerman, op. cit., p. 716 ff.

would be the facilities for such. More simply and specifically put, diagnosis in casework is the attempt of the social worker to understand the client's difficulty in order to offer him the help most likely to enable him to resolve his conflicts. There are two parts to any diagnostic study; knowledge of the individual client and the background knowledge of patterns of behavior.⁴ Experience shows that the client often comes to an agency presenting a problem and later through diagnostic exploration the central problem that manifests itself is quite unlike that of the original presenting problem. Good diagnosis is more than just labeling; the diagnosis should represent a specific disturbance in the developmental processes of the client. Failure to view it this way is to fail in understanding the value of diagnosis.⁵

However, there are certain major diagnostic classifications, for example, the psychoses, psychoneuroses and psychopathy. These differ widely from each other in their basis. They differ in symptomatology, etiology, defenses, and character structure. The basic differences are important

⁴ Florence Hollis, "The Relationship Between Psycho-social Diagnosis and Treatment," Social Casework, 32:67, February, 1951.

⁵ Staff Members of the Jewish Board of Guardians, Primary Behavior Disorders in Children.....Two Case Studies, p. 11.

in the bearing they have on therapy and prognosis.⁶

There are two schools of thought regarding the use of the diagnostic study. The above authors represent the school which sees the diagnostic study as a vital necessity in approaching the client. The opposing school, represented in the main by Rogers and Patterson see little use of the diagnostic study in treatment. Rogers feels that in most cases the diagnostic study hinders treatment and interferes with the treatment processes. It is only the exceptional case that requires a diagnostic study.⁷

Patterson goes further and would be content to discard the technique of case history, diagnostic testing, and differential diagnosis. "Since all maladjustment is similar in origin, diagnosis in terms of symptomatology or etiology or dynamics is not essential to therapy."⁸

Social work, particularly the area of child guidance, embraces the concept of diagnosis and its use wholeheartedly, and sees it as a necessary tool. However, the diagnostic thinking has been geared to the case in long treatment or the case referred for this treatment elsewhere. The relationship

6 Hollis, op. cit., p. 69.

7 Carl Rogers, Counseling and Psychotherapy, p. 81.

8 C. H. Patterson, "Is Psychotherapy Dependent Upon Diagnosis?" American Psychologist, 3:155, 1948.

of the diagnostic study and the short-term case needs to be examined as has been done with the long treatment case.⁹

In recent years there has been a marked increase of short-term cases. This new development points toward a new thinking in reference to the diagnostic study. Thomas suggests that short-term cases should receive more careful study and evaluation.¹⁰

9 Dorothy V. Thomas, "The Relationship Between Diagnostic Service and Short-Contact Cases," Social Casework, 32:74, February, 1951.

10 Ibid., p. 80.

CHAPTER IV

BACKGROUND MATERIAL OF THE TWO GROUPS

This chapter presents the background material for the purpose of giving a picture of the two groups from the point of view of age range, sources of referral, reasons for referral, outcome of the cases, and number of tests given and number of interviews.

TABLE I

AGE AND SEX DISTRIBUTION OF GROUP A

Age at Application	Boys	Girls	Total
2 years - 5 years	3	5	8
6 years - 9 years	5	2	7
10 years - 13 years	8	2	10
14 years - 17 years	3	4	7
Total	19	13	32

In Table I there is a wide age distribution; the youngest being two years of age and the oldest sixteen years

TABLE II

AGE AND SEX DISTRIBUTION OF GROUP B

Age of Application	Boys	Girls	Total
6 years - 9 years	1	2	3
10 years - 13 years	0	1	1
14 years - 17 years	1	0	1
Total	2	3	5

of age. The age distribution in Group B is from seven to fourteen years of age.

There is a greater concentration of boys of Group A in the post-odipal period. This is to be expected as one sees a greater manifestation of conflicts during this period. "The passing of the Oedipus complex in girls generally comes about in a more gradual and less complete way."¹

The reasons for a diagnostic study is not given in any standardized form in the records. They vary from worker to worker and are given in their own words. The writer has reworded them after selecting all those that are similar and seem to denote the same reasons. Table III shows the breakdown of the reasons for the diagnostic studies.

¹ Otto Fenichel, The Psychoanalytic Theory of Neurosis, p. 108.

TABLE III

REASONS FOR DIAGNOSTIC STUDIES OF ALL CASES

Reason	Number of Cases
1. Basis of treatment	4
2. Whether retardation due to emotional or organic factors	3
3. Clarifying mother-child relationships	1
4. Evaluation of child and determination of mother's accessibility	3
5. Area and/or basis of problem	3
6. To involve mother	1
7. To see if client meets eligibility requirements	4
8. To provide a limited service (Out-Area cases)	5
9. Requests from other agencies	13 *
Total	37

* See Table IV for source of these referrals.

Table III shows the various reasons for undertaking a diagnostic study. The majority, twenty-four cases, are undertaken for the Center's own needs in attempting to understand fully the child and his problem and to provide a limited service. Thirteen cases are requests by other agencies for diagnostic studies.

A precise analysis of the sources of referral to the Center is difficult to obtain. The Center encourages personal application, and a client makes the initial overture on his own behalf although he may have been referred by a school, doctor or other person. For the purposes of this study the writer is considering a case as a referral if the referral source contacted the Center prior to the client's application and specifically requested a diagnostic study. There were thirteen cases in this category. Table IV shows the breakdown of the requests for diagnostic studies from other agencies.

TABLE IV

SOURCE OF REFERRALS FROM OTHER AGENCIES

Source	Number of Cases
Court	5
Physician or Psychiatrist	4 *
School	2
Psychosomatic Clinic	1
Aid to Dependent Children	1
Total	13

* Three of these cases are three siblings referred by a psychiatrist. Only the oldest child could be taken in treatment.

The single agency referring the largest number of cases for diagnostic study is the court. The child is usually referred by the probation officer and the referral is accompanied by a brief summary. The large number of referrals from this agency is to be expected as the Center is a state supported agency. In all cases the referring agency contacted the Center before the client made his first contact. With the exception of the court referrals all other referrals were telephone calls by the referring agent to the Center. The only other agency to send a written summary was the Psychosomatic Clinic.

Table V shows the outcome of the diagnostic study for the two groups.

TABLE V
OUTCOME OF ALL CASES

Outcome	Number of Cases	
	Group A	Group B
Was or is now in treatment	14	0
Treatment rejected by parent	2	0
On treatment waiting list	5	0
Parent withdrew, claimed understanding from study	2	0
Referred to other agency		
Accepted by parent	2	1
Rejected by parent	0	1 *
Placement recommended		
Accepted by parent	5	0
Rejected by parent	2	2
Recommended consultation appointments with Center, but withdrew	0	1
Total	32	5

* The parent consented to a conference by the worker with the child's teacher.

A study of Table V shows that in Group A twenty-six cases accepted and carried out or were helped to carry out the plan based on the diagnostic findings. The remainder of

these, six cases, did not accept or carry out the findings. Of these six cases, however, two parents claimed new understanding of their problem through the diagnostic study and felt that they wanted to help themselves or give the situation another try. Thus, four cases rejected help; two of these cases rejected treatment and two cases rejected placement.

In comparison, Group B shows the reverse of Group A. The majority of the cases, four cases, rejected the findings of the study. One of these cases did consent to indirect help in the form of a conference by the worker with the child's teacher. In one case the findings of the study pointed toward an endocrine deficiency. This was presented to the parent who then carried out the recommendation. It is significant that these five cases were informed before the study began that treatment could not be given. It must be noted here again that the cases in Group B are situations where treatment seemed indicated at the time of application, but the Center could only offer a limited service.

Table VI shows a comparison of the number of psychological tests administered in the two groups.

TABLE VI

NUMBER OF TESTS GIVEN THE CHILDREN IN THE TWO GROUPS

Number of Tests	Number of Children	
	Group A	Group B
0	8	0
1	1	0
2	5	0
3	5	0
4	6	0
5	4	2
6	1	3
7	2	0
Total	32	5

Table VI shows that in Group A twenty-four children were given psychological tests. Of the eight that did not receive testing five were considered untestable because of various reasons ranging from extreme anxiety to extreme hyperactivity. In three other instances tests were not given as the child was seen diagnostically by a psychiatrist. In these cases testing was not considered necessary.

There is no standard battery of tests; each psychologist uses the tests that he feels are most adequate. There

is also no standard number of tests administered. Some children were given as few as one test and others as many as seven. The median number of tests given was two point five.

The Rorschach was the test most frequently used. It was given in all but two cases. The Goodenough Draw-a-Person Test is the next most frequently used followed by the Thematic Apperception Test and the children's version, the Children's Apperception Test. Intelligence test were used in only a few cases. The Center's use of the Rorschach and Thematic Apperception Test reflects the shift taking place in the field of clinical psychology.²

In Group B, it shows a different trend. In this group the testing appeared more complete in that the range is from five to six tests for the group. The median number of test is five point five per child. This group appears to be a more thoroughly studied group as compared with Group A.

Why this group was given more tests per child is beyond the scope of the study. The writer, however, makes two assumptions as to why this may have occurred. First, because treatment was indicated when the clients applied, they were considered a more disturbed group and therefore required more testing. Secondly, because only a diagnostic study could be

² Molly R. Harrower, editor, Recent Advances in Diagnostic Psychological Testing, p. 80 ff.

offered when treatment was indicated the workers tended to do more that was required of them for these particular clients.

Table VII compares the number of diagnostic interviews with the parent and the number of times the child was seen either for testing or interviews for the two groups.

TABLE VII

NUMBER OF INTERVIEWS OF PARENTS AND CHILDREN
IN THE TWO GROUPS

Number of Interviews	Number of Parents		Number of Children	
	Group A	Group B	Group A	Group B
1	7	1	2	0
2	6	0	11	0
3	9	1	7	1
4	6	0	5	1
5	4	0	4	1
6	0	2	2	2
7	0	1	1	0
Total	32	5	32	5

The number of interviews were from one to five for the parents of Group A, and one to seven for Group B. The median number of interviews for the parents in Group A is two point five, and for Group B four point five.

Now turning to the number of interviews for the children the frequency is somewhat the same as for the parents, and the same trends holds. Group A has a lower median number of interviews, two point seven as compared to the median number of interviews in Group B, four point five.

This trend was also evident in the number of tests given to the two groups. Group B was given more tests per person, and Group B had more interviews per person. The evidence shows that Group B was treated differently than Group A, both in psychological testing and in the casework interviews. Group B received approximately two more tests per person, and two more interviews per person although Group B was ostensibly receiving the same service from the Center as Group A.

CHAPTER V

PRESENTATION OF THE CASE MATERIAL

The cases presented for a survey will be in two major groups; Group A and Group B. The cases selected from each group will point out common characteristics and will give an overall picture of the diagnostic studies, such as referral source, reason for diagnostic studies and the outcome.

Of the thirty-two Group A cases eight have been selected as representative of this group.

The first two cases presented are representative of fourteen cases where psychiatric treatment followed the diagnostic study.

CASE 1

Babs, a seven year old girl whose immaturity, exhibitionism and fears caused severe disturbances at home and at school, was seen diagnostically to better understand the basis of her problem and to determine treatability. The mother was also evaluated and treatability determined.

The mother requested an appointment after the school nurse suggested it. Babs was described as a serious behavior problem in school, and at home she was hyperactive and had nocturnal enuresis, was unable to get along with siblings and other children. Mother was hostile to the school for making the suggestion. In the beginning of the study the mother tended to concentrate on Babs' slowness in learning, but later began to focus on the probability that Babs was emotionally disturbed.

Babs' mother experienced nervous spells after Babs was born. She returned to her own mother's home at intervals because of nervousness for strength and support. Babs was affected most by these separations.

Babs' mother was seen five times and the caseworker felt that the mother was seen to relate readily. Babs was the focus of the mother's own anxieties, fears of losing control. She has some insight that her own problems are related to Babs' problems. She would respond well to treatment. She was seen once after the study for interpretation.

Psychological Study.

Babs is a thin child in a perpetual state of tense excitement. She was seen five times and given two tests. She would not participate in formal testing procedures. She did provide one superior Rorschach response. Her Children's Apperception Test stories were concerned entirely with fear of mother's desertion. She is assumed to have average intellectual capacity.

The psychologist commented that the symptom formation arose from a neurotic disturbance on the Oedipal level. Babs' rivalry with the younger sister for the father is now fused with the rivalry with mother. Babs fear of harm parallels her mother's concern about bodily injury. The identification with the mother also has positives, namely, the vivaciousness and ability to establish relationships. Babs can derive considerable benefit from therapy.

CASE 2

Chuck, a twelve year old boy, was referred by the probation officer from the court. Chuck had been reported for indecent exposure in the park, but no court proceedings had been begun. Chuck's mother was hostile to the Center, because Chuck was too old to be coming to the Center, and the Center would not offer medical aid. She was concerned about the school situation: Chuck had been continually failing and was now in an ungraded class and doing poorly. Chuck is very withdrawn at home.

Socially the family is isolated because of the father's deafness, and his mother cannot get adjusted to the city. There is little warmth between husband and wife. The most important member of the household is Chuck's younger sister. She is ahead of him in school and is considered gifted. Chuck's mother finds pregnancy a horrible experience for her. Pain and sickness was the price one pays for being a woman. Any aggression on Chuck's part is punished severely.

The mother was seen four times in the study and seen once for interpretations of the findings.

The caseworker pointed out, after four interviews with the mother, that she could not accept her rejection of Chuck and when it became almost conscious she nearly went to pieces. She has no close relationships at all, and a treatment relationship would be too threatening to her.

Psychological Study.

Chuck had difficulty in attending to the testing. He was constantly preoccupied and had to be called to the task at hand. His performance is, therefore, only a partial indication of what he can do. Five tests were given in six interviews.

Chuck places in the borderline category of intelligence but this is not considered a valid measure. His Rorschach performance seems nearer the normal range of intelligence although he is not functioning there.

There is marked hostility to the parents, and a lack of sexual identification. He appears to be withdrawing into a world of fantasy, and regressing to earlier levels of functioning. In spite of this picture the psychologist felt that some attempt should be made to arrest the withdrawing process. The overall picture is a prepsychotic boy, and prognosis is doubtful.

A trial period of treatment of three months was undertaken because he did relate well to the psychologist.

The above cases represent two situations of treatment following a diagnostic study. Babs and her mother have been in treatment and have shown much improvement. Chuck was given a three month trial period and during that period his progress was so good that therapy was continued. He has now been in therapy for two years. In the meantime his mother was seen frequently, but no attempt was made to work out her problems. She has tried to follow the Center's recommendations and has eased the pressure on Chuck.

The outstanding factor in both cases was that treatment began and was continued in the diagnostic study. Babs' mother became aware of the problem, and Chuck himself related to the therapist. This situation holds in all the other twelve cases where treatment followed the diagnostic study.

Two other cases in Group A rejected treatment. The case presented was referred by the court, the other was self referred.

CASE 3

George was referred by the probation officer because of lewdness in speech and behavior. George was a large boy, fifteen years of age, who appears older than his actual age, but with a flabby unmasculine appearance.

George's mother was very upset over his behavior and cannot understand it. They have a "nice" home in a "nice" neighborhood. There was no drinking or cursing in the home.

George is the youngest of thirteen siblings and half siblings. His mother has over-protected him so that he is quite dependent and immature. He apparently got along until the advent of a baby in the home. George's sister, divorced, returned home with an infant. George's mother became quite attached to the baby and now has no need to baby George. He is now expected to act his age.

The mother was concerned whether George was guilty or not, and if he were then the court experience would frighten him into being a good boy. She attaches no importance to his trouble in learning. He has always been slow, and talks slowly. She feels that he is the one most unlike the rest of the family; the only one who wasn't "good." At nine months he had a hernia and has had to wear a truss ever since then.

The caseworker saw the mother as a resigned person, complaining and nagging rather than an openly aggressive one. She sees no connection between her relationship with George and his behavior. This lack of understanding of George's emotional problem would hinder treatment.

She was seen once during the study and once for interpretation.

Psychological Study.

George was seen three times and given two tests. He was found to be a severely limited and inflexible personality. Forced into an abrupt independence he is frightened, anxious and lost. He showed considerable tenseness which he attempted to alleviate through compulsive acts.

The psychologist felt that he is unable to gauge the rules of life in which he has been suddenly thrust. He is in great need of help in dealing with these feelings during the present turbulent time of adolescence.

Treatment was recommended and offered, but it was not accepted. The family felt that it was a sort of boyish prank, and now he was frightened enough not to do this again. The

family was supported in this stand by the probation officer who referred him. With this backing the family refused to accept their own role in George's behavior. In the other, treatment was refused for a similar reason; refusing to recognize the problem and the parent's role in contributing to the difficulty. This case, however, was complicated by an additional factor. The mother showed open fear and opposition to the father's likelihood of coming in for treatment.

The next case is one of five which, after the diagnostic study, accepted treatment but were placed on the waiting list.

CASE 4

Ronny is a ten year old boy referred by the mother because of poor school work. He is failing in practically every subject, day-dreams and does not want to learn. He was changed from a public school to a parochial school because he would get more discipline there. A diagnostic study was done to determine whether the problem was due to emotional or organic factors.

Ronny was a normal baby, coming two years after marriage. He was bottle fed and "broke" to the toilet by the age of two. He was a good baby, never complaining, and complying in every way to the strict routine. At eighteen months his father went into the service, and Ronny was placed in a nursery home. Later when he was taken back home, he slept with his mother until the age of five at which time his father returned home. Ronny had a series of traumatic hospital experiences. After his father's return, to which Ronny reacted strongly, a sister was born. When Ronny was nine a brother was born.

Ronny's mother works part time as a waitress in order to supplement her husband's income.

The caseworker felt that the mother showed a lack of warmth regarding her children. Rejection was experienced by the child when the father left and he was put in a nursery school. Later he re-experienced this rejection by the mother when the father returned to the home. Ronny also experienced a series of traumatic hospital episodes without adequate preparation. There is evidence of a severe emotional problem.

The mother was seen once during the study, and once to present the findings to her.

Psychological Study.

Five tests were given in three sessions. Ronny is a quiet, passive, conforming, and fearful appearing boy. When presented with the tests he gasped and seemed overcome with fear, but denied it. He tested within normal intelligence, but the test scatter indicated that he is not fulfilling his potential. The projective tests point out that Ronny is involved in an Oedipal situation and is extremely afraid of castration. He acts out in a weak, passive way and is afraid to grow. In response to the examiner's question about being questioned Ronny said that he felt like a criminal in a murder mystery.

Ronny is fearful, depressed and anxious as a result of the unsolved Oedipal situation. The basis of the problem is emotional rather than any retardation. As much of the problem is close to the surface, it is felt that Ronny would respond well to therapy.

Ronny's mother accepted his emotional problem, saw the need for treatment, and agreed to it. The case was then put on the waiting list. This case and the four others all showed similar characteristics to the group in treatment, in that they accepted treatment and there was treatment beginning and taking place during the diagnostic study. While on the

waiting list physical contact with the Center is terminated, but the clients are encouraged to contact the Center if any special problems arise.

The next case is a situation where the client claimed understanding from the study so did not follow through the recommendation for treatment. There are two cases in this sub-group.

CASE 5

Frank is a seven year old boy whose mother came to the Center for an evaluation of his mental ability, since he was experiencing serious learning problems. She thought that something might be disturbing him emotionally thereby causing a learning block. She had noticed that when he first went to school he seemed afraid to leave her. The diagnostic study was to be used as a tool to have Frank's mother become aware of her role in the relationship.

The early picture of Frank was a quiet, submissive child who developed rapidly. His toilet training was completed by the age of two. At this time his brother was born. Up to the age of six he sucked the edge of a diaper when he went to bed. His mother thought that he might have felt rejected because of the attention given to his brother. She never over-did giving affection to the children because she was brought up not to display affection openly. Frank likes to imitate his father. Frank is the middle child of three, and the family is well situated financially. The outstanding feature in the mother-child relationship is her fear of aggression on Frank's part. Frank's father remains in the background.

The caseworker saw Frank's mother as a rigid and castrating woman and Frank is suffering from this. Treatment would proceed with difficulty and resistance unless she is confronted with her damaging influence on Frank's development as a male.

She was seen four times but did not return for the interpretation interview.

Psychological Study.

Frank was seen for two sessions in which he was given two tests. He is tall, blond, and well-built, and he gave the impression of trying very hard to please. The intelligence tests indicate evidence of superior intellectual capacity. The learning problem is a result of emotional factors. Frank sees boys as passive beings under the power of outside forces. Women, on the other hand, are powerful, threatening figures who have teeth and claws. He shows great fear of castration and sees learning as an aggressive act. However, there are indications of positive male drive, and he could benefit from treatment. Prognosis appears good.

Frank's mother said that she gained understanding in the course of the diagnostic study, and felt she wanted to see if she could handle the situation herself. She was able to see her influence on Frank. Some time later she re-applied for her younger son. Frank is doing better in school. The second case in this sub-group, a father and daughter, withdrew after one interview claiming new understanding had been obtained.

It is difficult to evaluate precisely whether the clients did gain understanding during the diagnostic study. The study shows that in Frank's situation some understanding was gained in that his mother was able to return to the Center for further help. In the second case, Rose, it may or may not be so, but without further evidence to the contrary the client's statement must be accepted.

The next sub-group is concerned with two boys who were referred to another agency because they did not meet the Center's eligibility requirements for treatment. Although these two boys are twins they were studied as individual situations. This is the usual practice in the Center when offering services to more than one child of the same family.

CASE 6

Will is a ten year old boy brought in by his mother at the suggestion of her doctor. There is a question of mental deficiency with organic impairment. At the age of three Will was struck by a street car injuring his head. He is in an ungraded class at school. The diagnostic study was undertaken to see if treatment was advisable.

Will was average in walking and talking. His mother described toilet training as housebreaking, and commented that one would think she was talking about a dog. Wetting was controlled at nine months. Will is described as being very suggestible; and is easily led by other children. He and his brother have few relationships with other children. They argue with one another often. Will's brother is aware of Will's backwardness and protects him. These are the only children in the family, and their father feels bad because he and his wife are unable to have any more children. Will's mother had a hysterectomy.

Will's mother had planned at one time to place him in a special school, but withdrew because she couldn't leave him and would be worried to death about it.

The caseworker saw the parent's real choice was to keep Will at home and help him there. This seems possible since Will is showing some improvement in school, and with the aid of community resources he can be helped further. His mother needs casework support in her own problems.

She was seen four times and twice after the study for interpretation and help with a community resource.

Psychological Study.

Will is a blond boy of slight build who moves quickly and has a girlish appearance. He was seen four times. The six tests reveal a boy who is functioning at a defective level, but whose irregularity of performance would indicate that this is not purely mental deficiency. There are signs of organic impairment; strong fragmentation of the thinking process and disorganization of conceptual ability. There is fear of attack from males, and a wish to remain a baby.

The psychologist saw Will as a severely disturbed boy in whom there are signs of organic damage and psychotic processes. The latter was more prominent in the test material. Intensive treatment was recommended.

The Center is not set up to give the type of treatment required by Will. To be acceptable for treatment the child's emotional retardation must be due to emotional factors and not constitutional or organic ones. It was felt that constructive masculine activities with other boys under male leadership might help. Referral to the Boy's Club was recommended and carried out.

Will's brother was found to be similarly disturbed, but his intellectual processes were average. He was in need of treatment. Because the boys were so close, and because Will sought and needed the protection of his brother, both were referred to the Boy's Club where, in the past year, they have made marked improvement. Their mother is seen occasionally at the Center.

The final case presentations of Group A are two of seven cases where placement was recommended. Of the seven cases five accepted and carried out the recommendation, and two did not. A placement was considered accomplished if the client was seen for the first appointment at the other agency.

Case number seven illustrates a successful referral and case number eight an unsuccessful one.

CASE 7

Mary is a five year old girl who was referred by Aid to Dependent Children for temper tantrums, poor speech and inability to get along with other children. She was born during a critical period of the marital relationship. Her father was particularly abusive to his wife and denied that she was his child. Shortly after, when she was one, her mother divorced Mary's father. She is the second youngest of five children. Mary is different from the rest of the children in that she will not do what she is told.

Mary's mother was very anxious and over controlling with her because she was sickly. Mary demanded the bottle until two and a half years of age. Toilet training was difficult, and only accomplished recently. Mary walked and talked about the age of three. Her mother fears that she may be mentally deficient and often compares her with her ex-husband's mentally deficient sister. She appears to focus all her hostility on Mary.

The caseworker felt that the mother's anxiety about the child's symptoms makes it impossible for her to relate to Mary except in a restricting way. Her extreme rigidity prevents her from accepting messiness in Mary. She is in need of help but would not respond readily, would be threatened, would react with hostility and would withdraw from treatment.

The mother was seen twice during the study and three times after for interpretation and placement

which was carried out by a children's agency.

Psychological Study.

Mary was found to be untestable so was seen twice diagnostically by a psychiatrist. Mary is a chubby, short girl who speaks indistinctly. It was felt that Mary is functioning at a low average in intelligence.

Mary is a severely disturbed, hyperactive child with short attention span and marked indecisiveness. As a result of identification with the aunt, the mother's troubled state, and punitive behavior, Mary has failed to develop emotionally with the resultant lack of integration of affective drives and a tendency to operate on a primitive oral level. Therapy will be of long duration.

In view of the severity of the problem and the mother's inaccessibility, placement in a foster home was recommended with treatment beginning after the placement.

The placement was worked through with the mother, and Mary was placed in a foster home. She was then taken in treatment at the Center and is showing improvement. There were five cases in which placement was accepted. Three cases dealt with situations where the problem was on an emotional basis, but the parent was not amenable to treatment. Placement in a foster home and then treatment for the child was carried out. It appears significant that in each of these three cases the child was seen to be different from the rest of the children of the family. There were three or more children in each of these three families.

The other two cases of this group were mentally deficient children for whom institutional care was recommended.

Both children were placed in the recommended institution.

The following case illustrates a situation where placement was rejected by the parent.

CASE 8

This six year old boy was referred by the Psychosomatic Clinic of the City Hospital for questionable mental deficiency. Karl was first brought to the Clinic because of unmanageable behavior at school. He was not allowed to attend school after one week. Karl's mother does not view him as a problem as she can manage him at home. He did not present a problem until she remarried her first husband. Karl's father wants to place him and his mother opposes this. The mother was seen three times.

Karl was born several months after the divorce. Karl's mother was very run down after his birth. He was very sickly at birth and was to be kept at the hospital until he improved. The mother removed him against the wishes of the hospital, but had to return him when he became worse. At first she thought he wouldn't live. Karl walked at one and a half, but did not speak plainly until the age of four. He was given everything that he wanted. He was punished by being put to bed. His mother struck him once and she is still extremely guilty about it.

Karl lives with his parents, a six month old sister and a maternal grandfather. The family receives public assistance. The father attends the State Hospital Out-Patient Clinic for a "spasm." He also has a police record. He is extremely abusive to Karl, beating him and telling him he should be sent away.

Karl's mother was placed in a foster home at the age of two and at fourteen was placed in an institution for feebleminded children. She remained there until the age of twenty-one and was then placed on five years probation.

The caseworker states that Karl's mother is in conflict over the position that she is in. She does not want to give up Karl as she intends to act out her former deprivations by giving him everything, and yet she does not want to give up her husband. Treatment is contra-indicated.

She was seen three times and once after the study for interpretation and clarification.

Psychological Study.

Karl is a small dark boy who speaks very indistinctly. He is always chewing on something. Karl was seen three times and given three tests.

Karl is functioning on a defective level but may have low average intelligence. He is very disturbed emotionally and cannot differentiate between the real world and the unreal. There is complete lack of identity and controls. He feels that the whole world is out to get him and there is nothing left in the world for him but death and insanity.

The psychologist considered Karl to be pre-psychotic, with or without organic involvement; it cannot be ruled out. Institutional care is recommended so that he can get the care he needs and at the same time protect those around him.

The mother, who was mentally inadequate and emotionally disturbed, could not be worked with. She flatly refused to place Karl because of her own experience at being placed in an institution. She could not give up the child.

A similar situation existed in the rejection of placement for Alvin, a nine year old boy functioning at a defective level with organic brain damage. Even though the Center felt he would become explosive in his behavior, his mother refused to place him saying that he meant too much to her to let him go.

Both parents in the above situations were quite disturbed with their own problems and could not accept the fact that their children had not developed normally. In both cases the children were necessary to satisfy the needs of the mothers. In trying to satisfy these needs they invested great amounts of care in the rearing of the retarded children. This is evidenced by the fact that both mothers denied the existence of a problem and felt that they could help the child in spite of his difficulty.

There are five cases in Group B. Four will be presented as the outcome in two cases is identical. It should be noted here again that these cases are situations where treatment was indicated from the application material, but because of certain eligibility requirements the Center could offer only the diagnostic study. The clients were informed of the limitations on application and all accepted this at the initial interview. It is significant that in this group all but one client rejected the major recommendations; two rejected placement; one rejected referral to a family agency, but did consent to a secondary recommendation; one withdrew; and one carried out the recommendation for medical consultation.

CASE 1

Ann's mother came to the Center at the suggestion of the school nurse. Ann, a seven year old girl, cannot learn, has a speech impediment, and seems to be in another world. After the mother made application she showed great reluctance to come in but eventually agreed to come in and talk things over with the worker.

Ann is the older of two girls. Ann's father is described as being extremely nervous, insecure and fearful. He is convinced that he is dying of cancer. He has many other somatic complaints. He is fearful that something will happen to the children and cannot allow them any freedom.

The family lives in a two-family house owned by Ann's maternal grandmother who lives upstairs. She is dying of cancer. Recently a maternal aunt died of cancer and another has arthritis.

Ann was born prematurely and was breast-fed for six weeks. Her mother felt that breast-feeding was harmful to Ann and painful to herself. Ann cried constantly for the first three years, had temper tantrums and banged her head. She was given many enemas. At the age of eighteen months she had a severe case of tonsillitis, and a high fever lasting about a week. From that time on she has been puny, sickly and slow to develop. Toilet training was difficult; she soiled until three and had enuresis until six. She had a severe case of worms and was tied down in order to force the medicine down her throat. At present Ann is in the second grade, and may not be promoted.

Ann's mother is an extremely disturbed woman. She cannot accept the fact that her daughter has a problem. Any treatment plan for Ann would be hard to carry out. A neurological study was recommended for differential diagnosis, but Ann's mother would not have it done. It would prove nothing as there is nothing wrong with Ann. She feels that she is just Ann, and, therefore, Ann will be all right because she is.

The mother was seen six times diagnostically and once for interpretation.

Psychological Study.

Ann is a dark, plain, scrawny girl. She was seen five times and given six tests. The testing situation cannot be considered representative of her capacity to perform, but it is representative of her current behavior. She reacted negatively to the test situation and could not relate to the examiner. She showed a marked inadequacy in organizational ability, and unrealistic, distorted approach to her environment in the intellectual and emotional spheres.

The psychologist saw Ann as having psychosis with or without organic involvement. Treatment is necessary or she may be expected to withdraw further and manifest sporadic explosive behavior. A special school placement was seen best for Ann.

Ann's mother wished to know whether Ann was mentally retarded but when confronted with it denied the possibility. She resisted coming in for the presentation of the findings but came eventually after cancelling several appointments. She rejected the recommendation of special school placement and refused to have a report forwarded to the referral source. Later she wrote a letter saying that she could not part with Ann, and, further, Ann was doing better in school.

Matt is an eight year old prepsychotic boy in need of treatment. A treatment home placement was recommended but his mother rejected it. She was unable to say outright that she did not want to go through with it, but would allow the Center to make appointments for her at the treatment home which she never kept. After a few instances of this, she dropped out of contact altogether. All the contacts after

the one to explain the diagnostic findings were by letter. Matt's mother could not accept his problem and felt that he would outgrow it. This mother had already placed two younger children, a boy and a girl, in a foster home. Her emotional tie to Matt was that she could not bear to part with him.

The next case shows the one situation where the mother carried out the Center's recommendation.

CASE 2

Roberta, an eleven year old girl, came at the suggestion of the school because of reading difficulties. Roberta is in the fourth grade and, for the past year, had been tutored in her reading.

Roberta was born two and a half years after the marriage and is the oldest of three siblings. From the beginning she was not a well child. Roberta was brought up by the "book" as her mother wanted to be very careful, because of Roberta's semi club-foot. She had a cast on her foot for seven months. Occasionally Roberta still walks with a limp. She also had infected eyes and ears.

Roberta was breast-fed and never had a bottle. She was toilet trained at ten months. Roberta was viewed as a very contented child who did not need as much care as did the younger sister. Roberta's mother dates the problems to the day when, at the age of five, Roberta was bitten severely by a dog. Later her mother bought her a dog to allay her fear. Nothing is mentioned by the mother of the youngest child, a boy.

About two years ago Roberta had two foster sisters from the Division of Child Guardianship. They were looked upon as sisters and she got along well with them. Roberta's mother sees herself as a good protecting woman, and feels this trait came down to her from her mother and is something to be admired.

The caseworker saw a constant comparison of the girls by the mother and a tendency to be very over-protective toward Roberta. This over-protection appears to be a reaction to an underlying rejection of Roberta as shown by the praise of the sister.

The mother was seen twice and once to present the findings.

Psychological Study.

Roberta is a tall, overweight, flabby girl. She is constantly salivating and must swallow often. She was quite compliant in the test situation and was given five tests. She appears to be functioning consistently at an intellectual level that approximates mental deficiency.

The personality picture shows a lack of spontaneity and difficulty in responding to new situations. She tends to withdraw from contacts with others.

The psychologist saw Roberta as a girl functioning at a defective level, but a question as to whether she is actually defective has to be raised. In view of her appearance and early history endocrinological examination seems indicated. The mentally retarded functioning cannot be explained solely on an emotional basis.

Roberta's mother accepted the findings and promised to consult an endocrinologist. Later the endocrinologist contacted the Center to give the information that Roberta was undergoing treatment with him and seemed to be improving. Roberta's mother also requested that a copy of the findings be sent to the school, the referral source. Examination shows that Roberta's mother had some concern for her and her problem.

This next case shows where the referral to another agency was rejected because it was too threatening to the

client, but she did consent to help in an indirect way.

CASE 3

Joan's mother asked for help after the school principal suggested it. Joan, an eight year old girl, had difficulty in reading. She had a speech impediment, was fearful and disobedient.

Joan is the younger of two girls and was born prematurely. She was bottle fed and demanded a great deal of attention and care so that her mother feels that she may have spoiled her. Joan developed slowly, was slow in talking and difficult to toilet train.

Joan's father, a college graduate unable to work in his chosen field, works in a factory. Her mother also works in a factory to supplement the income. They were married when she was seventeen, twelve years ago, and it was never accepted by his family to whom he still has a strong emotional tie. The marital relationship appears unsatisfactory to Joan's mother who sees her easily rejected, self-deprecating husband as another child whom she must handle "with kid gloves." Joan has been preferred by her father to the older sister. They have formed an alliance against the mother. Her mother resents this and thinks it is because they are alike.

The caseworker saw Joan's mother as a woman who relates with difficulty and guilt about her hostility toward Joan. She is using Joan in her poor marital adjustment. She has built up strong resistances to help. Although both child and mother need treatment she would withdraw as her own involvement became clear. She cancelled four appointments during the course of the study.

She was seen six times diagnostically and once after for interpretation.

Psychological Study.

Joan is a slight, thin-faced, small girl whose upper and lower lips are scarred. She was given six tests in six sessions and had to be

bribed by her mother to stay with the examiner. Joan is capable of borderline intellectual functioning, but at present her emotional difficulties hamper and inhibit her learning and efficiency. She seems to be defending herself from her impulses regarding her father and seeks protection by the mother. Her mother is not an adequate protector, hence little relief from these threats.

The psychologist felt that her difficulties were in part related to being used in the marital conflict. She finds it profitable to appear dumb. Treatment is indicated but it is essential for both parents to accept help for themselves for lasting improvement in the child. In school a non-pressuring, encouragement from an understanding teacher would be helpful to Joan.

Joan's mother could not accept the findings of the study in reference to Joan's involvement in the family situation. She denied any marital problem and rejected the suggestion of a referral to a family agency. She wanted to know if the school could help Joan. She was in favor of a conference between the Center and the school. A conference was held by the mother's worker with the principal and Joan's teacher. The Center's resources were held open to the school should they need them at a later date in Joan's school career.

Many months later the Center received a report that Joan had been referred to a private speech therapist. The discussion of the findings with the school had not helped very much as the principal felt that the information given to him by the Center was not definite enough. The relationship with the speech therapist was encouraged as she was a permissive non-pressuring individual.

The final case represents a situation in which the client would be seen occasionally for interpretation but withdrew from the Center.

CASE 4

Alan's mother requested help at the Center for her fourteen year old son. The high school principal suggested her coming to the Center. Alan has been failing and has become sullen and withdrawn. Beatings and punitive measures do not seem to help.

Alan is the third of six children. A sister and a brother are honor students, the sister in high school and the brother in college. All the children but Alan have conformed to the restriction on aggression expected by the parents. Alan is described as a non-conformist from the very beginning.

Alan was breast-fed for two months, then put on the bottle. His mother could give no information on feeding and toilet training because there were so many children. Unlike the others he cried a lot, slept less and was restless. He now feels picked on and cries easily.

Alan's father, who suffers from migraine headaches, is described as the easier one with the children. The mother is the strict one who does the punishing. The only girl is the favorite with both mother and father. Alan's mother spoke of herself being the favorite one in her family because she was a sickly child. She has worked on and off in order to save money to buy the farm on which they now live.

The caseworker saw Alan's mother as having gained some insight into her problem and Alan's. However, her fears of aggressive behavior should not be touched upon. The worker felt that Alan's mother should come back in three months to see where she stood at this point and for further interpretation of the problem, if needed.

She was seen twice during the diagnostic study and once for interpretation.

Psychological Study.

Alan was seen four times and given six tests. He is a sturdy, blond boy who is small for his age. He identifies with the weak passive father, and reacts against accepting this inferior role. Alan feels himself to be inferior as a result of long consistent deprivation. His mother keeps him in the house on any pretext.

Intellectually he is functioning on the superior level with emphasis on the concrete and performance aspects rather than abstract or verbal.

Alan, it was felt, could benefit from therapy as he is pretty much intact. He is rebelling against things as they are. He is sensitive, intelligent and controlled.

Alan's mother apparently accepted the findings and suggestions of the Center. The principal was informed of the boy's problem. Alan's mother failed to keep the appointment. She was finally contacted by the worker after seven months. Alan had run away from home to work on a farm. He was now back at home but not attending school. She did not want to come to the Center for further discussion.

In four of these cases the workers saw the mothers so emotionally disturbed that treatment would be difficult and prognosis doubtful. Roberta's mother was the exception. The worker makes no statement about her capacity for treatment and the case record does not show this. Possibly the four cases might have been helped had the Center been able to extend help beyond the diagnostic study.

CHAPTER VI

SUMMARY AND CONCLUSIONS

The purpose of this study is to determine the value of a diagnostic study used as a limited service. A comparison was made of diagnostic studies done on cases eligible for treatment, Group A, and those who are not eligible for treatment, Group B, because of residence outside a specific geographical area but had been accepted by the center for a diagnostic study. Were these clients helped by the diagnostic study as a limited service and was this in keeping with the aims of the Center which is to extend psychiatric help to children with problems? These are the general questions the writer asked.

The Center offered different types of help to the clients of both groups based on the diagnostic findings and the limitations of the Center. Analysis of the thirty-two cases in Group A shows that twenty-three cases were offered treatment. Two cases were referred to other agencies and placement was recommended for the child in seven cases.

In the five cases of Group B no treatment could be offered because of the eligibility requirement. Thus, the Center could offer only referral to another agency or consultation. Two children were recommended for institutional

placement. One was referred for medical consultation and one mother was given a consultation appointment at a later date at the Center.

A study of the outcomes of the two groups shows that for Group A nineteen cases accepted treatment. Two cases rejected treatment and two refused treatment claiming that they had gained understanding of their situation through the diagnostic study. Alexander and French feel that treatment may be initiated during a diagnostic study and reveal new understanding to the client about his problem.¹ There were two referrals to another agency; both accepted. Of the seven recommendations for placement, five cases accepted and carried out the recommendation. Two rejected the recommendation. In the five cases which carried out the recommendation, some special factors have to be considered. In these cases the parents came to the agency for help in placing the child. The parents had considered placement of the child before coming to the Center.

Thus, out of thirty-two cases, twenty-six accepted the help offered and six did not.

In the five cases of Group B, four cases rejected the help offered and one case accepted and carried it out. Both placement referral were rejected by the parent. The parent

¹ Franz Alexander and Thomas French, Psychoanalytic Therapy, p. 116.

who was referred to a family agency rejected this, but she did consent to a secondary offer of help. A conference was held with the school about the child. In another case the recommendation for a consultation appointment was never carried out and, when later contacted, refused to come to the Center.

The source of the referral for the most part came from the parent except in thirteen cases in Group A. These were actual requests from other agencies for diagnostic studies. In Group B, the clients came at the suggestion of a school or doctor.

The reasons for the diagnostic studies of Group A were varied. The majority, nineteen, were made for the Center's own reasons in attempting to understand fully the child and his problem. In Group B there was only one reason for the study to be made because of the Center's eligibility requirement. In the five cases it was given as a limited service.

It is significant that in all instances the request for a diagnostic study came from some other source than the parent.

The number of interviews and psychological tests given to each group show that Group B received more tests per child and more interviews per parent than did Group A. It is difficult to determine why this occurred. The writer suggests two reasons why this may have occurred. These reasons are not verifiable as there is no direct evidence to substantiate it

in the records. The clients of Group B were seen by the workers as being more disturbed because the application material stressed the need for treatment, and, therefore, these clients were given more consideration by the workers. The workers, being aware of the Center's limitations in these situations, tended to go beyond what they were expected to do routinely. The workers were also aware that service for these clients would be concluded with the one interview following the diagnostic study in which the findings were interpreted to the client.

It can be concluded that on the whole Group B received little help in contrast to Group A, which received extensive help. The workers in Group B saw the mothers in four cases as being emotionally disturbed to the point that prognosis was doubtful and treatment would be difficult. These mothers appeared to need continued contact in order to meet their needs and resistances. These four mothers did not relate well and showed overt hostility toward the Center during the diagnostic studies. Case number seven in Group A is a situation quite similar to these four. The mother was hostile and prognosis appeared doubtful. This mother was seen twice after the interpretive interview in order to help the mother carry out the recommendation of placement.

This bears out the general feeling in the field of social work that diagnostic studies are a prelude to treatment

and without ways and means to utilize the findings of the study they fall short of helping the client and carrying out the aim of the Center.

Some clients, however, can benefit from a limited service; others cannot. Therefore, there is a need to delineate between those who can use a limited service and those who cannot. One parent in Group B, Roberta, received understanding that enabled her to take the necessary steps to resolve her problem, and two cases in Group A, Frank and Rose, the parents obtained understanding of their problem. This is in keeping with Alexander and French's view.²

This study brings out that the diagnostic study as a limited service can and does have value. The value lies in the discriminate use the Center can make of it. As the study showed, certain types of clients do benefit from such a service and others do not. In using the diagnostic study as a limited service, care must be used in applying it.

This study raises questions for further investigation of how to select the individual who can benefit from a limited service. What criteria would go into an evaluation of an individual regarding his ability to utilize to the fullest extent a limited service? It also raises the question of the concept of the diagnostic study and its relation to treatment.

² Supra, p. 53.

The diagnostic study, as a limited study, needs to be looked at and varied accordingly in order to make efficient use of it. This means a re-examination of the diagnostic study and its relation to short-term services as has been done in its relation to long-term services.³

Approved:

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Dean

³ Thomas, op. cit., p. 80.

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APPENDIX

TOWNS IN THE GREATER WORCESTER AREA

Worcester

Auburn

Boylston

Grafton

Holden

Leicester

Millbury

North Grafton

Paxton

Shrewsbury

West Boylston

1000
1000

1000 1000 1000 1000

1000

1000 1000 1000 1000