FAMILY DIAGNOSIS AND TREATMENT
IN A
CHILDREN'S PSYCHIATRIC CLINIC

An Assessment of the Casework Focus from the Recording.

by

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ABSTRACT

There have been many changes in the focus and direction of social casework since Mary Richmond published Social Diagnosis in 1917. Casework in her day emphasized the socio-economic aspects of the family's adaptation to society. With the advent of psychoanalytical concepts, the focus shifted from the family's social reality to the individual's subjective response to it, as one way of understanding the client's maladjustment to his life circumstances. In agencies and clinics, office interviews with individuals replaced home visits to the family. Consequently, the caseworker's knowledge of the day-to-day social functioning of the client and his family was often incomplete.

Caseworkers and psychiatrists in Child Guidance Clinics learned that the child could not be helped with his emotional difficulties unless the parents were included in the treatment process, since the child's maladjustment so frequently stems from unhealthy relationships with his parents. While the focus was upon the child and his family, the emotional aspect of each parent's adaptation was emphasized. The interplay between family members' personalities and the problems for which they were seeking help was still too complex for full understanding. The search for helpful concepts is still in process.

Current casework emphasis on the client's social functioning is attempting to integrate psychological and social concepts in casework theory. Role theory, combined with psychological concepts, holds the promise of providing a method by which the caseworker can diagnose and treat the problematic aspects of the individual's and family's adaptation. In order to understand the individual, it is necessary to know how he interacts with family members, they with him, and his group with society at large.

This study is an exploratory assessment, from casework recording alone, of the extent to which psycho-social diagnosis and treatment has been adapted to casework practice for families with disturbed children in the Children's Clinic of the B.C. Mental Health Centre. Twenty cases of disturbed children were selected: between the ages of five and ten years living with their own parents; capable of attending public schools; and not suffering from physical handicaps. Most of the children had siblings. They were active cases in which treatment had proceeded a substantial distance. Two rating scales were: (a) the
child's emotional and social adjustment and (b) parental and family relationships and strengths. These pointed up the areas of information obtained by the caseworker for the psychosocial diagnosis of the child's family, and also made it possible to compare the child's adaptation with that of his family's.

The evidence is that the social functioning of the family as a unit is not apparent from the recording, that most emphasis is upon the mother-child relationship, and that the child's relationships with other family members are not sufficiently explored. The Casework contributions to the diagnostic study of the child's problems are largely in the area of the parents' (particularly the mother's) emotional adjustment, and the child's particular development.

The original intention was to measure the child's and parents' social functioning between two points in the treatment process, but the recorded data was insufficient for this purpose. Only descriptive comparisons are possible, also a descriptive evaluation of the outcome of treatment in relation to the casework focus. The recording which described the greatest improvements in family relationships, and in the parents' and child's social functioning, was oriented, in the treatment phase, to the client in his family, even though this focus was not evident in the diagnostic study. Those cases which showed the least movement emphasized the emotional adjustment of individual members of the family. The main reference point in the former cases was the client's interaction with people and situations in his current life circumstances; in the latter cases, the worker's efforts were directed towards helping the client with his emotional conflicts, which stemmed from his early life experiences.

This is an exploratory study of areas highly significant for family casework in the Children's Clinic. Although the conclusions require repeated research to verify their validity, they nevertheless suggest that a casework focus on the client in his family holds more promise of helping than a focus which emphasizes the client's emotional adjustment alone. Such an orientation contributes to the definition of the casework function, and distinguishes the caseworker's role from that of the psychiatrist. It has contributions to make also, in the task of integrating theory and practice in family casework.
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# TABLE OF CONTENTS

Chapter 1. **Family Casework and its Application to Child Guidance Practice**

The current trends in social casework - family casework. Casework practice in a psychiatric clinic; definition of the casework function. Role differentiation between psychiatry and casework. Some psychiatric contributions to family therapy. Focus of study: Is casework in the Children's Clinic individual- or family-centred? Concepts for family casework: role theory; ego psychology. Related social work studies: the St. Paul Project; Current theses in casework measurement. Methodology... 1

Chapter 2. **Client and Family Assessment in Diagnosis**

Symptoms of emotional disturbance in children; symptoms in the sample group. Socio-economic factors in sample cases. Families' relationships with their communities. Inter-relationships within families in the sample group; reciprocal parent-child relationships. Nuclear family relationships with the extended family. Family solidarity. Comparison of child's treatability with impairment in the parent-child relationship. Individual or family focus? 46

Chapter 3. **Family Assessment in Treatment**

The diagnostic conference; clinical assessments of the sample cases. Six points which emerge from analysis of treatment focus. (1) Criteria to determine treatment goals, (2) Recording of treatment goals; caseworkers and parents, (3) Criteria for assignment of shared and unit cases, (4) Individual, joint and family interviewing methods in the treatment phase, (5) Involvement of family members in the treatment process, (6) Assessment of treatment. Conclusions: strengths and weaknesses in the casework focus. 80

Chapter 4. **Improving the Family Focus**

The community's awareness of the problem of disturbed families; the Clinic's role in the community. Research and practice in
TABLE OF CONTENTS (continued)

Chapter 4 (continued)

family diagnosis and treatment - contributions from social work. Findings from sample case records. Recommended changes in: the social history format; recording policy and practice. Other ways to improve recording practices: the "Varwig-McCallum" approaches. Conclusions on the effectiveness of family casework. Continuing needs: casework focus; recording methods; professional research. .......................... 129

Appendices:

A. Child's Schedule
B. Parents' and family Schedule.
C. Social History Outline
D. Progress Conference Format
E. Closing Summary
F. Bibliography.
Chapter 1.

FAMILY CASEWORK AND ITS APPLICATION
TO CHILD GUIDANCE PRACTICE

Current Trends in Social Casework:

The history of social casework reveals a changing emphasis from a primarily socio-environmental approach to individual and family problems prior to World War I to a "bio-psychic" model of personality in the thirties based on psychoanalytic concepts which stressed understanding the individual's intra-psychic conflicts in relation to the problems for which he was seeking help. During this period, inner and outer stresses were clearly separated. "By 1940, however, caseworkers were beginning to express their concern that focusing on the emotional condition of the individual had resulted in subordinating and neutralizing their understanding of social factors."¹ During the last twenty years the dichotomy between social and psychological components, although recognized as impeding effective casework practice, has persisted, and casework theory is said to have made only small advances in resolving this problem.² From a review of the literature and from observation of casework practice, Dr. Sherman observes that a gap exists between theory which

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² Ibid., p. 16.
emphasizes psycho-social integration and "actual practice of analyzes, diagnosis and treatment of specific cases which deals almost exclusively with emotional aspects of personality and personality maladjustment."^1

Dr. Nathan Ackerman states:

"The historical focus on the individual has brought a wealth of knowledge of internal mental processes but it has imposed a blindness as to the urgency of evaluating illness as a family process as well. Criteria for emotional illness and health cannot be restricted to the individual; they must encompass the individual within the group and the group as well. The ills of the individual, the family and society are a continuum."^2

He goes on to suggest that "our conspicuous failure so far to prevent mental illness derives from our failure to cope with the mental health problems of family life."^3

Professionals in the mental health field are turning to this same point again and again - that the individual's adjustment has been considered in terms of his own intrapsychic conflicts without sufficient recognition to the health and the pathology of the primary group in which he lives. Although this trend is being recognized and influenced

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1 Sherman, Exploring the Base for Family Therapy, p. 17.


3 Ibid., p. 9.
by psychiatry, the social work profession has been traditionally concerned with helping families towards healthier levels of functioning, and it is in this area that the training and experience of social workers enables them to function.

Casework Practice in a Psychiatric Setting

How is this trend towards family therapy influencing social work in a psychiatric setting, such as Child Guidance Clinics?

For many years, it has been recognized in Child Guidance Clinics in North America that treating the emotionally disturbed child in isolation from his family is not an effective method. Jackson & Satir write:

"The Child Guidance Movement, which was initially developed through the efforts of the Juvenile Court to treat delinquent children specifically, rather naturally expanded to look for and include expeditious and economical means of diagnosing and treating neurotic and psychotic children. Experience, especially on the part of social workers, has led to the conclusion that treating the child is not enough and, more recently, that treating the child and the mother may not be enough."1

In many Child Guidance Clinics in North America it became traditional to include the mother, with an ever

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widening recognition since the 1940's of the need to involve the father in treatment; recently, more attention is being given to the wisdom of including other significant persons in the family, such as siblings, living-in relatives and members of the extended family.

Despite the fact that the family milieu is seen as the focal point in understanding and treating the child, individual diagnosis and treatment is a better developed clinical entity than family diagnosis, with the result that, although the main figures in a family may be involved in treatment, they may be viewed by social workers as individuals against the back-drop of the family rather than as active members of the group whose social adaptation influences and is influenced by other family members in a dynamic, ever-changing way. Dr. Sherman writes:

"Changing from family-oriented to family diagnosis and treatment is more than an increase in intensity of the same approach. It represents a shift to viewing the distress of the individual as less the problem than a symptom of the problem of pathology in the whole family. Family Diagnosis is oriented to the client in the family and their reciprocal interplay; it replaces the separatism expressed in the phrase "the client and his family".... The "in" orientation is holistic; the "and" orientation is atomistic. These differing orientations reflect differences not only in personality theory but also in practical family analysis. One approach is to comprehend and analyze the whole (the family) as a necessary concurrent condition to understanding or analyzing the part (the individual);
the other approach defines components (individuals) and attempts to comprehend the whole (the family) by interrelation and synthesis... The holistic orientation is harmonious with social work tradition."

Casework has been traditionally concerned with the relationship of the client to the significant people and to the social institutions in his environment. A popular and widely accepted definition of casework today is offered by Helen Perlman. She writes: "Casework is a process, used by certain human welfare agencies, to help individuals to cope more effectively with their problems in social functioning." She describes social functioning as "an individual's person-to-person, person-to-group, person-to-situation, transactions." It is therefore not only the client's emotional adjustment that is the province of social casework, but the problematic ways in which his psychological, physical and social self affects, and is affected by, persons and situations in his environment. In Child Guidance Clinics, the most frequent problem which underlies the child's symptoms is found in the parent-child relationship, parti-

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1 Sherman, *Exploring the Base for Family Therapy*, p. 18.


cularly the mother-child pair. What is happening in other family relationships, however, such as marital and sibling interaction, may have marked effects on the mother's and child's responses to each other. In addition, significant relationships and situations outside the family may contribute to impairment in family relationships and to the child's disturbance. Diagnosis and treatment of the psychological, physical, and social factors which contribute to dysfunctioning in parent-child relationships is therefore an appropriate casework focus in Child Guidance Clinics. The central reference point is located in the caseworker's goal to enable parents and child to achieve more satisfying ways of adapting to each other.

This orientation is not intended to suggest that the profession abandon individual diagnosis and treatment in a clinical setting, but rather that the psychosocial implications of family group life be understood in as complete a way as possible, and utilized in the treatment of family members to help them improve their relationships with each other, particularly with the disturbed child.

This approach is oriented to the child in his family. However, if the gap between psychosocial theory and practice exists in social agencies, which means that the interaction between the client and his family is not
understood and treated, it is very likely more evident in psychiatric clinics. In these settings, psychoanalytic concepts and methods, which stress emotional factors in the individual's adjustment, may be expected to exert an even greater influence on social casework. This may mean that the child's and parents' relationship difficulties are viewed only in terms of each member's individual emotional conflicts, without sufficient knowledge of the impact of their relationships, and their current life experiences, upon each other. Not only the problems, but the resources of the family group may be overlooked by the caseworker. Furthermore, if the caseworker concentrates on the client's personality dynamics, role confusion between the social worker's and the psychiatrist's function ensues, which creates difficulties in team work and in the appropriate assignment of cases.

Differentiation Between Psychiatry and Casework

It has often been observed by psychiatrists and social workers that the function and goals of these two disciplines tend to merge in a psychiatric setting. Social work has gained considerable knowledge from psychiatry of personality dynamics and of techniques in working with disturbed individuals; many psychiatrists have, in turn, extended their sphere of interest "into the realm of group behaviour, social patterns, and social pathology."¹

Some overlapping of the functions of these two professions is therefore to be expected, and social workers and psychiatrists often treat the same kinds of problems. Lucille Austin states that the aims and methods of the two disciplines are, however, quite distinct.¹ It is one of the arguments of this thesis that some differentiation of these roles is essential if caseworkers are to become more certain of their function in a psychiatric setting.

Dr. Coleman² states that differentiation of the psychiatrist's and caseworker's function becomes extremely difficult when the two professions are working together. He believes that their functions can and do overlap in some areas, but he maintains that their methods and goals must be essentially distinct. In his view, the caseworker does not define the problem in terms of the client's intrapsychic conflict; rather, it is the problem of a client in relation to a distressing situation. The caseworker deals with people's feelings, with the impact of personality on the situation, and in the area of the relation of a person to a situation of distress. She reduces anxiety by understanding the client's distress, and by relating it to its situational


source. She strengthens the client's defenses by supporting even his rationalizations when they do not conflict with the immediate reality issues. She does not attack defenses but supports neurotic equilibrium. The caseworker's tools are "identification of feeling as related to current problems, situational clarification, and the sharing of plans and, if necessary, the burden of decisions with his clients." The goal of casework is "to help the client with his situational problems, and not to modify the client's character attitudes or his neurotic adaptations, although such changes do occur almost as a by-product of the casework process."  

Psychotherapy, on the other hand, "makes use of a patient's situational stress for an understanding of the disturbance of the dynamic equilibrium which has been precipitated by the new situation." The goal of psychotherapy is to gradually undermine neurotic defenses so that they may be replaced by more spontaneous and more realistic attitudes. The psychiatrist is not so concerned about an individual's particular social situation as he is about the pathological personality trends which emerge in the patient's response to that situation.

2 Ibid., p. 248.
3 Ibid., p. 249.
According to this view, the basic difference in function between the psychiatrist and the social worker emerges in the selection of the problem focus, in the establishment of goals, and in the methods used to achieve them. The social worker is concerned with the person in his situation, and attempts to help the client achieve more harmonious relations between himself and the particular problem which he brings to the agency. The psychiatrist, on the other hand, is more concerned with the individual's personality structure, and attempts to enable the patient to modify and change pathological elements of his personality. Insight is a method which is utilized by both professions, but each in its own unique way; casework uses insight to obtain the co-operation of the conscious ego in dealing with situational problems; psychotherapy uses it as an aid in the process of dealing with the patient's intrapsychic conflicts. Similarly, transference phenomena are recognized by both professions, but the "caseworker works within the transference, and the therapist works with the transference. The caseworker, recognizing transference impulses, moves to replace them with feelings related to the current situation, while the therapist attempts to provide some reliving and working through of these impulses."\(^1\)

\(^1\) Coleman, *Journal of Social Casework*, p. 246.
Helen Perlman enlarges and makes more specific the term "situation" so that the relationship of the client with his particular environment is understood as a two-way, interacting process. In her view, the problematic aspects of the client's interaction with his environment is the appropriate casework focus. She writes:

"The problems within the purview of social casework are those which vitally affect or are affected by, a person's social functioning.... The importance of the caseworker's orientation to the client's problem as lying in his inability to function satisfactorily in one or more of his major roles, or in his inability to meet the deprivations and assaults of his life-circumstances, is that it helps the caseworker chart his focus, his work plan, and his goals. It means that he will constantly keep before him the need to enable his client to cope with the frustrations and gain the potential gratifications in his every-day living. And, since this living takes place in dynamic interaction with other persons, social circumstances, culturally determined expectations and permissions, the caseworker will take full measure of these forces in each case in order to know how they need to be influenced and utilized in the interest of the client's best social adaptation." 1

It is the intention of this analysis to examine whether caseworkers attempt to enhance the client's social functioning, or whether changes and reorganization in the client's personality structure is the main treatment objective.

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The casework focus which is subscribed to in this study entails treatment of the client and his dynamic interaction with his problem situation.

**Psychiatric Contributions to Family Therapy:**

Dr. Ackerman suggests a framework for personality theory in which he has attempted to integrate intrapsychic and interpersonal processes:

"Thus I regard the progressive stages of personality organization of the child as advancing levels of biosocial integration with, and differentiation from, the environment. The basic drives of the child are to be evaluated within the frame of changing integrations of personality and changing integrations of the individual into family relationships. At each stage of maturation, drive, defense, perception of self, perception of persons in the environment, conflict and anxiety are partial phases of integral units of adaptation. The urges for food, love, preservation of self, and sexual expression are structured by the continuous interplay of image of self and image of interpersonal experience with the significant others in the family. Behaviour is goal-directed. The direction of striving is determined by personal identity and value orientation. Pleasurable experience is sought, pain avoided. Pleasure may come with need satisfaction or new learning, the adventuresome exploration and expanding mastery of the outer world." 1

The balancing of inner needs with outer realities, within and between family members, will determine each

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1 Ackerman, N.W., *Psychodynamics of Family Life*, p. 50.
individual's adaptation to the group and to society. Inner needs and outer realities are, however, in a constant state of flux; the former change as maturation occurs, and as outer reality shifts. To illustrate, a traumatic experience to a child, such as the loss of a parent, may be offset by a parent surrogate and as his grief diminishes, by the child's gradual acceptance of that loss. It becomes important to look not only for pathology within an individual and his situation, but for areas of health as well, and it is only recently that the concept of health is receiving some attention. Jackson and Satir, in reviewing psychiatric development in family diagnosis and treatment, state:

"Gradually an awareness has been developing of the existence of health within the same framework in which pathology exists, which has led to a beginning re-evaluation of emotional illness. The concept of "adaptation" has helped focus on the "why" of the illness rather than on fixed psychopathological symptoms." ¹

Dr. Ackerman suggests

"...it is useful to think of the family as a kind of carrier of elements predisposing both to mental illness and mental health. Degrees of success or adaptation in the paired family roles of husband and wife, father and mother, parent and child, child and sibling, bear

directly on the question of staying well or getting ill. What are the clinical psychodynamics and social features which distinguish predominantly sick from relatively healthy types of families?" 1

It is not a simple task to distinguish health producing from pathology-producing family interrelationships for it involves "the subtle and complex weave of relations of the individual to family group and accommodation of personality to role requirements." 2 Dr. Ackerman goes on to state the crucial question:

"Is the integration of family relationships preserved despite conflict, or does conflict tend to destroy the family tie, the link of the individual and family identity, and thus cause an intensification of individual pathology?" 3

These questions lead practitioners to search out the whys of family health and breakdown and, just as patterns of individual behaviour have been diagnosed and treatment geared to these diagnoses, may it not be possible to identify patterns of family functioning as well? Social work has recently identified distinct family types, based on economic, marital, and child-bearing patterns of functioning, which will be described in detail in Chapter 4.

1 Ackerman, *Psychodynamics of Family Life*, p. 104.
Focus of Study

This thesis will attempt to assess whether the casework recording in a Child Guidance Clinic reflects a focus on the social functioning of a child and his family in the casework contribution to clinical diagnosis and treatment of children's emotional disorders; or does the recording emphasize each family member's individual emotional problems? To paraphrase Dr. Sherman, does the psychosocial dichotomy exist in a Child Guidance Clinic, even though this setting has long recognized that the child's behaviour is symptomatic of relationship difficulties between the parents and the child and, more recently, that his emotional problems are an expression of pathology within the whole family group?

The diagnostic and treatment periods will be separated for the purposes of this study, although it is recognized that they are complementary parts of the casework process in practice. Diagnosis is used here to designate that period of the family's contact with the Clinic up to and including the diagnostic conference. This marks the termination of the team's formal study period and the formulation of treatment goals. Treatment designates the period immediately following the diagnostic conference to termination on the closed cases, and to the point of the latest entries in the active files.

This study will attempt to identify the information that is obtained from parents and other resources about their
disturbed child, what the caseworker's evaluation of the problem is, and what the treatment goals are. Particular emphasis will be placed upon determining whether the case-recording reflects concentration on each individual member's emotional conflicts, or upon the current social functioning of family life which affects the child's adaptation. Areas in the recording which are pertinent to this focus will be identified, as well as relevant areas that are not recorded. Recommendations for a change in recording practices will be made where indicated. Recording of the treatment period with the parents will be studied, and such questions will be asked as: why are family members assigned to one, or more than one worker; is there evidence of the caseworkers' awareness of current family relationships and how they affect the child's emotional adjustment? A particularly significant question involves the caseworker's and family members' discussion of treatment goals: how do parents perceive their roles in relation to the child and to the caseworker in helping their younster? An attempt will be made to determine if there is a relationship between the outcome of treatment and the casework focus.

While this study is mainly concerned with the identification of information and methods which contribute to family diagnosis and treatment, it cannot be over-emphasized that the way in which the caseworker develops
and uses the treatment relationship is of the utmost importance in helping the client achieve a more favourable adaptation to his family. It is beyond the scope of this study to elaborate on this aspect of casework, but it is recognized here as a basic element in the helping process.

An analysis of the recording is not synonymous with an analysis of casework practice and skills. Many caseworkers give an excellent service without, however, recording the basis for their diagnosis and methods of treatment. Conversely, the recording of all facts that are pertinent to a psychological diagnosis does not necessarily lead to skillful practice. However, social workers are constantly seeking to understand which information should be obtained from the client in order to assess his participation in the problem he is troubled with, and to work out with him, ways in which he can be helped to come to terms with his difficulty. The recording should reflect the caseworker's thinking in these areas. Such recording provides the caseworker with an opportunity to assess his own practice; it is also invaluable in supervisory discussions and in consultation with other disciplines. Furthermore, well-kept records are essential for research purposes.

More scientific recording is only one of the avenues leading to improved casework services, but it is a valuable tool which has not been adequately utilized by the profession
in its search to establish its own diagnostic and treatment methods.

Concepts for Family Diagnosis:

What concepts can be utilized in family diagnosis?

Psychoanalytical theory provides a framework for depth understanding of the individual's emotional life. It permits caseworkers to estimate the client's level of psychosexual development; to understand the defenses he utilizes to handle his anxiety; to view the client's behaviour as purposeful if the conscious and unconscious forces which underly his adaptation can be understood. It has taught caseworkers to look for cause and affect relationships between the client's present behaviour and attitudes and his past history, particularly his experiences within his own family. Psychoanalytical theory has contributed the concept of transference and counter-transference in the treatment relationship, that is, that the caseworker and the client may react to each other either positively or negatively as a result of past experiences in other important relationships.

Gordon Hamilton \(^1\) outlines three major psychoanalytic contributions to casework: 1) The client's account of his history and problem cannot be taken literally. Be-

cause of his defensive structure, there is often distortion.  
2) The understanding of transference and counter-transference phenomena in the client-worker relationship.  
3) Parents' complaints about their child are frequently a repetition of their own childhood experiences, and may have little to do with the child's actual problem. Similarly, the client often displaces and projects his own unconscious wishes and fears onto other people in his environment.

Psychoanalytic concepts contribute significantly to the diagnosis and treatment of an individual's personality problems which may be an important factor in the difficulties for which he is seeking help. Considerable light may be shed upon current inter-relationship difficulties within a family once the individual personalities of the participants are understood. A compulsive mother, for example, requests help for an exhibitionistic, acting-out child. His behaviour has made her very anxious, but she may be reacting towards the child in a way which provokes further acting-out. Her anxiety over his behaviour may be a reflection of her own unresolved conflicts in dealing with her aggressive and sexual impulses. The caseworker may have an excellent grasp of the mother's contributions to the child's behaviour, and the reasons behind her conflicting expectations of him. How the worker uses this knowledge will depend on her understanding of the
caseworker's function. There has been considerable dis-
cussion on whether it is a social work function to interpret
underlying conflicts of which the client is not consciously
aware. The view supported here is that interpretation of
such material does not lie within the province of casework,
for its training does not equip its practitioners to under-
take psychiatric responsibilities. The mother may, with
sufficient support, make the connection herself, but even
this insight will be unfruitful if it does not result in
improvement of her functioning as a mother.

Psychoanalytic theory has contributed significantly
to the part the individual's emotional difficulties play in
the problems for which he is seeking help. Treatment is
facilitated by an understanding of transference and counter-
transference phenomena. What these concepts cannot do,
however, is provide a framework for evaluating other signi-
ficant factors in current family relationships and situations
which are the external realities of the client's problem.
It remains for social work to adapt psychoanalytic knowledge
to casework practice.

The advent of ego psychology was one step in this
direction. Howard Parad states: "Ego psychology provides
us with a comprehensive approach to understanding how the
human personality deals with the complicated network of forces
and counterforces from instinct, conscience, and the larger socio-cultural environment." 1 Annette Garrett states: "It is the sum total of the integrating efforts of the personality." 2 The ego faces three ways, and receives stimuli from the id, the superego, and external reality. The impact of reality on the individual is added to the Freudian concepts. The client's ego strengths, that is, his capacity to bear frustration for a purpose, is given more recognition or, in other words, his current functioning and adaptability are assessed. Annette Garrett adds, "A full appreciation of ego psychology reveals new meaning as we integrate the concept that the unconscious ego operations are manifested in a myriad of ordinary, day-by-day, characteristic ways of functioning." 3 In the pre-Freudian era, data on the client's social functioning was routinely secured but its significance was not grasped. During the Freudian period, social workers lost sight of the value of knowing the facts of the client's current life situation, and how he expressed himself in the significant roles he was called upon to play.


3 Ibid., p. 46.
Since the facts of his social situation and adaptation were often not secured, it was not possible to know how the client expressed himself in his daily behaviour, and valuable clues about his personality, his external reality, and his participation in his problem, were missed.

Ego psychology recognizes the importance of delineating the client's personality as well as the nature of his situation. Florence Hollis states:

"A thorough understanding of the situation is necessary in part to determine whether changes can be brought about in the situation itself and, in part, to analyze specifically what changes the client himself needs to make in order to relate himself more constructively to his total life situation."

She adds:

"I cannot overemphasize the importance of getting from the client the concrete details of the daily and past events in his life - of his actual functioning ... We cannot rely solely on the client's subjective reactions. It is only in this way that we can check for the internal consistency of his story, and estimate the adequacy of his reactions to his life events and his interpretation of them... When it comes to treatment itself, only specific material can be used in helping the client."

In Child Guidance practice, the child's primary situation is his family milieu. His relationships with his parents and siblings, and theirs with him, must be explored

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as fully as possible, as well as any outside situations and persons which may have a bearing on the child's difficulties.

Ego psychology has contributed to casework the importance of understanding the inter-action of the individual with his situation. It represents a significant attempt in social casework to integrate the psychological and social factors which comprise the client's problem.

Role theory represents a further step in this direction, for it provides a conceptual framework to delineate those areas in the client's current functioning which are impaired, and those in which his adaptation is favourable. Further, it helps the caseworker identify the client's major problem, and lesser, but related, difficulties. It cannot be overemphasized that role theory, without utilizing psychological concepts, contributes little to casework practice. It is a sociological theory, and unless psychological understanding is combined with it, casework will not develop, but could return to the sociological approach of the pre-Freudian era. It is worth recalling that social work's excessive stress on the emotional adjustment of the individual was, in part, a reaction to discouragement over the minimal results that an environmental approach brought to families in distress.

Role theory does not provide a method for simplified casework practice; rather, it adds a further dimension to the already complex body of knowledge. If used in conjunction
with psychological concepts, it holds the promise of providing a method for family diagnosis. Sanford Sherman writes, "If the social science concepts are viewed as a source of departure, and the psychological dimensions "built in", there can be considerable reward in the new insights gained." ¹

In a study entitled "Role, Stress and Social Casework Practice" ² which drew its conceptual framework from such sources as Werner W. Boehm's Curriculum Study, ³ Jessie Bernard, ⁴ and Dr. Ackerman, ⁵ the author reached the conclusion that social role theory would be a usable tool for family assessment. The significant features of social role theory in relation to family diagnosis will be outlined below. This study concludes:

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¹ Sherman, Exploring the Base for Family Therapy, p. 17.


⁵ Ackerman, N.D. Psychodynamics of Family Life.
"The tremendous contribution of the social role theory is that it leads from an understanding of individual dynamics to an understanding of family, group, and eventually community dynamics. While it utilizes psychoanalytic and ego psychology theories, it has integrated them with sociological theories, * or, in other words, has put out understanding of individual dynamics in a social context. Thus is provided a better balanced perspective of man in relation to society." 1

In addition, the author suggests that this theory provides a relevant base for involving the client in the helping process. The caseworker clarifies her own role and the client learns what he can expect from the agency.

There are three major concepts in social role, those of role, stress and problem.

Social roles are viewed as units of social functioning. The tasks described for specific roles are defined with some leeway by society. For example, under normal circumstances, parents are expected to provide for their children's physical and emotional needs, but how this will be done, and to what extent, is not defined by society.

Each individual functions in a variety of roles. An adult male may be a spouse, father, son, sibling, employee, neighbour and so on; similarly, a child may be a son, a sibling, a grandchild, a pupil and a playmate. The way in

1 Hawley, Role, Stress and Social Casework Practice, p. 163.

* The author questions whether this integration has actually been achieved, and believes further study is required to accomplish this goal.
which he performs each function will depend on his physical and intellectual endowments, on his emotional development and upon social factors.

There are a number of components to the role concept. "Role perception" is the individual's understanding of the requirements of his, and other people's, particular roles. "Reciprocity" refers to the relationships of the reciprocal roles, such as the marital or parent-child relationship. "Inter-relatedness of roles" refers to the effects of changes in performance of one role upon performance of other roles. Thus, if a child is experiencing difficulties in meeting the requirements of his school, his feelings of fear, inadequacy or resentment, may be expressed in other relationships and tasks, particularly those which are connected with the school situation. In this way, impairment in one role can be related to dysfunctioning in another, and the connection made between the child's school performance and his adaptation to other roles.

Role network is a particularly relevant concept for family diagnosis, for it provides a view of the client as an inter-acting unit in a system of roles. It refers to the client's major social relationships, to the functions he performs, as well as the reciprocal performance of those with whom he inter-acts. Since the child's disturbance is con-
sidered to be symptomatic of pathology within the family, an understanding of each member's role network may reveal the outstanding problem areas. Use of this concept would enable the caseworker to be more alert to the father-child relationship, as well as parent-sibling and child-sibling inter-action. Of particular significance is the inclusion of the father in diagnosing and treating the child's disturbance. His relationship with the problem child, as well as the resources he might contribute to his improvement, are too infrequently explored in Child Guidance Clinics. Similarly, the position of siblings in the family, and their relationships with parents and the disturbed child are often overlooked. Without this knowledge, it is impossible to formulate ideas as to the purpose the disturbed child's behaviour serves to the group, or to evaluate the stresses placed upon him, and the resources that are available to him in his own family.

The role network concept does not provide an historical view of family relationships; it describes their adaptation at one point in time. Obviously, a full historical view of the family's network would be impossible to obtain. However, if their present inter-action is understood, it may be possible for the parents to recall significant changes in their relationships with each other and with their
children which would establish some historical perspective of the family as a unit, and which might shed more light upon the needs the child's disturbance is meeting.

Through an understanding of the client's role network, the caseworker can attempt to grasp the problematic inter-relationships amongst family members, and between the nuclear group and other significant persons and situations interacting with them. This knowledge is necessary to evaluate the possible sources of stress to which the family is reacting, and which is finding expression in the emotional disturbance of one of its members.

Stress is defined as a situation which involves threat to the performance of social roles. The stress factor refers to the threats which arise within the individual (physical or psychological), or from his environment within his network of roles. The resulting role impairment will be a secondary source of stress. Specific values will be threatened, according to the individual's emotional development and social situation. An examination of the client's values will enable the caseworker to understand his subjective response in the context of his particular culture and class. To illustrate, a child who steals in a stratum of society where delinquency is a definite pattern will generally not create so much anxiety in the parents as the child from
a middle-class family whose parents are regarded as good citizens. Thus, the mores of the particular culture or strata of society to which the family belongs will have a bearing on the way in which the parents react to irregular behaviour in one of its members. Their personal values will also have a marked bearing on their reaction to stress. It may be extremely important to a mother, for a variety of reasons, to achieve success as a mother, and to raise physically and mentally healthy children. Only as the particular values which underly the mother's reaction to her child are known can the caseworker empathize with her, and understand her reaction to the problem for which she is requesting help.

The application of role theory helps to identify the major and related relationship problems which may be contributing to the child's disturbance. The carry-over of impairment from one role to another, and between one pair of relationships and another, can be recognized. This theory helps to identify the location of the greatest source of stress to the family, and to the child.

It should be added that, through an assessment of the family members' role performance, areas of strength can be located. Casework attempts to build on the client's resources, as well as helping individuals recognize and work
out their problems. It is therefore important to look for roles that are well and satisfyingly carried out, and tasks that are mastered. Multi-problem families experience role impairment in many, if not all, areas of living. The family's relationship with social institutions may be poor; adults are unable to carry spouse and parent roles; they may need to depend on others to provide for the family, and the children may be physically and emotionally neglected. Health problems throughout the family are frequently an additional difficulty. With the average middle-class families who seek help at Child Guidance Clinics, their adjustment to society's customs and laws is usually good. Management of income may be a problem, but seldom are these families dependent upon outside resources for their sustenance. Housing facilities are frequently adequate, sometimes luxurious. The fathers are usually steadily employed, and many of the mothers take pride in their home-making. Their children are well-cared for within the parents' means. Their role performance in major areas is usually adequate within society's standards. Problems arise, however, in the subtleties of role performance. The father may be an adequate provider but is dissatisfied with his job status; the mother cares for her children, but may find her task more burdensome than rewarding; husband and wife may not contemplate separation or divorce, but find their marriage dissatisfying. Old conflicts are aroused by their relationship and they may unwittingly use their children
in their struggle with themselves and with each other.

There are, therefore, many strengths to build on in a large percentage of families who seek help from a Child Guidance Clinic. A fairly superficial examination of the role performance of each individual may reveal these assets. It is the more subtle elements of role performance, however, which require the application of psychological concepts to understand what is happening within a family that produces illness in one of its members.

Once the individual family member's ego strengths have been assessed, and the main characteristics of their relationships with each other understood in relation to the disturbed child's behaviour, the major problem(s) can be identified. It is essential at this point to decide how the healthier family members can be mobilized to strengthen the ones who are under the greatest stress. To illustrate, a distraught mother, overburdened with the care of an autistic child, may need the security which a compulsive husband can provide. He may have personality problems of his own, but his very need to provide well for his family and to organize their lives to some extent, may need to be supported, rather than questioned, and ways found in which his wife can share more fully with him the child's care. The mother, too, will need the caseworker's support. She may need to share her anxiety and guilt, to express the
concern and resentment she feels towards the child, but she also requires the stabilizing influence of her husband, which will not be available to her if he is deeply engaged in attempting to sort out his own conflicts. The goal of casework treatment with families is to help them function more adequately as a group, and not to work out neurotic conflicts without reference to the main problem and the family balance.

It is through a combination of role theory and ego psychology that casework diagnosis and treatment of the family can, to some extent, be achieved. Consideration is given not only to the individual's emotional adjustment, but also to the relationship between his adaptation and the balance of health and pathology within the family. This is particularly significant in casework treatment with children. Because the child's defenses are less fixed, his impulses are more easily expressed. If he moves too quickly to express these impulses before his parents can tolerate it, they may react by controlling him more severely, thus intensifying the conflict between them. Not only, then, does an individual's ego strengths need careful assessment, but also the ability of the family to withstand freer expression of the feelings which underly the child's symptoms. The goal of improved functioning of parent and child must be kept in steady focus by the caseworker. This may be achieved by helping a parent and child in their performance in related
roles, or in direct help with their attitudes which underly dysfunctioning in the parent-child relationship, or by a combination of both approaches.

Role theory provides a dynamic picture of the individual client inter-acting with his family and with other people and situations outside the group. Ego psychology contributes an understanding of each individual's personality patterns. The caseworker must have this knowledge to help parents improve their functioning. It should be noted, however, that helping the client understand himself better will not be any more beneficial than an educational approach which does not take into account the client's personality patterns, unless it results in better role performance. This is the aim of casework and the test of the effectiveness of its service.

Related Social Work Studies

The St. Paul Study:

The St. Paul Study ¹ is a pioneer project in integration of services on two levels, the community and the family unit. Of particular relevance to this study is the Project's use of a social diagnosis and a "Profile" for a tentative measurement of family functioning. This Profile brings together in an organized form a large amount of data

about the family which explains how it operates as a social unit. Nine areas of family functioning are outlined in order of their prevalence: Child care and training; individual behaviour and adjustment; family relationships and unity; social activities; relationship to family-centred worker; use of community resources; economic practices; health problems and practices; home and household practices. It was found that the problematic functioning in the less frequent areas was symptomatic of overall family disorganization. Conversely, dysfunctioning only in the more frequent areas does not presuppose family disorganization. Although all these classifications are not relevant for application in a Child Guidance Clinic where the clientele fall generally within the middle class, it would be enlightening to adapt a scaled profile to establish a comparative level for middle-class family functioning. Such a profile might lead to a classification of interpersonal and social problems which these families experience.

In addition to the Project's emphasis on diagnosis of the family's social functioning, two other aspects are relevant to this study. Concentrated services were given these families to help them improve their adaptation in the nine areas mentioned, and recording techniques were developed, so that research could be conducted on their use of casework services. It became possible to compare their function-
ing at the beginning of the project and upon completion of it. Such research is essential if a pilot program is to have the support of its community. A similar analysis of casework services in agencies and clinics is also necessary if social work is to gain the community support it needs. It follows that recording practices require considerable revision to enable the researcher to accomplish this goal.

Current Theses on Casework Measurement

Varwig and McCallum Studies:

These studies are more closely related to this thesis than the St. Paul project. The physically handicapped child, not the family, was the principal client, and the family's social and emotional adaptation were studied in detail. By employing a rating scale, it was possible to compare the child's adaptation to his handicap to the social functioning of his family at the beginning of therapy and after a two-year treatment period. Both these studies showed a definite connection between the child's adaptability to his handicap and the stability of his family. Children of those families who suffered from social problems, such as economic hardships, were found to have greater difficulties in adjusting to their handicaps than those children.


whose families did not encounter this problem. Where the major stress appeared to be inter-relationship difficulties, particularly in the marital relationship, threatening or causing the break-up of the home, the child's inability to make use of treatment was most pronounced.

These theses established two things: 1) that casework service in clinics for physically disabled children fulfils the important function of helping families with the problems which interfere with their child's adaptability to his handicap; 2) improved recording methods to measure the child's and family's functioning between two points in time. Such a rating scale clarifies the casework service which is required, and can also be used to measure movement in the child's and parents' social functioning as a result of provision of these services.

The focus of this study is different from the two projects mentioned, in that social work has long been recognized as an established part of Child Guidance operations. There is a need, however, to assess to what extent the child's emotional disturbance is related to the family's current functioning and, more specifically, to identify those areas of dysfunctioning. If the family's stability can influence the child's adaptability to a physical handicap, then it is likely to have an even greater effect on his ability to overcome his emotional handicaps or problems. It is for this
reason that the child should be understood both as an individual with his own needs, drives, and conflicts, as well as a person interacting with other people, particularly his family group, and in the relationship process, is influencing them and being influenced by them. The child is relatively helpless to change the conditions of his life that are unsatisfactory to him, and must adapt in the best way he can to his primary group. The family milieu can therefore help him or handicap him.

The Hawley Study: 1

This study on "Role, Stress and Casework Practice" attempted to apply role theory concepts to the casework recording of Child Guidance cases. The author concluded that some of the important roles performed by the client and those in his role network were not recorded, with the result that diagnosis of the child's and family's functioning was incomplete. Some of the important areas which were omitted were the father-child relationship, sibling relationships with the parents and the disturbed child, and the family's interaction with the community.

The significance of the Hawley thesis for this study lies in the fact that the focus on the individual's functioning and those in his role network can contribute to casework diagnosis of the family. The identification of

sources of stress to each family member, and their reaction to it in terms of role impairment, clarifies the client's interaction with his problem, as well as the impact of his reaction to stress on other family members. In Child Guidance Clinics, the child is the principal client or patient. If these aspects of his behaviour which appear to be a reaction to stress within the family can be identified, the areas in which the family requires help in order to provide a more stable environment for him can be clarified. Clinical diagnosis will reveal whether the child, as well as his parents, requires treatment.

A second contribution this study makes is in the area of standardizing recording which is valuable for research purposes. It has been mentioned that casework recording in most settings is not designed for research. Scientific analysis of the problems which are brought to social workers, and of the service given, is therefore extremely difficult to undertake. The Hawley study suggests a method for standardizing the recording. Material for comparing the individual's social functioning, and the family's adaptation, between two or more points in time, would be readily available.

The Hawley study was concerned primarily with the application of role theory to casework practice. Psychological
concepts were mentioned, but were not emphasized. Role theory can identify the problems within a family and the child's reaction to them in terms of his social functioning. This present study emphasizes the necessity of using psychological concepts as well, in order to understand what lies behind the outward behaviour of family members.

**Selection of Sample Cases:**

Cases of children between five and ten years of age, living in their own families, and who received treatment in 1961, were selected. The recent year of activity was chosen so that an assessment could be made of current recording practices. Age selection is based on the operation of the two main treatment teams in this particular clinic. One team is concerned with children up to eight years of age; the other accepts children over eight and under eighteen years. It was considered that this selection would give the best cross-sectional picture of casework recording. The choice of children living in their own homes with both parents is self-evident for this family-focused study. Cases were omitted where severe physical handicaps on the part of the child complicated family problems, as were those cases where the child was considered too ill emotionally to attend public school. A further consideration was the achievement of the diagnostic study and, preferably, at least six months of treatment following assessment. Approximately thirty
cases met these requirements. Of this number, twenty were selected because of time limitations and the availability of the files at the time they were required for this study. Some of the writer's own cases are included, and attempts have been made to assess these as objectively as the other cases.

Setting of Study

The setting of this enquiry is the Children's Clinic, Mental Health Centre, formerly known as the Child Guidance Clinic. Although the Clinic has other functions in addition to helping emotionally disturbed children, these will not be enumerated since they are irrelevant to the scope of this study. Staff ratios are approximately four social workers to one psychiatrist, and two social workers to one psychologist. This means that social workers carry the largest number of treatment cases.

The Clinic is a Provincial Government service and is available to families residing in the province, although for practical purposes, treatment services are confined to adjacent municipalities. Intake is controlled to ensure quality of service, and parents are encouraged to seek help elsewhere when overloading may threaten this objective. This Clinic, in company with most Child Guidance settings where the demand for service exceeds the supply, has suffered
intermittently from waiting lists and a highly selective intake. For this reason, it would seem timely to study the current recording to determine whether new concepts in family diagnosis and treatment are being utilized. The writer recognizes that new concepts cannot be accepted and utilized without study, testing and evaluation, but offers this piece of research as a contribution to this process.

**Methodology**

Methodology for this study has been adapted from two sources, the Varwig and McCallum theses on physically handicapped children and their families. The Varwig and McCallum studies employed two formulated schedules to rate the physical, social, intellectual and emotional adaptation of the child and the social functioning of his parents at two points in time. A rating scale was developed which measured movement in the child's adaptation to his physical handicap, and in the parents' functioning. Comparisons were then made between a child's progress in treatment and the stability of his family.

It was the original intention of this study to devise a similar rating scale. However, there was not sufficient material in the casework recording during the

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1 Varwig, *Family Contributions in Pre-School Treatment of the Hearing Handicapped Child*.

2 McCallum, *Family Differentials in the Habilitation of Children with Brain Injuries*.

3 The schedules adapted from these for the present study are reproduced in appendices A, B.
treatment period to measure movement of the child's adaptation to his emotional problems and the parents' social functioning. Furthermore, the Varwig and McCallum studies had at their disposal periodic medical assessments regarding the extent of the child's physical impairment. Such material can be equated to the psychological and psychiatric assessments of the child's emotional adjustment in the Children's Clinic. However, diagnosis of the child's adaptation is recorded only during the study period, so that there are no standardized devices to measure movement in the child's emotional development. Psychological assessment of the child when treatment terminates would be extremely useful for research purposes.

The two schedules can be applied only to the diagnostic stage of each family's contact with the Clinic. Attempts will be made to compare the extent of the child's disturbance with parental attitudes and relationships, with areas of dysfunctioning within the family, and with significant relationships and situations outside the group. These comparisons will not be tabulated statistically because of the lack of specific information in the recording. Only general trends will, therefore, be described. One of the procedures which will be given particular attention is the social history outline.
Regarding assessment of the family's functioning during the treatment period, there are sufficient casework evaluations in some records on at least one family member to describe whether the parent's relationship to his child, and in some instances, to his spouse and other important people in his environment, have improved. In no cases, however, were assessments recorded on all family members involved in treatment. In those records which did evaluate one client's functioning, sufficient material was available to describe, generally, whether or not movement had occurred. An attempt will be made to relate improvement in family member's functioning to the casework focus. It should be possible to hypothesize whether one factor in the client's movement is due to a casework emphasis on his emotional conflicts, related to his own early experiences, or whether the focus on the client's current interaction with his role network might have contributed to his improved adaptation.

Schedule "A" (see Appendix 1) will be used to evaluate the child's functioning. It comprises the following components: the child's evaluation of himself; his view of his relationships with father, mother, siblings and peers and his place in the family group. These factors are essentially subjective in nature. A second major area
comprises objective components, such as the psychologist's evaluation of the child's emotional maturity and functioning, based on observation and the tabulated results of standardized psychological tests. An objective view of the child's functioning is also obtained by school adjustment, the "ability to relate" and "evaluation of emotional disturbance" categories. It is implied in the "Symptoms of Disturbance" classification insofar as neurotic children are thought to be somewhat higher on the ego spectrum than children with predominantly behavioural symptoms of disturbance. Most of the material for Schedule A was readily available from psychological reports, while "physical development", school adjustment and symptomotology were taken from the social histories.

Schedule "B" attempts to evaluate parental attitudes towards the child, family inter-relationships, the solidarity of the group, socio-economic conditions, and the family's interaction with their community of residence. This schedule does not lend itself to an objective and subjective classification of parental and family functioning, for this information is collected by the caseworker in a series of relatively unstructured interviews, and evaluations are not so precisely articulated as in the psychological reports. Parents are understandably guarded in expressing some of their real attitudes towards spouse, parents and children, and it is
frequently not until later interviews that the full range of their attitudes, and how these affect their role performance, are understood by the caseworker. In some cases, tentative evaluations of marital and parent-child relationships were made by the caseworker, while in other records, it was necessary to draw arbitrary conclusions from inferences in the files, particularly in the area of marital and father-child relationships. The two schedules, taken together, establish to a limited extent, role reciprocity.

The application of these schedules to the sample cases will point up areas of information that are recorded, and those that are not. It will be possible to assess whether casework is concerned mainly with emotional factors in each family member's adjustment, or whether their adaptation to each other and to the social conditions of their lives contribute to the psychosocial diagnosis. Schedule "B" will explore to what extent assessments are made of family relationships, and whether, in fact, the child's symptoms are judged to be an expression of pathology in the whole family's adaptation. Since the most common-problem-to-be-worked in a Child Guidance Clinic is the parent-child relationship, Schedule "B" will illustrate whether caseworkers explore the inner and outer strengths and stresses that impinge on that relationship.
This study must be regarded as exploratory, because of the limited number of cases. Nevertheless, an analysis of critical points relating to family casework will be attempted.
Chapter 72

CLIENT AND FAMILY ASSESSMENT IN DIAGNOSIS

Symptoms of Emotional Disturbance in Children:

What are some of the symptoms of disturbance that bring parents to consult a Child Guidance Clinic?

Stone and Church, from extensive clinical experience recorded in their book, *Childhood and Adolescence* 1, suggest that emotional disturbances in the toddler and pre-school years are manifested in such symptoms as skin irritations or eruptions, jerky or flaccid body movements, sleep disturbances such as nightmares and bedtime fears, vomiting, excessive handling of the genitals and eneurises and soiling past the age of four. The authors state "Emotional upset at this age is tied to body functioning, whether vegetative or motor, and may foreshadow hysterical and psychosomatic manifestations of later years." 2 They suggest the most prominent difficulties of the middle years, i.e. six to twelve years, revolve around schooling and the child's ability to learn. In addition, persistence of behaviour which was quite normal at an earlier stage, such as speech difficulties, tantrums, thumb sucking and eneurises are considered to be symptoms of disturbance in this age group.

1 Stone, J.L. and Church, J. *Childhood and Adolescence*, London House, New York, 1957,

2 Ibid., p. 355.
The child may be manifesting abnormal social behaviour ranging from withdrawal, from social participation or overconformity, to delinquency, although the latter symptom is usually associated with the adolescent period. Nevertheless certain delinquent traits may appear in the child of this age, such as stealing, vandalism and physical aggression. The authors draw a distinction between various types of delinquency ranging from (a) normal or casual delinquent behaviour in six and seven year olds, such as a limited amount of experimental stealing from parents, to (b) psychopathic delinquency, in which the child habitually engages in delinquent acts with no apparent inner conflict as he is virtually lacking in conscience. Somewhere between these extremes of normal to abnormal delinquency lies the category of "neurotic delinquency", in which the child who feels isolated, steals from parents to express his need for love as well as his anger at them for depriving him of love.

Margaret W. Gerard ¹ discusses psychological disturbances in children within the framework of Freudian theory. She describes problems in the oral, anal, oedipal, latency, and adolescent stages of development. She states:

"When we speak of psychic disorders in childhood, be they classified as behaviour problems, neuroses, or

autonomic symptoms, we are concerned in general with the disorders in adaptation to the environment in which the child finds himself. For this reason, some behaviour may be considered abnormal in one environment and not in another...... Similar differences occur within a culture from one social group to another and are superficially evident in differences in manners, sexual behaviour and so forth. In even greater degree, differences occur from one age to another. What may be a serious symptom in an adult may represent normal behaviour for a two-year-old and only questionable behaviour in a five-year-old, as, for example, nocturnal bed wetting, temper tantrums, fantastic lying, genital exposure. It is obvious that consideration of a disorder must always be undertaken in view of the expected or "normal" behaviour of a child at the age of occurrence and with recognition that environmental demands and expectations change with the age of any child. 1

What constitutes emotional disturbances in children then, varies according to the age of the child and the cultural and social norms of his environment. In addition, certain modes of behaviour which may be considered symptomatic of disturbance at one period of time in society may be viewed as normal at another period, as for example thumb sucking past infancy and "eneurises" and "soiling" past the age of two. However, within the context of society's expectations of children at given ages, Dr. Gerard describes emotional disorders at the various stages of development. The present

study is concerned only with the oedipal and latency periods, although Dr. Gerard states, and Stone and Church confirm, that symptoms which develop in any age past infancy may be a carryover of unresolved problems from a former stage or stages.

Dr. Gerard describes the symptoms of the oedipal or sexual period (beginning around three and lasting approximately until six years of age) as excessive masturbation, feelings of inferiority, and fear of injury which, when intensified, may lead to "peeping", exhibiting of genitals, "tomboy" behaviour in girls or "sissy" behaviour in boys, and rivalry complicated by exaggerated rage, stubbornness, dependent longing and greed. Anxiety symptoms may become excessive with repetitious nightmares and fear of the dark, of new situations and strange persons. Phobias may arise to displace the more generalized anxiety. Pathological motor activities, such as stammering and tics, may begin, as well as asthma, enuresis, constipation, colitis and feeding difficulties. She concludes:

"Indications of some unacceptable behaviour symptoms are often found at this time, such as sadistic cruelty and masochistic submission, uncontrollable stealing and lying, insatiable demanding with concomitant selfishness."

1 Gerard, Dynamic Psychiatry, p. 171.
The latency period delineates those years between the sexual period of the oedipal phase and the sexual maturation of adolescence, and extends from approximately six to twelve years. Because this is the period in which the child is developing standards of behaviour, he undertakes many experiments so that symptoms may occur transiently and then give place to more adequate behaviour. Psychopathology in childhood is suspected only when a symptom remains fixed in spite of its adaptive inadequacy. If transient symptoms are replaced by other symptoms, however, it is likely the child is emotionally disturbed. Dr. Gerard classifies the psychic disturbances of this period into the following categories: 1) Infantile phenomena or marked developmental immaturity; 2) motor disorders; 3) conduct problems; 4) common neuroses; 5) vegetative disorders, and 6) psychosis.

Infantile phenomena include various infantile activities such as thumb-sucking, incontinence, or excessive masturbation; motor disorders occur as excessive purposeless activity, inhibition of movements, awkwardness, tics and stammering; conduct problems cover a variety of symptoms from withdrawn behaviour to aggressive conduct disorders ranging from mild disobedience and stubbornness to serious delinquencies. Under common neurosis are included the various neurotic constellations such as phobias, compulsions,
hysterical phenomena, learning inhibitions; vegetarian disorders comprise allergic disorders and other organic diseases which are thought to be psychogenic in origin such as duodenal ulcer and ulcerative colitis. The psychoses comprise those cases which disclose severe pathological ego defects, disorientation to reality, and delusional life.

What causes these psychic disturbances in childhood? The development of the child occurs as a result of the "interaction between the maturational processes and environmental influences." ¹ According to the Freudian frame of reference, conflicts for the child arise between "instinctual drives and environmental demands, between instinctual drives and superego standards and between opposing instincts." ² A healthy adjustment follows when these various demands are satisfied in a balanced way, but symptoms of the kind enumerated above appear when methods of solving these intra-psychic and inter-personal conflicts are unsatisfactory. While constitutional factors such as intellectual capacity and physical endowment, may play an important part in the child's development, his family plays

¹ Gerard, Dynamic Psychiatry, p. 168.
² Loc. cit.
the exceedingly prominent role of interpreting to the child the rules which society expects him to obey, and by example and explicit instruction show him the ways in which he can direct his energy to conform and still gain satisfactions for his needs. The personalities of the child's mother, father, siblings and other people in his environment will strongly influence the child's choice of modes of impulse and relationship satisfactions. Since the young child is so close to, and dependent on his parents, particularly the mother, he tends to react to both her conscious and unconscious wishes, and later, his father's, in ways which he perceives will please his parents if his feelings towards them are predominantly positive. Conversely, he tends to frustrate his parents' expectations if his relationship with them is predominantly negative. Celia Mitchell suggests that one child in a family may be selected by one parent to "represent the unacceptable part of the parent's personality - the aggressive, the greedy, or the unsuccessful element - while another child has always been the lovable one."¹ Vogel and Bell² hypothesize that the disturbed family group, led by the parents, selects one child to act out unresolved conflicts which would otherwise threaten the survival of the family. It is frequently when the child moves beyond the


primary group into the community and his symptoms cause
neighbours, teachers and doctors concern, that the parents
become sufficiently mobilized to seek help for the child.
This may serve to explain in part the reason for parents'
concern in their children's adjustment to elementary school.

Symptoms of emotional disturbance in children are
considered, then, to be the outward manifestation of intra­
psychic conflicts and unhealthy relationships with one or
both parents or with the entire family group. It should be
clear that a thorough understanding of the inner conflicts
a child struggles with during the five main stages of his
development is essential for social work practice in a child
guidance clinic. However, it would also seem to be very
relevant for diagnosis and treatment of children's emotional
disorders to have an accurate knowledge of family members'
repeated responses to the child and the purpose his behaviour
fulfils for the family. Celia Mitchell supports this view
when she says,

"Only if the entire family group is
seen in the process of interacting can
the worker see the actual, rather than
the projected, picture. As a result,
the worker's entire conceptualization
and management of the problem are
altered." 1

1 Mitchell, Celia, Exploring the Base for Family Therapy,
1961, p. 81.
Symptoms of Disturbance in the Sample Group

Many of the symptoms described above appear in the sample group. In none of the twenty cases studied did parents complain of only one symptom; rather, each case shows a constellation of three or more symptoms, some of them easily recognized by the parents as indications of maladjustment, while others are viewed as evidence of the child's willfulness, "bad" nature or poor physical health. Frank emotional disturbances, exemplified by a child's obvious lack of confidence, sleeplessness, excessive crying, tics and fears and phobias were found in half of the sample. These may be thought of as "neurotic" disturbances since these children seemed to be containing their conflicts within themselves, compared to those children who were actively and aggressively behaving in a hostile and more anti-social fashion, and were presenting disciplinary problems to their parents. The problems of these children are symptomatic of behaviour disorders. Specifically, these symptoms consisted of stubbornness, resistance to parents' discipline, destructive behaviour and petty pilfering. There were nine cases in which parents complained about such symptoms in their children. One case only was found to fall in both categories, but further investigation revealed that this particular child responded to discipline by reiterating that no one loved him, thus making it difficult for the mother to carry through on her requirements of the child, rather than the youngster.
engaging in destructive and defiant behaviour. Stealing was reported as occurring in only two cases; actively destructive behaviour occurred in three instances. School problems in terms of the child's inability to cope with academic requirements occurred in ten of the cases; ages of these children ranged from six to ten years. Of these children five suffered from neurotic symptoms while five were described as discipline problems in their homes; in this sample, therefore, there is no correlation between school failure and the type of symptoms the parents describe in their children. This cannot be considered absolute, however, since there are likely many variations according to each parent's perception of what constitutes a disciplinary problem or a manifestation of a neurotic conflict. Two children were reported as having mild speech defects while three children were eneuritic or soiling. Eight children had difficulties in peer relationships, three because they were too "bossy" and stubborn with peers, and five because they were too shy and reticent to involve themselves very much with playmates; the former three children fall into the disciplinary problem category while the latter five all belong to the neurotic classification. Only two children were showing obviously psychosomatic symptoms, such as asthma, but this is to be expected since the case selection omitted children suffering from serious and handicapping
physical illnesses. It is interesting to note, however, that, even though these children are considered to be in good health, sixty percent had suffered one very serious illness in the past or were unusually susceptible to minor infections, while one child or five percent had had frequent serious illnesses.

Thus, judging from the symptoms described by the parents, the sample divides almost evenly into two categories: (a) those children who are obviously unhappy and tend towards self-punishment; and (b) those who are actively engaged in conflicts with their parents and punish others. The first group may be thought of as more frankly neurotic than the second, but the behaviour disorders in the second group appear to be mild and do not, except in one case, constitute a problem outside the family except in the area of learning difficulties, a problem shared almost evenly by the two groups.

These two main categories total eighteen cases; of the two remaining cases, one child was considered to be relatively healthy following clinical investigation, while the second child was moderately disturbed but parents' concern about his poor school progress caused them to concentrate initially on this symptom, and it was not until later that they described other problems. Formal learning is the one activity that takes place outside the families about which
parents expressed concern. Half the cases presented the child's learning difficulty as a major problem, despite the fact that all the children with the exception of one, tested within the average to superior range of intelligence. This is particularly significant in view of the fact that, at the time of parents' application, six children of the sample group were five years of age, five were six years old, two were seven, two eight, three were nine and two ten years of age. Some children, then, were not attending school although of these non-attenders at least one had experienced difficulty in kindergarten, and another child had been evaluated as unready for school on the basis of psychological tests. Since only one child was lacking in native intelligence, it may be postulated that unfavourable attitudes towards learning were interfering with their response to formal education, and that these attitudes were likely developed in the interaction between mother-father-child.

From the point of view of obvious relationship difficulties within families, these cases constitute excellent material for the purpose of this study, which is to evaluate whether social workers diagnose and treat family relationships in a particular child guidance clinic. In addition, these children and most of their parents have favourable physical and intellectual constitutional endowments.
Clinical evaluation revealed that slow emotional development was the main problem area of most of these children; one child was considered "normal" in emotional development. The information on his interviews was meager, but from available recording he indicated independence and self-assurance appropriate to his age. Ten children were considered to be somewhat immature in terms of requiring more frequent assurance and support than "normal" children in their age groups, while nine children were described as being markedly underdeveloped emotionally. Their behaviour was characterized by excessive dependency on the parents or by denial of normal dependency needs.

**Socio-Economic Factors in the Sample Cases**

A similar homogeneity is found regarding socio-economic factors in the sample group. Most of the families can be placed in the middle-class strata of society judged by occupation, income and living standards, although it is impossible to be very accurate in this area because of the incompleteness of some of the recording for the particular requirements of this study. Since the Clinic is a free service, there is no need to obtain exact information as to a family's income and expenditures; most of the interviews take place within the Clinic, so that income and living standards, unless they constitute a definite problem for the parents, are not likely to be discussed. Much of the
material for this section was taken from inferences in the recording rather than from explicit information.

Seven of the fathers had good work records with permanent employment; seven were employed but their positions were tenuous because of economic conditions, relationship difficulties with the employer, or other dissatisfactions with their jobs. There was insufficient recording in five cases to classify these families' economic conditions. In thirteen cases, the fathers appeared to have been adequately educated and trained to maintain their current positions. Three fathers had obtained partial training, with the possibility of completing it; two had no specific training and two cases were not recorded. None of the mothers held positions outside the home, although two of them supplemented the family income by part-time jobs in the home.

Generally speaking, economic problems are not prevalent amongst families attending the Clinic. This may be explained by the kinds of difficulties a family is struggling with. If there are severe economic crises, the parents' energies are taken up with providing shelter, food and clothing for their family. However, if parents can anticipate a regular income, they become more aware of unmet emotional needs. There is limited discussion, therefore, between the parents and caseworker regarding the family's
economic conditions. More exploration of certain aspects of their financial situation would, however, throw some light on family functioning. In some cases, it might be of value to explore both the father's and mother's attitudes towards his employment, how the father functions in his position, and whether any particular stresses in this area impair parents' relationships with each other. A related area that requires more clarification in cases where parents complain of insufficient funds or tenuous employment, is financial management. Who handles the money and how, would highlight dominant and submissive characteristics in the parents, and would give some indication of how they relate to each other. None of the cases studied recorded any aspect of financial management, although this was a problem in at least four instances.

Most of the families have been residents of British Columbia for some years although few are native to the province. One family had immigrated to Canada from the British Isles three years ago, and two families had recently moved from other parts of Canada. These circumstances constituted special problems of adjustment for all three, in terms of loss of close relationships and a temporary lowering of living standards. One family is of the Jewish faith, the rest are Christian. In only three cases, however, was there much affiliation with a religious institution.
The Family's Relationship with the Community

Only two families indicated positive, close relationships with neighbors and active participation in community affairs; seven families appeared to have minimal contact with people in their immediate vicinity while two families were openly hostile towards the people and institutions in their district. Of these two latter families, one child was considered to be a severe disciplinary problem and the other child was nervous. Eight cases did not describe the families' interaction with their community of residence. Some exploration of families' relationships with their community might point up family patterns of relating which could have an important bearing on diagnosis and treatment; for example, the child who is experiencing difficulties with playmates may be reflecting the parents' withdrawn or aggressive patterns in relationships, and the whole family may require help to involve themselves in a more satisfying way with the people with whom they could have almost daily contact. Furthermore, valuable resources which could strengthen the family might be discovered. Some mental health workers believe that emotionally ill people who appear to make spontaneous recoveries have the ability to seek out healthy people in their environment which facilitates their recovery. Perhaps one way of helping the family with the problem child lies in strengthening their ties with their community of residence, or at any rate to ascertain whether there are potential sources of strength or of stress in this area during the fact finding period.
Inter-relationships within the Sample Families

Information on inter-relationships within the families was taken from two main sources: the parents' view, excerpted from the social histories and intake notes; and the child's view, taken from psychology reports and psychiatrist's notes. It was interesting to compare the parents' concepts of their relationship with the child with his attitude towards them. More will be said about this below.

In some cases it was difficult to evaluate exactly how the parents did feel about the child for whom they sought treatment. This is partly due to the fact that parents are often too fearful to reveal negative attitudes about their child in the early stages of contact. Often they feel highly ambivalent because the child has become a source of embarrassment and confusion to them, and whatever distorted the relationship initially has become complicated by the child's response to parental attitudes. Parents are frequently fearful of criticism from the "experts", whom they know advocate giving as much love and understanding to youngsters as possible, and they may feel guilty that they have been unable to meet what they consider the expected standards to be. In addition, the disturbed child may be an important factor in the delicate balance of neurotic family relationships, which parents may unconsciously fear.
to disturb. It is no wonder, then, with parents' conscious and unconscious hopes, fears and defences, that it is difficult to obtain clear, precise concepts of the attitudes that are uppermost in their relationships with the child, and how these attitudes are expressed in their day-to-day contact with him. Nevertheless, if diagnosis is to be as accurate as possible, a more explicit assessment of basic parental attitudes is essential. In some instances it may not be possible to obtain this in a one-to-one interview and, in such cases, a home visit or family interview may be indicated if the family is ready and willing to participate in such a plan. Some parents may be too fearful to permit such exploration in the early stages of contact; where this situation exists more time is required to build a trusting relationship between the social worker and the family before a diagnosis can be made. Whatever methods are chosen, within the casework principles of respect and concern for individual family members, the goal of obtaining as complete an understanding as possible of parental attitudes towards the child is of the utmost importance.

This point needs emphasizing because it was not clear from some of the records that workers were attempting to evaluate how the mother and father did feel towards their problem child. Some of the histories tend to give an excellent picture of parents' past circumstances, feelings and
behaviour without, however, relating these factors to current attitudes towards the child. One may conjecture that a mother, who has had a poor relationship with her own father, may feel hostile towards the child who reminds her of him, but this remains only conjecture unless this hypothesis is tested. Many of the decisions made in the area of family relationships in Schedule B were of necessity, somewhat arbitrary.

From the information obtained on mother-child relationships, none of the relationships were considered to be predominantly positive, eleven were ambivalent, six were described as basically negative, while there was insufficient information on three cases to make a decision. In father-child relationships, two were positive, seven were ambivalent, one was negative, and ten were not recorded. Of the "marital relationships," twelve were impaired, two severely, five were not recorded, and two marriages were considered to be healthy. Generally, the connections between unsatisfactory marital and parent-child relationships were not recorded, with the result that mothers and fathers tend to be viewed firstly as individuals, secondly as parents, and thirdly as spouses. There is minimal exploration of their role network. This is understandable in view of the fact that, until recently, there was no conceptual framework within which to relate the very complicated interactions between family members. However, role theory may provide this tool, particularly the concepts of
reciprocal roles, the role network, and the way in which an individual's various roles influence each other, as for example the marital and the parental roles. It is worthy of note that, of the ten cases in which the father's relationship towards the child was not recorded, seven of these cases were boys about to enter, or well advanced in, the latency period. This is the time in the male child's life in which much of his masculine identification is either strengthened or weakened; the need to include the father is particularly important for this age group. If the father will not participate, his resistance should be assessed to determine whether treatment will enhance or threaten the family balance. In one case it was apparent that the father's resentment about his wife and child attending the Clinic placed additional stress on the mother's relationship with her husband, although she appeared to gain in self-understanding through her interviews with the social worker. Such gains and losses need to be carefully weighed in terms of total family functioning.

Regarding siblings, it was observed in some of the sample cases that, once the problem child improved, the "well-adjusted", sibling began to show signs of disturbance to the extent that parents requested help for him. Harold I. is an example of this; this child was referred a year after his brother had been in treatment. While such requests may
be the parents' way of testing the worker's confidence in them, it may also indicate that the family balance is shifting, but the need to find a scape-goat within the group has remained constant. Perhaps including the "good" sibling in the early stages might shorten the diagnostic and treatment time required to assist families with their relationship problems.

Celia Mitchell gives an excellent illustration of the effectiveness of early involvement of the "good" and "bad" sibling. 1 A widow with two boys, aged seven and fourteen, sought help for the older child by whom she felt victimized because of his negative attitude towards her and the younger boy. During a family session involving all three members it became apparent that the mother was displacing and carrying over strong feelings of rage which she had felt for her own mother onto the older boy. At the same time she exploited intimacy with the younger child who represented her unfulfilled baby self still craving for union with the mother. Unwittingly, this mother provoked the older boy's attacks on the younger by her obvious preference for him. The mother's recognition of the two sides of her problem made her more available for treatment, and the older boy was relieved of guilt to find he was not the sole cause of family distress.

Such projections on the part of parents may be revealed after several individual interviews. Family sessions early in contact, if skillfully handled, may reveal more rapidly the causes of one child's symptoms; the worker is thus in a better position to guide the family towards the source of their problem. Furthermore, treatment is made accessible to the child who is considered well-adjusted by the parents, but who may actually be as disturbed as the child with obvious symptoms and, as Miss Mitchell points out, the problem child is absolved of total responsibility for family disharmony.

Dr. Vogel and Bell studied a small group of families with disturbed children. They compared them to healthy families and found that scapegoating of one child was common to all the dysfunctioning families, but was not prevalent amongst the healthy ones. They report that this pattern is not clearly revealed if the family is treated only as a collection of separate personalities without some understanding of family dynamics. They suggest that the personality of the child who is selected for scapegoating may be damaged severely unless treatment is geared towards helping the family function more adequately without needing to sacrifice one of their members in order to maintain a balance.

1 Bell, N.W., and Vogel, E.F. A Modern Introduction to the Family.
Regarding sibling relationships, four children expressed ambivalence towards brothers and sisters, seven were predominantly hostile, one child had no siblings while eight were unrecorded. In six cases the concepts the child communicated in interviews of his relationship with siblings was different from the parents' view, with the latter generally feeling that there was less hostility than the child expressed to the psychologist. In only one case did the parents' and child's view coincide; while it was impossible to compare twelve cases because of insufficient material. These results suggest that diagnostic material regarding sibling relationships is incomplete, which means that family diagnosis is incomplete.

Even from this small sample, it is evident that both fathers and siblings might be encouraged to participate more in the diagnostic period, so that a fuller understanding may be gained of inter-personal relationships within a family and how the child's disturbance is related to family functioning.

Reciprocal Parent-Child Relationships - Comparison of their Views

It was interesting to compare the child's view of his relationships with parents, with the parents' views. It is more possible to obtain specific impressions of the child's feelings for his parents because his defenses are less complex, and the use of projective techniques enables
the psychologist to make a more definite evaluation of the child's attitudes. Recording on seven of the cases suggests that mother and child feel the same way towards each other; of the seven, four pairs indicate ambivalence, while in three cases the mother-child relationships were predominantly negativistic or withdrawn for both participants; in nine cases the mother's and child's views appeared different. The most prevalent pattern that emerges here is the child's feeling more negativistic or withdrawn than the mother appears to, for in six out of the nine cases the child's attitude is described as predominantly hostile, and the mother ambivalent, while in three cases the opposite circumstance is revealed. The study of reciprocal relationships in terms of comparing the kinds and degrees of feelings evidenced by both participants in a parent-child relationship would provide an interesting subject for further research. No conjectures can be made about these differences here since there are too many variables to merit any hypothesis. In the twelve cases in which father-child relationships could be compared, the same pattern emerges of the child indicating stronger feelings of isolation or hostility in regard to the father than he expresses about the child. Eight of the cases did not record enough information about the father's relationship with the child to make any comparisons.
Regarding the parents' view of the child's role in the family; in eight cases both parents seemed to communicate to the social worker a desire to have the child take his appropriate place in the family, but their ambivalent feelings towards him made it difficult for them to give him adequate support and acceptance to achieve this goal; in three cases there is insufficient information to evaluate the parents' wishes, while in the remaining nine cases the mothers and fathers express different opinions. This may be indicative of each parent having conflicting ideas regarding the child's place in the family, or it may be due to lack of clarity in the recording or the methods of research. If the first point is relevant, this would help clarify the etiology of the child's disturbance, for conflicting expectations from the parents confuse the child and contribute to his insecurity.

In comparing the child's view of his role in the family with the parents' view, a good deal of discrepancy is found; although the child's concept may be distorted or exaggerated, this is nevertheless the way he feels about his place in the family. A very salient diagnostic point may well involve further clarification of the parents' attitudes in this area; if the child's view is distorted parents must be helped to find ways of helping him feel an

1 This information was obtained from the psychological reports.
important part of the family group; if the child's concept is realistic, much work will be required with the family to help them find healthier ways of relating to the child. All these children studied showed a marked lack of confidence and self-acceptance, which may be partially attributed to lack of parental support in finding a satisfying place for themselves within the family group.

**Nuclear Family Relationships with the Extended Family**

Regarding the nuclear family's relationships with the extended family, information in the social histories was frequently very complete in the area of the parents' attitudes towards own parents, and in several instances there were explicit and implicit connections made between each parents' attitudes towards his extended family and the parent-child relationship. However, fact-finding in this area may have been incomplete in terms of what actually happened between nuclear family members when the extended family created stress for them, as for example in one family where the maternal grandmother who was mentally ill and caused the mother considerable distress. While parents' current attitudes towards self and the extended family, based on past experiences, are very important in gaining an

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1 "nuclear family" refers to parents and their dependent children.

2 "extended family" refers to maternal and paternal relatives.
understanding of the person's functioning as a son or daughter, sibling, mother or father, what continues to happen in nuclear and extended family inter-relationships is also very relevant; for these relationships are seldom static and may contribute to or detract from healthy family functioning. Since parents are seeking help for their child, the way in which he is affected and reacts to harmony or disharmony with the extended family, is of particular note. In one case the recording was very clear and connected inter-familial relationship difficulties to the child's disturbance.

Family Solidarity

An attempt was made to assess family solidarity; as in the other items on the schedule, three classifications were established, which ranged from the healthy group with a strong sense of cohesiveness and family identification, to the family experiencing persistent and severe conflict which threatened to disrupt the group. There was generally sufficient information from the social history and intake notes to evaluate family unity or disunity. There was insufficient recording on only four cases; in one case the material was sufficient but was not adaptable to any one of the three categories as the parents were very closely identified with each other and shared many interests in common, but were united against the disturbed child. Thirteen cases
fell within the middle group, typified by ambivalent relationships and inappropriate handling of conflicts and crises. These families were obviously experiencing interrelationship difficulties, but not to the extent that continuation of the family group was threatened. Only one case fell in the latter-mentioned category, and one family appeared to have achieved a predominantly healthy balance. Practically all the families studied then have some positive ties, have previously weathered crises without disintegrating and, by the very fact of their voluntary application, have some motivation to cope with their problems. The degree to which parents can focus on family difficulties which are contributing to the child's disturbance, rather than on the symptoms the child is manifesting, will depend on the emotional health inherent in each parent, as well as the professional workers' understanding of individual and family dynamics.

One aspect of family solidarity is how the child feels about his place in the group. Thirteen children gave indications of feeling isolated, excluded or scapegoated, two felt somewhat accepted, none appeared to feel fully loved by parents, while five cases were not recorded. This recalls Bell and Vogel's studies on disturbed families.

1 Bell, N.W., and Vogel, E.F. A Modern Introduction to the Family.
and their general tendency to select one member as the focal point for unresolved conflicts. In none of the sample group was the concept of the child's disturbance as a reflection of pathology within the total family group evident.

Comparison of Child's Treatability with Impairment in Parent-Child Relationships

There was a connection between the Clinical assessment of the child's capacity for relationships, and the quality of his relationships with parents. Seven children showed a definite capacity for relationships; none of the parents of these children had brought out a basically hostile attitude towards them, although the father's attitude is not recorded in three cases, and the mother's attitude is not noted in one. Eight children were considered difficult to assess regarding their motivation for relationships. In five of these cases, parents expressed predominantly negative feelings for the children in this group; in one case both parents expressed ambivalent attitudes; in one case one parent was ambivalent and the other positive. It is perhaps significant that of the seven children who have a good capacity for relationships, not one parent is recorded as having a basically negative attitude towards the children in this group, while of the eight children whose motivation for relationships is questionable,
five parents had expressed predominantly negative attitudes towards them. Two children were considered to be lacking any perceivable motivation for relationships; one of the fathers had rejected one of these children from birth, while the other youngster was an only child who was caught up in an extremely neurotic and ambivalent relationship with both parents. No recording was available on three cases as to the children's ability to relate. These findings support the hypothesis that a child's capacity for healthy relationships depends on the quality of his relationships with his parents.

Family or Individual Focus?

The casework recording in the diagnostic period illustrates that there is frequently a wealth of material on the mother's background and on her concerns about the child. The history of the child is generally very complete, with much pertinent material on his physical, emotional, and mental development; possible traumatic events, such as separations from parents, serious illnesses and accidents, and the birth of new siblings, are frequently recorded. Attempts are made to interview the father at least once in the study period to obtain his view of the child, and to involve him in treatment if this is indicated and he is willing. Siblings may be observed in the waiting room if parents happen to bring them. In these ways, a general
impression of each family member's adaptation may be obtained. However, it is most often individuals who stand out clearly, and there is minimal description of prominent patterns of interaction between the mother and father, the mother-child and father-child pairs and siblings. Casework assessments of the various inter-relationships within a family are not made. Evaluations are lacking, also, of the parents' social functioning, so that it becomes difficult to assess if they are experiencing problems in one particular role, or if there are related areas of impairment. Each parent's adaptation to the various roles he is called upon to play is one way of assessing ego strengths, and also provides information on the client's role network. Sanford Sherman writes:

"...if we are to understand the individual, we must also understand the structure, function, and vital processes of the group as a discrete system. It is for this reason that, in the past decade, "family diagnosis" has been coming to the fore as a focus of interest."  

In reviewing the diagnostic material of the twenty sample cases, an individual, rather than a family focus, emerges. If casework is to be family-centred, more clarification is needed on each parent's attitudes towards the child, and how these attitudes are expressed in their current relationships. Material regarding the father's relationship

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1 Sherman, Sanford, Exploring the Base for Family Therapy, 1961, p. 18.
with the child is particularly lacking. This may indicate that the mother-child relationship is assumed, without sufficient evidence, to be the most disturbed. Connecting links are missing between the effects of impaired marital relationships on each parent-child pair, as well as the influence of parents' socio-economic status on their functioning as mothers and fathers. More understanding and possibly involvement of siblings is indicated in the diagnostic period. In some cases, this may be obtained in family sessions for through this method, both verbal and non-verbal expressions of parental attitudes towards children, and vice versa, may illustrate the roles each child plays, and how these roles are related to the problem child's particular adjustment. There is no indication, from the sample cases, of the concept that the child's disturbance is a reflection of pathology in the total family, for sufficient information is not collected on members' inter-relationships to speculate on the purpose his disturbance is serving.

It is relevant to family diagnosis to gain a clearer understanding of the inter-action of the family group with its community of residence, for in this way, main characteristics of the group's way of relating may be identified. Furthermore, sources of potential strength or additional stress may be located. Most of the interviews take place within the Clinic, and it is likely that more
home visits would clarify patterns of behaviour within the group as well as with the neighborhood. For the child who is experiencing difficulties at school, more frequent contact between the worker, public health nurse and teacher is indicated. In none of the cases was a school visit recorded, although in several instances phone contacts had been made with the nurse. This method of communication maintains a liaison between Clinic and school, but does not clarify the child's particular problem, nor the resources that are available to him, as well as a face-to-face interview with the teacher who has daily contact with him.

Because the parents' social functioning is not fully explored, it is not always possible to estimate what the greatest stresses are that impinge on the parents, and on their relationship with the disturbed child. There may be a very realistic problem which is interfering with the parents' ability to cope with their youngster. Unless many areas of functioning are explored, it cannot always be assumed that parents need prolonged help with their particular attitudes towards the child. Furthermore, some parents' egos may be too weak to permit intensive exploration of their negative attitudes, and in such cases, help may need to be directed towards supporting them to become more adequate in related roles, which may indirectly improve their relationship with the child. If important areas of
parents' functioning is known to the caseworker, alternate approaches to help them with their adaptation will suggest themselves.
Chapter 3.
FAMILY ASSESSMENT IN TREATMENT

The Diagnostic Conference

The formal assessment period in the Children's Clinic terminates with the diagnostic conference; team members, who have been working with the parents and child, meet to pool and discuss their findings, and to formulate a diagnostically-based treatment plan. The psychiatrist has generally held at least one interview with the child and parents; these may be individual, joint or family interviews, or a combination of all three, depending on the orientation of the psychiatrist. The psychologist has held anywhere from one to five interviews with the child, although three sessions are more usual. These interviews are structured around psychological testing devices; the purpose is to obtain as objective an estimate as possible of the child's intellectual and emotional functioning and capacity. The social worker may have held from three to ten (sometimes more) interviews with the parents, depending on the complexity of the case and the conference schedule. It is the social worker's role at these conferences to present her view of family functioning in relation to the child's problem, salient historical factors in the parents' and child's development, and an assessment of parents' personality
strengths and limitations. For the sake of convenience to the team, this material is contained in the social history and circulated prior to conference. The social worker, in discussion with the psychiatrist and psychologist, also participates in the formulation of diagnosis and treatment goals and has carte blanche, within her area of competence, to hold different opinions from other team members on the findings and recommendations.

Case Assignment Conventions According to Discipline in the Children's Clinic

Because of the staff ratio, social workers carry the largest percentage of cases in treatment. Psychologists are assigned a few children for play therapy, because their function at the present time is largely diagnostic. Medical staff undertake some cases when the diagnosis indicates that psychiatric interviews are required; such cases may involve patients with psychosomatic problems, pre-psychotic children and adults, as well as psychotic children. Their goals may be directed towards enabling their patients to change and reorganize those aspects of their personalities which are contributing to their illness. Generally, however, the psychiatrist's treatment time is limited by his consultative function. Other disciplines with special training and skills may take the same types of cases, but the main focus of the social worker's contribution should be in
supporting and strengthening their clients' defenses so that they can adapt themselves more adequately to their life situations.  

Clinical Assessments of the Sample Cases

Of the twenty children in this study, treatment was recommended for nineteen; one child was not considered sufficiently disturbed to need therapy, although his mother required professional help. In another case it was questioned whether out-patient treatment for the child was adequate. However, lacking a residential resource, the child was accepted by the Clinic. Of the nineteen children, ten were moderately disturbed; for these children, specific areas of maladjustment were indicated, but other areas were relatively free of disturbance. A child of this type may feel inadequate or rejected in family or peer relationships, but has some healthy outlets which give him a sense of satisfaction, such as scholastic achievement. Anne B. is such an example; this child finds minimal satisfactions in

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1 It is the usual procedure for all professions to schedule weekly in-Clinic interviews for their treatment cases. Exceptions to this procedure may be found in cases of disturbed individuals who require more frequent interviews, also when social workers make the occasional home visit to parents or children who, for acceptable reasons, are unable to keep their in-office appointments. Another exception to weekly interviews is the Day Centre program for children, which involves daily attendance for a selected group of children over a period of several months.
her relationships generally, is considered an excellent student, and is liked by her principal and teacher. Seven children were considered to be disturbed in all areas, while there was insufficient recording on two cases to make an evaluation. Mary N. is an example of general impairment; she feels restricted and rejected by parents, and does not have a close relationship with any adult; her adaptation at school is poor, for she views the teacher's instructions as further evidence of excessive demands, and is unable to achieve an average standing despite good intellectual potential. She feels inferior to an older sister; does not relate well to female peers, preferring male companionship; and is boyish in mannerisms and interests. Mary is unable to invest herself in any activity for long. Regressive features show up in frequent soiling incidents, and in feeding habits. Her impairment is severe in both kind and degree. Similarly, Norman O. (case 13) is considered impaired in all areas, but his sexual identification appears healthier and his regressions are not so severe as Mary N's.

A correlation between the extent of the child's impairment and emotional development might have been expected, but this is not evident and may be due to the crudeness of the measurement devices. It must be mentioned that there are varying degrees of health and pathology in each category, and the schedule used in this study does not provide
for the degree but rather the general areas of impairment. There is some correlation, however, between the recorded negative attitudes of parents and the extent of the child's impairment. For example, of the seven children whose functioning was most disturbed, four parents (one father and three mothers) expressed predominantly negative attitudes towards them, (three unrecorded), compared to only three indications of basically rejecting parental attitudes, (eight unrecorded) of the ten children considered moderately disturbed. This is a slight correlation involving many variables; further investigation would be required on these cases to determine whether the parents' negative attitudes make the most significant contributions to these children's disturbances. However, it is generally accepted that parental attitudes do have a marked bearing on the adaptation of their offspring; how these feelings are expressed in their day-to-day contact with their children, and the latters' response to them, would seem to be as relevant to the treatment of disturbed family members as understanding the origin of parental attitudes. It was mentioned in Chapter 2 that the day-to-day interaction of family members might be recorded more fully.

**Six Points Related to Analytical Objective of Study**

The analytical objective of this study, which is to evaluate whether the casework recording in the sample group
is oriented to the client in his family, or whether it is
centred in the individual's emotional adjustment, has
brought to light six points which, in summary, illustrate
the need to establish more definite family casework goals
and treatment methods, and indicate some of the steps that
are required to achieve this objective.

It is apparent from some of the records that
caseworkers are attempting to assist clients individually
with their emotional conflicts, without connecting the
affects of these conflicts on the family relationships
for which they are seeking help; conversely, the impact of
environmental problems on the individual does not appear
to be evaluated. The interaction of the client with his
particular problem situation becomes vague when caseworkers
attempt to help the individual work through such conflicts
as hostility towards authority or a deep-seated sexual
problem, without relating such material to the particular
difficulty at hand. In other instances, it is apparent
that the casework focus is oriented to that aspect of the
client's social interaction which is identified as the
problem area. In a Child Guidance Clinic, parent-child
and marital relationships, as well as clients' relation­
ships with their extended family, comprise their major
problems. The caseworker's efforts should therefore be
directed towards helping her client achieve a greater sense of adequacy and security in these relationships.

The six points referred to above are, briefly:

1. The need for a more explicit casework evaluation of parents' ego strengths, motivation and goals in formulating treatment objectives; 2. The necessity to record problem areas which the caseworker and parents identify as the focus for treatment following the diagnostic conference, and at points when these goals change; 3. The desirability of establishing more definitive criteria for the assignment of a family to one worker or to two or more workers; related to this point is the need for caseworkers on shared cases to give more attention to the relationship between their client's treatment and that of other family members; 4. More definitive criteria should be developed to determine when joint and family interviewing is the most appropriate to enable family members to work together on their relationship problems; 5. Direct or indirect inclusion of family members (other than the mother and the child) is necessary when treatment threatens the equilibrium of the family.

6. Caseworkers need to become more certain of their main function, which is to help their clients improve their social

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1 The term "unit case" will be used where one caseworker carries the total family in treatment; "shared case" will designate two or more workers assigned to one family.
functionings. The cases which report the greatest improvement in the problems for which the parents sought help, focus on the individual's role performance, and the reciprocal relationships with other family members.

A word should be said about the limitations of analyzing the treatment focus from the records alone. The writer is aware that many workers are certain of their function and give an excellent service without, however, recording the data in a way that can be used in this study. Complete recording does not always reflect the quality of the service given. However, in a multi-discipline setting, it is essential for each discipline to maintain its own professional function. Dr. Coleman believes that this can be accomplished only through "constant awareness, self-examination and study of procedure." ¹ The study of recording is one method that can be used to determine whether casework practice is compatible with its theory. It is believed, therefore, that more attention should be given to improving recording practices in the Children's Clinic.

Criteria in Determining Casework Treatment Goals

The criteria in use at the present time to determine the nature of treatment and its probable duration are the

extent of the child's and parents' disturbance, and the parents' motivation in seeking help. The three disciplines above-mentioned participate in planning for the kind and duration of treatment.

Many of the psychological reports in the sample cases include some evaluation of the child's accessibility to treatment, and, in cases where the child gave evidence of severe impairment, the reports state that long-term treatment will likely be required before much improvement can be anticipated. While there is no definite treatment time suggested, such cases may be carried from one to three years in actual practice.

The psychiatrist uses the information obtained by the social worker and the psychologist, as well as his own interview (s) with the family, as a basis for his psychiatric assessment. If the social worker is to carry the family in treatment, such consultation is invaluable in planning treatment goals, for it may relate the etiology of the problems to the personality structures of family members, and thus provides a broader basis for planning than a psychosocial assessment alone could do. However, because the social worker has had longer contact with the parents, generally she is in the best position to evaluate the parents' motivation for help, to gain an impression of
what they would like treatment to accomplish, and how much time and effort they are able to invest in the process. Many parents state they would like their child to be "happier", or "better adjusted" or "more successful" for the child's own sake; how the Children's Clinic can help in the achievement of this goal is not recorded in thirteen of the sample cases.

It would appear that the symptoms of psychopathology within the child and his parents are given much consideration at the diagnostic conference in relation to the establishment of a treatment program for them. However, parents' ego strengths, motivation and goals are not sufficiently assessed in the recording, nor related to the treatment goals. The recording cannot always accurately reflect team and client-worker interaction and conclusions, but it is suggested that treatment goals might be recorded in relation to the problem and the family's capacity and motivation to use casework services. There are no definitive criteria in regard to probable duration of treatment at the present time: more precisely formulated treatment goals could contribute to the establishment of such criteria.

What factors are needed to clarify parents' motivation for help and their expectations of the Clinic?
Valuable clues can be found in the problems which immediately precipitated their application for help with the disturbed child, as well as in understanding their attitudes towards a psychiatric clinic, and the child's problems. These factors should be related to the team's treatment goals for the child and his parents. The following examples illustrate the results of accepting children for treatment, without an adequate assessment of the parents' motivation.

In the case of Freddie G., it was a public health agency and not the parents who requested help from the Clinic. On several occasions, the mother stated that she was attending the Clinic because the health agency had suggested it, and because the Clinic thought her child required treatment. This boy's main problem appeared to be his response to his mother's overprotectiveness, and her inability to permit normal expressions of hostility and aggression, while his father encouraged him to be a "tough little man". Freddie was very responsive to treatment and soon began to bring out his pent-up anger, first in interviews, then at home and in the community. The mother was fearful of his aggressive behaviour and complained of it in her interviews, but since she could not see this as his response to her rigid demands, she could not be helped with it. When the child's worker left the Clinic and a waiting period was necessary before he could be re-assigned,
the mother withdrew since her worker could not make the decisions for her as to whether or not she should continue, and she was unable to make any part of this decision herself. While both the mother and the child responded to their workers' interest in, and acceptance of them, an additional stress was placed on the mother-child relationship when the boy expressed his negative feelings towards her; a fuller exploration of the mother's motivation and understanding of clinical treatment might have changed the focus of the child's interviews so that his defences could have been supported until the mother could tolerate his hostility better. It would seem from the recording that there was little observable improvement in this case, and the mother and child appeared to be functioning much the same at the end of treatment as at the beginning.

Another example where motivation does not appear to have been sufficiently related to the treatment goals is in the case of Norman O., where the child, always considered the well-adjusted one by parents, began to show symptoms of disturbance when his sibling improved during treatment. The parents withdrew shortly after treatment of the second child was initiated; it appears that they were unable to tolerate having two disturbed children, and began to report great improvements in both of them. But a few months later they re-applied, when they could no longer
ignore the second child's disturbed behaviour. It would seem that a more thorough exploration of parents' motivation in seeking help for the second sibling might have revealed that they required more support around their adequacy as parents before including the child in the treatment process. Premature involvement and withdrawal of a child may make him less trusting of, and therefore less accessible to, future therapeutic relationships.

In all cases where it is possible to evaluate the outcome of treatment, some correlation is observable between the family's use of clinical services, the precipitating factor in referral, parental attitudes towards a psychiatric clinic, and their understanding and acceptance of treatment goals. Six cases are positive examples of the relationship of the above-mentioned factors to the outcome of treatment; some degree of improvement is recorded in all these cases. It follows that such factors should be recorded in each case as a basis for determining goals, and for estimating at least provisionally the duration of treatment needed for the family's attainment of these goals.

An additional point, related to parents' motivation, is the urgent need felt by some parents for clinical services. In many cases, application is made at the point of greatest stress in the parent-child relationship when parents' moti-
vation is strongest. Most of the private cases 1 that are accepted tend to be judged as requiring long-term treatment because of the pathology evident in family members' personalities and relationships. This means that immediate service is not usually available to families in crises. A realistic concern exists that brief services could lead to superficial methods which might jeopardize the service which is available to a small number of families. However, Howard Parad and Gerald Caplan 2 show that intervention can have the greatest result for the least effort when it takes place at the height of a family crisis, in cases where the family's pathology is not of a severe and long-standing nature. It is possible that more definite evaluations of parents' motivation in the cases that are accepted could curtail the treatment time required in some instances. More time would then be available for an emergency type of service for families in crisis whose functioning is not basically impaired.

Further consideration should be given to the development of criteria for both long and short-term treatment.

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1 Private cases are those in which parents apply for direct service themselves. Diagnostic services are offered to families who are engaged with a social or health agency, and the referring agency generally carries treatment responsibilities.

Such things as parents' motivation and expectation, their expressed attitudes towards the child and the extent of health and pathology in the family are some of the factors that would contribute to such criteria. Because goals might change as treatment proceeds, these criteria would need to be flexible enough to adapt them to each family's needs.

Recorded Discussion of Treatment Goals with Parents

In the sample group of twenty cases, there was insufficient information on two-thirds of them to indicate whether social workers and parents had established goals for treatment. In many of these cases, the treatment program was not referred to except to interpret clinical findings to the parents, and to arrange interviews with the mother and the child, and in some cases with the father. It is apparent from subsequent recording on some of these cases that parents and social worker are working together to achieve a common goal, despite the fact that this is not explicitly recorded, while in other cases there does not seem to be a shared purpose between the caseworker and the parents. In one-third of the sample, goals are implied sufficiently to conclude that parents understood what treatment involved. An attempt was made in case 11 to establish mutually compatible treatment goals between the mother and the worker, but this was not achieved, with the worker
apparently concentrating too much, for the comfort of the mother, on her emotional conflicts, related to her own early experiences. In case 10, the mother withdrew but returned briefly to another caseworker before withdrawing permanently, and complained that she had not been clear on the purpose of interviews. While much of the difficulty can be attributed to the psychopathology of both these mothers, it was apparent from the recording that they might have been encouraged to describe their own goals more fully, and an attempt made either to connect with these views, to discontinue treatment, or to transfer the case to another worker, on the basis of insurmountable difficulties in establishing a common purpose for interviews. Helen Perlman argues that, when the client has been brought properly into a problem-solving relationship with the agency,

"the client and caseworker both know, as they could not have known otherwise, where and how they go from here. In striving for this goal, the problem-solving means and the problem-solving ends are as one." 1

The case of Mrs. S., (Case 16), illustrates that this can be achieved. The mother became ambivalent about her child continuing in therapy; she had been discussing marital problems and wondered if treatment for the child was necessary. However, clinical assessment had shown Ruth

to be a very anxious youngster who was in need of direct therapy, and the social worker recorded: "I mentioned that the clinic thought the child could be helped by coming for individual treatment sessions, as she is overly fearful. I explained that I thought we could help Mrs. S., too, in discussing daily happenings around the home, and helping her to understand and cope with family reactions. It was suggested that if there could be less disagreement in the home, it might help the children, and I wondered if Mrs. S. with all her strength could help Mr. S. come into the picture more as far as the children were concerned. We commented on the extreme rivalry between the two girls." Here the social worker interpreted the recommendations to the mother in a way she could understand; she was able to permit the child to remain in therapy and both made progress. It is conjectured that Mrs. S. may not have been able to do this without the worker's simple statement of treatment goals, and this would have had to lead to the mother's termination as well. Mrs. S.'s response to the above explanation is not recorded, but from later entries, it is apparent she connected with this goal herself and was working towards it.

Summary recordings of discussions on the focus of treatment between the caseworker and the client should be included in each file. A format, outlining relevant material
to record, could provide a helpful guide to the social worker. This suggestion is being made because it would help the worker and client explore what the focus of treatment shall be, and would also provide a reference point for the team's progress conferences, held approximately every six months. Such a format might include a summary of parents' responses to the findings, and might isolate specific areas of agreement and disagreement between the clients and the clinical assessment, and conclude with current treatment objectives which the client and the worker can share. In Child Guidance Clinics, the focus of interviews shifts from time to time because the child may be representative of one or more related problems in the family, e.g., an unsatisfactory marital relationship, conflicts with other siblings, difficulties with the extended family, etc. However, it would seem expeditious to record major shifts in treatment objectives when these occur, and to establish some method of making these readily accessible on the file for the caseworkers' and teams' reference, as well as for research purposes. Helen Perlman expresses these ideas succinctly when she says:

"The necessity of clarifying the idea of goal in our practice is dictated by several considerations: the caseworker's self-esteem and working effectiveness hinges on it; the content, methods and duration of treatment relate to it; and
the availability of agency service to a widening clientele depends upon it."

Criteria for Assignment of Shared and Unit Cases

According to current policy, one social worker is assigned to the family during the diagnostic period and continues, wherever feasible, with the family as a unit following assessment; continuity of the same caseworker with a family can therefore be cited as a criterion. In practice, however, a larger percentage of cases are shared amongst two or more workers, Reasons for this will be elaborated below. In the sample, four cases were carried by one worker, thirteen cases were shared by two workers, while three were shared by three. In only two cases were other disciplines directly involved in the treatment of a family member.

Continuity in time is another criterion which is employed wherever possible. Procedures were changed in the Social Service Department three years ago to end the waiting period then in existence between the assessment and continued service sections of the Department. Formerly, the intake worker completed the diagnostic study and contributed to treatment formulations; the case was then transferred to the continued service section. Because this system created a

1 Perlman, Social Casework, p. 199.
waiting period between the diagnostic and treatment periods, procedures were altered to provide for immediate ongoing service between these phases of a family's contact with the Clinic.

The psychosocial and psychiatric assessments of family members are carefully considered in the assignment of cases; no established criteria can be cited in relation to diagnostic considerations, however, because team members decide together whether cases are to be carried by social workers as a family unit or shared by two or more workers, and a variety of opinions exists on this subject. It may be said that the following circumstances have a bearing on the type of assignment made: 1) a child, because of his limited ego strength, may require his own therapist before he can develop a sense of trust in him; he may still experience anxiety when he expresses previously prohibited feelings and ideas, but until he and his parents are able to share, understand and accept those attitudes which underlie his symptoms, he may more readily place his trust in his own therapist without as much fear that his worker will discuss his behaviour with his parents; 2) a child may need to feel that his therapist belongs only to him before he is able to share him with other family members; 3) extreme disharmony and competitiveness between the parents suggest separate workers for each one; 4) parents with very weak egos may
need to have the sole attention of their worker before they, like the child, can share her with other family members; 5) extremely possessive and over-protective parents may find great difficulty in relating to a caseworker who is able to establish a relationship with their child and who permits behaviour which they do not allow; 6) parents or children, may be assigned to a caseworker whose sex facilitates their involvement in working on the problem-to-be-solved.

Conversely, where the above circumstances do not exist, and where there is evidence of family unity in working towards a resolution of their mutually recognized problems, unit assignments may be made. It should be added that the individual worker's preferences have a definite bearing on unit or shared assignments.

The foregoing criteria and situations contribute to assignment decisions. The formulation of more definitive criteria is extremely difficult because of the varying needs of each family, and because of the differing orientations amongst and within the three disciplines.

Collaboration on Shared Cases

Formal and informal consultation takes place amongst social workers sharing the same cases; casework and team conferences are formally structured and are
recorded on the file. A good deal of the collaboration, however, is informal, and frequently takes place on a weekly or bi-monthly basis following interviews of family members. These informal conferences are not recorded, so that it is not possible to gain information on their frequency or content from the files. However, from the writer's own experience in this setting, it can be stated that frequent discussions do take place in which the content of interviews with family members is communicated. Such consultations further the caseworker's understanding of family relationships, and assist her in the treatment of the individual with whom she is working. This contributes towards a family focus. Collaboration between caseworkers could possibly be used in a more structured manner with clients, however; to elaborate, there is little reference in the recorded interviews studied to indicate that discussions are held between the caseworkers and the clients regarding each individual's expectations of treatment for other family members. The recording suggests that little consideration is given towards helping family members work towards similar or complimentary goals. The principle of confidentiality may interfere with caseworkers making creative use of the interview situation to repair broken communication lines between family members. More thought could be given to the connection of each individual's treatment with that of other family members, to improve
communication between them, and to help them strive for common objectives. This is particularly important in working with parents who have unrealistic hopes about the results of treatment for other family members. The case of Mr. and Mrs. R. illustrates this point. Mrs. R. hoped that the caseworker could help her husband become less hostile with their son, and more communicative with her. The father, however, was unable to discuss these problems in his interviews, and the mother continued to expect more change in her husband's behaviour than was possible. It might have been more beneficial to help Mrs. R. accept the limitations of treatment for her husband, and to encourage her to participate in bringing about changes in their relationships herself.

Problems Inherent in Unit and Shared Cases

Either type of assignment presents its own problems: practical problems in scheduling interviews are experienced with unit assignments since there are limited transportation facilities to the Clinic, which is geographically isolated from the metropolitan area. Two or three trips a week may be necessary for family members, or, alternately, the child and possibly his siblings may have to wait while parents are interviewed. This situation may lead to frequent disruption of parents' interviews. Professional problems arise in relation to communicating content of
interviews between family members, and workers may become concerned about each client's rights to confidentiality. This is particularly so in the case of the child; overprotective parents may find great difficulty in permitting the child the privacy of his interviews, and yet they have a right to know the worker's opinion as to how the child is progressing in treatment. Furthermore, communication between family members has frequently broken down, and one of the worker's tasks is to facilitate communication amongst them. How can this be done, and at the same time necessary privacy be maintained? These problems have tended to oriente many social workers towards shared cases whether or not there is enough cohesion within a family to permit unit treatment. However, shared cases are generally more time-consuming since frequent conferences must be held between the child's and parents' workers, if they are to be kept informed of developments in treatment. Social workers could establish more definitive criteria for unit and shared assignments, and the above-mentioned problems inherent in unit cases should be given further consideration and study.

Criteria for Individual, Joint and Family Interviews

A) Individual Interviews

Most of the interviews recorded on the sample cases are individual sessions between one client and the caseworker; this is to be expected, since sixteen of the
cases were shared by two or more caseworkers.

The preponderance of individual interviews stems from a number of causes. Caseworkers have received most of their training in this method and are therefore more knowledgable and comfortable with it; psychoanalytic theories and techniques have influenced social work in relation to transference and counter-transference phenomena, which were thought to interfere with the establishment of a therapeutic relationship if more than one client were interviewed at the same time; individual interviews have become customary through force of habit, and caseworkers may experience anxiety in attempting group interviewing. Some of the criteria that apply to the assignment of cases on an individual basis also apply to the structuring of single-client interviews, such as family members' disparity in treatment goals, and clients' needs for privacy and attention, before they are able to share the worker with other family members. Furthermore, no matter how free and comfortable the family may become with each other, one or more of its members may need to spend some time in individual interviews to sort out attitudes which may not be done in the presence of other family members. There are no definite criteria for structuring individual interviews, but rather a variety of considerations that are applied to each case; custom and caseworkers' preferences are also involved.
B) Joint Interviews

A few of the sample cases record the occasional joint interview between the parents and the caseworker in the treatment period. Two criteria can be identified:
1) Where parents indicate "jointness of purpose", that is, a willingness to work together on some phase of a problem;
2) Where individual interviews fail, because each parent cannot move from a subjective viewpoint to some understanding of their marital or parent-child difficulties.

The number of joint interviews in the sample is too meagre to draw any conclusions on the effectiveness of this method, except in the diagnostic period. Some of the recording in joint interviews described, clearly, the interaction which took place between the mother and the father. Even in the treatment period, such interviews might be extremely helpful if the kinds of problems parents are experiencing with each other are not clear. Periodic joint interviews might also be useful to evaluate with the parents, the gains that have been made by the child and themselves, and to decide on future treatment objectives.

The joint interview method is one with which most caseworkers have some familiarity. It can be used as one means of establishing or maintaining a family focus in casework, and could provide a basis for family group interviews.
C) Family Group Interviews

While no criteria exist for family group interviewing, the Social Service Department in the Children's Clinic is interested in exploring this area, and in testing out criteria suggested in the literature. None of the cases studied recorded family interviews.

Social work has been traditionally concerned with the "family group as a whole". 1 Mary Richmond's description of family group interviewing sounds amazingly modern. She observed that caseworkers see "several of the members of the family assembled in their home environment, acting and reacting upon one another, each taking a share in the development of the client's story, each revealing in ways other than words social facts of real significance." 2

Family interviewing today takes cognizance of psychological, as well as social, factors. To the knowledge of the family as a social, cultural and economic group, an understanding of unconscious processes, ego functioning and role performance has been added.

Frances H. Scherz 3 suggests criteria for the use of multi-client interviewing, and contraindications to such

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1 Richmond, Mary E., Social Diagnosis, Russell Sage Foundation, New York, 1917, p. 15.
2 Ibid., p. 134.
a method. In her opinion, such interviews are effective with:

1) acting-out character disorders with their major problems in the area of family relationships, and when the first goal in treatment is to help them examine their role behaviour. Children may be included in interviews after the marital partners have made some progress in understanding their respective roles, and are able to behave constructively towards each other;

2) neurotic parents of phobic children. Frances Sherz writes, "We have found that, in some instances, the hostile-dependent tie between mother and child is loosened more readily when the parents are first treated through joint interviews." ¹;

3) families in which the crucial problem is the chronic illness of one of its members, and where the initial treatment goal is one of furthering family members' understanding of the nature of the disablement, and of reducing their guilt;

4) families that can tolerate the anxiety of working on their problems with each other, and where the first treatment aim is to help family members improve their role functioning and their patterns of communication. "When the participants work together as family members who share a mutual responsibility, impetus is given to the process of working out of the most acute and hurtful problems." ²

5) Parents who are unable to cope simultaneously


² Loc. cit.
with both their own and their child's problems, but may be able to respond to an approach that emphasizes their handling of the child; 6) certain chaotic family situations in which order has to be introduced, and where individual family members feel overwhelmed by the complexity of the problems.

The six situations outlined above all have potential for adaptation to Child Guidance practice. It is worth noting that the author conceives of family interviewing only in relation to a family's readiness to profit from this method. She also believes that multi-client interviews should be interspersed with individual interviews, where indicated, and with the same caseworker. This could present many problems to the worker, particularly in the area of establishing a consistent relationship and focus with the client alone, and in the family group. Thoughtful experimentation would either confirm or refute whether both individual and group interviewing methods could be carried out by the same caseworker.

Miss Scherz outlines four situations where family interviewing is contraindicated. One is when family members are motivated to support, primarily, each other's destructive defenses. The second is when the disturbance of one family member produces the crucial family conflict to which other
individuals are reacting. A third situation is when an individual is overwhelmed by intrapersonal anxiety, or is excessively fearful of revealing himself to other family members, and a fourth, when a client is unable to tolerate sharing the worker with others. In these situations, Mrs. Sherz suggests that individual interviews are the preferred treatment method.

In many of the current publications on family interviewing, recognition is consistently given to the fact that caseworkers' training and experience have prepared them for individual and joint interviewing but not for group sessions; therefore, certain anxieties and resistances may be expected as social workers attempt this new method. It is apparent from the above criteria that there can be no absolute answers regarding timing and methodology of family sessions but, as in individual casework, certain general principles can be formulated and adapted to each family's needs. Miss Scherz \(^1\) states that the following techniques have been found useful in conducting group interviews:

1) Since the aim of multi-client interviewing is to further the understanding by the participants of the significance of the interaction between them, any intervention by the worker should be done in terms of this interaction. Thus the worker's interpretations of an individual's behaviour

\(^1\) Scherz, *Journal of Social Casework.*
should indicate how the participants are affected. The author is referring here to behaviour and communication that either promotes or interferes with family functioning;

2) The worker should "occupy a position of empathic neutrality." He should avoid involvement as a referee or in making decisions for family members. "The worker must concentrate not on the specifics of what is being said but on its essential meaning and significance." 

3) The worker offers support to all members, does not condone the use of destructive defenses, and does not permit one member to control the interview.

4) Non-verbal communication ought to receive as much of the worker's attention as verbal communication; both should be discussed with the participants. Thus the obvious and subtle interactions amongst family members are brought to their attention and, once they recognize what has happened, they can be helped later to understand it. 

5) The ultimate goal of family interviewing is to help the members utilize the potential resources for understanding each other, and for meeting each others' needs. The caseworker becomes increasingly less active as he perceives this happening; and continues to intervene only when he can facilitate communication between family members.


2 *Loc. cit.*
It can be seen that the same techniques that contribute to effective casework with individuals may be utilized in family interviewing. The essential difference and challenge seems to be, however, that the worker is in a more demanding situation, with several persons requiring his support and attention at the same time. This factor may present a particular difficulty for social workers in child guidance settings; much self-awareness and discipline on the part of the worker frequently needs to be exercised to avoid identifying with the problem child who is often misunderstood and mistreated, however unwittingly, by the parents and siblings. Careful study is therefore required to evaluate both the family's readiness for group interviews and the workers' professional readiness, to provide the necessary guidance to improve family functioning through this method.

It is in the area of family interviewing that casework and group work might achieve some measure of integration. The two methods have been rather sharply separated in schools of social work and in the field. Group workers, however, may be called upon to practice individual counselling, particularly in Neighbourhood Houses; caseworkers are becoming more interested in group methods as the focus of their attention expands from the individual to the family group. Max Siporin ¹ observes that investigation is required

on the relevant group work methods and skills which could be applied to family-centred treatment. He believes that such an enquiry would bring casework and group work together, and that complimentary methods of help to individuals and to family groups could be developed more effectively, through the collaboration of caseworkers and group workers.

Involvement of Family Members in Treatment

A) Fathers

In all the sample cases, with the exception of one, plans were made during the diagnostic conference to involve the child and the mother in treatment. It is the Clinic's policy to involve both parents during the assessment period and, where indicated, to include the father in treatment.

Of the twenty cases, fifteen fathers were involved in treatment, while five did not participate. Of the former group, five had regular interviews and the focus changed in three of these cases to the marital relationship, which seemed to be creating greater difficulties than the parent-child relationship. Consideration was given in these cases to joint interviews, but the parents did not appear to have enough jointness of purpose to make this a feasible treatment method. Separate workers were assigned during treatment to each parent in two of these cases because of parents' needs for male and female identification, and also because of the
severity of the marital problem and their unreadiness to share one worker. Ten fathers were peripherally involved, that is, interviews were offered when the mothers indicated their husbands had some concern about a particular phase in treatment. In some cases, the recording states clearly the reasons for the fathers' limited involvement; for example, in case 18 both parents agreed that the major problem was in the mother-child relationship, and the father was interviewed whenever he indicated, through the mother, that treatment was impinging on him in a way that made him anxious. Similarly, in case 19, the parents agreed that the mother-child relationship was the main focus of treatment, and the father was brought in twice on a "reporting" basis, and confirmed the improvement that his wife had indicated in her interviews. In case 11 the recording stated that the father lacked motivation and was not considered to have much potential strength in supporting the mother's and child's treatment; he was a very passive person who seemed content to accept whatever came along, and showed no desire to play a more active role in his family. Of the fifteen cases where fathers were included in the process, reasons can be found for either their intensive or peripheral involvement with the Clinic. The bases of involvement vary from the team's and parents' mutual recognition of where the main
problems were located, to resistance on the part of some fathers. Whenever possible, resistant fathers should be involved either directly, or indirectly, through the mother, so that he may have some sense of participating in processes that are affecting the family. This would also keep the worker more informed of any changes in the family balance, and might help the wife feel more supported by her husband. Much direct involvement may not be necessary where the mother acts as a communicating link between the Clinic and her husband, as in case 18. In the transfer summary on case 19, the worker recorded that she might have included the father more as a means of strengthening the marital relationship.

Of the five cases where the fathers were not included in treatment, few comments can be located in the recording to explain their non-participation. In the case of Brian C., it was the father who applied for help with the child, which is a rare occurrence since it is usually mothers who make the initial request for service. Personality investigation revealed the child's main difficulties were centred around his relationship with his mother; there were suggestions of a better relationship with his father, or "at least a desire for it." The father was described as being more patient with the child than the mother, and spent much of his free time with him. It was difficult for the father to

1 Quoted from the psychological report.
attend the Clinic regularly, because his employment took him away from home for long periods of time. However, in Case 15, the father was away from home for approximately the same amount of time, and was able to maintain fairly frequent appointments. In case 6, the father questioned through his wife whether his child needed treatment, but arrangements were not made for him to discuss this question with the worker. Part of the child's problem, however, appeared to stem from conflicting expectations from parents, and the father was concerned about the mother's overprotectiveness of which she gave evidence in her interviews. In case 13, the father did not think his child was disturbed, but did question his laxness with his children, which the mother complained about in her interviews. The father stated his willingness to co-operate, although the worker recorded that he was not motivated to attend the Clinic on a regular basis. The impression this recording gives is that the father could be included peripherally, and support given to him to be more consistent with the children, and to share responsibility for child-rearing with his wife. Similarly, in case 14, there is no record of why the father was not included; from the information given in the social history, he appeared to be considerably stronger than his wife, and was able to give her some support with the children. His willingness to participate in the Clinic program is recorded. When the second child was referred for treatment, he communicated
through his wife his dissatisfaction with the boy missing school to keep Clinic appointments, but there is no record of the worker discussing this with him. In case 16, the father expressed willingness to have interviews; he recognized his daughter's problems of fearfulness, excitability and loneliness, and felt resentful that she did not confide in him and his wife. One of the mother's main problems was her inability to share her daughters with her husband, and there was considerable marital conflict. However, despite his lack of involvement, the mother was helped in both areas. Nevertheless, it is possible that the father resented his non-involvement in the treatment process.

Lack of data on the records does not necessarily mean that the fathers' non-participation in treatment was not diagnostically based; it may mean that this information was not recorded. However, if a family focus is to be maintained, it would seem necessary to record such decisions for the workers' and the teams' reference formulating goals and in assessing achievement of those goals. The formulation of some policy regarding the fathers' involvement would support a family focus, and would guard against unnecessary exclusion of the father if this does occur. It is interesting to note that of the five cases where the fathers are not included, there does not seem to be a relationship between the mother's and child's use of treatment and the father's non-
participation; two of these mothers reported improvement in their self-confidence and established an extremely good relationship with their workers. Two of the mothers were difficult to engage and made apparently little progress, while the mother with two siblings in treatment appeared to withdraw because of her concern about having two disturbed children. While this sample is too limited to establish any definite conclusions, it does suggest that there are many other factors in addition to the direct involvement of the father than contribute towards effective treatment in a Child Guidance Clinic.

B) Sibling Involvement

Many of the referred children in the sample expressed excessive resentment towards brothers and sisters, and the siblings themselves sometimes showed behaviour which was thought to be symptomatic of disturbance, such as demanding, attention-seeking conduct, and difficulty in separating from their parents. In three of the cases help was requested and given for a second sibling; in one case the mother requested service for a second child but was helped by the caseworker so that referral became unnecessary. In three cases, the caseworkers' observations of the siblings indicate that treatment for them may have been desirable. This is a total of seven out of twenty cases. As with the fathers, direct involvement of siblings may not be necessary if the parents can be helped with their relationships with
their children; however, regarding the three children who were the second sibling in each family to be referred, it is wondered if the treatment time required by these families might have been shortened by involvement of the siblings in the diagnostic and post-diagnostic periods. It is interesting to note that these children appeared to represent the "good" side of the mothers until the disturbed child began to improve, and it is possible that this may be evaluated in the assessment period by the early inclusion of these children. In such cases, careful judgment would be required as to whether parents' defenses could tolerate the possibility of revealing the "normal" child's disturbance before a trusting relationship had been developed with the caseworker.

Assessment of Treatment: Progress Conferences and Casework Evaluations

Evaluation of treatment may be said to be a continuing process in social casework through the worker's assessment as each case proceeds, and in consultation with the supervisor. Such assessments are not specifically recorded in most of the sample cases, however; in some cases, the evaluation is implicit in each recorded interview; in a few instances, workers' impressions of the client's functioning are recorded briefly at the end of each interview, while some of the cases do not assess the client's functioning but
are descriptive of his or her conversation and behaviour. While it is obvious in some instances that assessments are made, the absence of explicit data in the recording makes it impossible in this type of study to evaluate progress in treatment in some of the sample cases.

**Progress Conferences**

It is the policy of the Children's Clinic to hold progress conferences on treatment cases every six months, with the full team attending. Wherever possible, it is expected that caseworkers will prepare written summaries, and a format is available to assist in the compilation of this material, which provides an excellent guide for evaluating movement in family-focused casework. (See Appendix D). The purpose of such conferences is to evaluate families' needs and use of Clinical services and, with the help of the team, to clarify future treatment goals.

In the sample group, five contained some recording on progress conferences every six months. There was recording on only two of these cases on both the progress conference summary and the results of the conferences. These notes were clear and precise and gave an excellent account of the caseworkers' contacts with the family in relation to original and continuing treatment goals.

One progress conference was held after one year's
treatment in one case; in five instances, the average conference was one in one-and-a-half to two years. In nine records, no progress conferences are noted, although the treatment time on these cases averages twenty months. This does not necessarily mean that conferences were not held, but may signify that they were not recorded. Progress conference summaries and discussion provide an opportunity for the caseworker to clarify her own thinking on cases in relation to clients' clinical and psychosocial diagnoses, and their aims and use of treatment. Recording of such information is valuable for the worker's and team's reference, for transfer of cases, and for research purposes, and should therefore be included on each file.

Outcome of Treatment

At attempt was made to assess the improvement in the child's and parents' functioning in all cases, with particular attention to the closed cases. The recorded

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1 At the time of writing, ten of the sample cases have been closed, nine are active, while one case cannot be evaluated since the recording terminates over a year ago in mid-treatment, and the disposition is not recorded. The average time for duration of treatment of eighteen cases is fifteen months, and fourteen months for the closed cases. Two cases were excluded from this average; one family withdrew following the diagnostic assessment, and the status of one case cannot be determined from the recording. Inclusion of the time spent with families in the assessment period would increase the average further by two to three months. The average time spent to this point on the active cases is sixteen months. It can be seen from these figures that treatment is generally long-term; the writer thinks that this is a fairly representative sample of the Children's Clinic direct service cases.
caseworker's assessments on the families with whom they were working are used to determine movement. There is no other standard procedure for assessment on termination except the social work evaluation. Other disciplines could contribute more to the evaluations of progress when a family terminates.

The recording conventions in the Children's Clinic call for a closing summary of the family's problems, course and outcome of treatment, and reasons for closing. (See Appendix E) While only a third of the closed cases in the sample used this format, there were sufficient evaluations on one family member in all terminated cases to draw conclusions regarding improvement or non-improvement in family members' functioning at the end of treatment.

Fifty percent of the closed cases recorded marked improvement in family relationships and the child's adaptation at the end of treatment; twenty percent showed improvement in the child's functioning but there were still important areas of malfunctioning in the family; twenty percent showed no improvement in either the child's or parents' relationships and adaptation while ten percent withdrew before treatment was established. The writer thought that it might be possible to relate such factors as clinical assessment of the child's impairment, the marital relationship and family solidarity, to outcome of treatment, in order to
remove some of the variables not directly related to the service given. However, insufficient recorded data made this impossible. It must be kept in mind that the degree of impairment in the child's functioning, and in family relationships, and in the ego strengths of individual family members, do have a strong bearing on whether or not families are able to utilize Clinical services to their advantage. These factors do limit the following conclusion, and further research is needed to determine its validity.

Of the closed cases which record the greatest improvement, the caseworker in each one focused on current family relationships, although the personality dynamics of individual family members appeared from the recording to be kept very much in mind by the caseworkers. The clients' past experiences were discussed but were generally related to current individual and family problems. In addition, the clients' strengths were supported and healthy functioning was sought out as well as areas of pathology. The following excerpt from one of these cases illustrates the last point: "Mrs. V. thought she would end up just like her mother, with every problem her mother had, including arthritis. (Mrs. V's mother had been intermittently psychotic since the client's childhood). I asked her to look at herself as an individual and to recount some of the things she did well; she thinks she is a good cook, she knows she can make the family comfortable,
and she makes all her children's clothes." 1 This excerpt is taken from the file after several months of treatment; the mother had described her childhood and her feelings about it. Her past could not be changed, but her functioning as a wife and mother could be supported and enhanced.

Another significant point in the cases which showed the greatest improvement is that, in every case except one, the recording described the activity of the caseworker as well as the client's activity. Thus if the caseworker strengthened defences, clarified a point, or encouraged insight, the recording made this clear. Both clients and workers seemed certain of their roles. In case 10, which showed no improvement, a family focus was maintained but the caseworker did not record her own activity. The mother withdrew from treatment and returned briefly to another caseworker who recorded that Mrs. K. seemed confused about the purpose of interviews, and appeared to feel that she must report on past and current events in her child's life without really involving herself. The caseworker attempted to help the mother understand the purpose of interviews, but she was angry because she felt she had not been helped, and would not continue. The psychiatric assessment stated that marked paranoidal trends were evident in this family, which

1 Quoted from case 18.
undoubtedly contributed to the mother's inability to use casework services. However, the early recording gives no indication that the mother's interviews were anything more than reporting sessions.

Another relevant factor in regard to family-focused treatment is related to the involvement of one or several family members. In the six successfully treated cases, five fathers were involved only peripherally, that is, they had a maximum of ten interviews during the entire course of treatment, while one father was not involved directly at all. However, they were included in such a way that a family focus was maintained; the wives were helped, where needed, with their relationships with their husbands. Furthermore, in five cases, the workers arranged interviews with the fathers when their concern about treatment appeared to place additional stress on them and on the mothers. It would seem from the sample cases that intensive involvement of fathers in treatment is not essential in helping the mother and the child, provided they are included where necessary in the treatment process. Factors which contribute to the team's decision to include the father in treatment are the clinical assessment of the child's core problem, and the father's capacity and motivation to use the service. If the father is to be involved, it is the caseworker's task to help him
select a focus which is acceptable to him, and which is also workable. Case 17 illustrates the importance of the focus being acceptable to the father.

Mr. T.'s main problem appeared to be in the area of male identification. He was very uncertain of himself in the husband and father roles, and dissatisfied with his low status job. His wife was concerned about their poor marital relationship, which did appear to be a major stress in the family to which the disturbed child was reacting. The father had weekly interviews for one year with the caseworker and withdrew because he "resisted seeing himself as a patient." 1 This father was involved in treatment because of the mother's concern about the marriage, and because of the Clinical assessment; his participation was essential in stabilizing the family. The caseworker devoted much thought and attention to helping this father, but the focus which was selected was apparently not acceptable to him. At the beginning of treatment, Mr. T. was interested in obtaining vocational counselling so that he could find employment which might offer him more satisfactions. This aspect of his male identification was not explored by the caseworker, and the initial focus was on his unsatisfactory sexual relations

1 Quoted from the casework recording.
with his wife. While communication between the parents improved to some extent, the last two entries strongly suggest that the father was still looking for some kind of vocational guidance. It is conjectured that strengthening the father's role performance in the area in which he wanted help might have proved more rewarding to Mr. T. and to the caseworker.

An important point to consider in including fathers in treatment is, therefore, how they can be helped to improve their functioning as husbands and fathers. This may mean that the focus will be on related roles if the client is unable to work directly on his adaptation as a spouse and parent. The T. case, described above, is a good example of this. It is representative of some of the cases studied which concentrate on the client's emotional adjustment, and do not give sufficient attention to other factors in the client's life situation.

Of the nine active cases, three showed moderate improvement in one family member's functioning, one showed no improvement, while no evaluations are recorded on five cases. Of the three cases with moderate improvement, two are family-focused.

Conclusions: Strengths and Weaknesses in the Casework Focus

Half the closed cases in the sample group emphasize
the client's social functioning, as well as the adaptation of other family members. Fathers are included in treatment where necessary, and attention is given to the adjustment of other than the referred child. These cases record the greatest improvement in family members' adaptation. Forty percent of the closed cases placed more emphasis on the client's emotional adjustment, and record less improvement than the above-mentioned group. It is possible that improvements in the client's expressed attitudes and feelings assumed more importance in these cases, and if so, his actual functioning would likely not be recorded and may have improved more than the files indicate. However, enhancement of the individual's adaptation to people and circumstances in his environment is the aim of casework services, and should therefore be given adequate attention.

In order to achieve or maintain a family focus in the Children's Clinic, the client must be enabled to establish realistic expectations of the helping process for himself and for other family members, and to discover goals which can be shared by other persons in his group. More attention should be given to the development of criteria on family unit and shared cases; consideration should also be given to more extensive use of joint and family interviewing as a means of facilitating involvement of family members on a common problem-to-be-worked. But most of all, the
casework treatment function needs defining. The importance of this for casework in a psychiatric setting has been mentioned in some detail in chapter one. The responsibility for determining casework focus and goals lies in two directions: the individual practitioner must try to determine what his function is through selecting a focus which is in keeping with social work concepts, and by putting it to the test of experience; it is the task of administration to help the worker with this, and to provide opportunities to discuss and compare casework's area of competence with that of psychiatry.
Chapter 4

IMPROVING THE FAMILY FOCUS

The Community's Awareness of Disturbed Families: Resources

Social agencies, medical, legal and educational institutions, religious and recreational organizations and private citizens come into daily contact with individuals from families whose functioning is impaired from a mild to a severe degree. Community concern is expressed in many ways about the increasing disorganization of families as a result of personality difficulties and unhealthy social conditions.

This concern finds expression in the establishment and maintenance of agencies whose functions are to cope with the various aspects of family disorganization. Services may be divided into three main categories: 1. Those which are preventive; 2. Restorative services; 3. Those which help individuals from families which are about to, or have already, disintegrated. A great number of different agencies exists for each level of service according to the physical, psychological, intellectual, economic and social needs which they are established to serve. The Community Information Service of the Greater Vancouver Community Chest and Council lists approximately 435 general services in the metropolitan Vancouver district alone; 1 many of these organizations are

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devoted to the above-mentioned goals. This gives some indication of this community's awareness of and concern about disturbed families.

A few of these services may be thought of as preventive in nature; religious, recreational and educational institutions contribute to healthy family functioning and are therefore preventive of family disruption. Social agencies cannot be preventive in scope because they are established to assist with existing social problems which the community has recognized. Most of their efforts are, therefore, restorative of family life at the best, and, at the least, they provide for the needs of disorganized families. Child protection agencies are a good example of this observation. Social work philosophy emphasizes that no home can replace the child's own family, but these agencies are so occupied with the results of family disintegration, that only a small part of their time can be devoted to restorative functions.

Through the aid of mass communication media, communities are becoming increasingly aware of the cost to individuals and to society of serious family breakdown. Professionals in the mental health field have turned to the study of etiology, diagnosis and treatment of family disruption which can lead to consideration of prevention of family breakdown.
Social work action is required on two levels:
1. A more systematized understanding of healthy and pathological family functioning; 2. Mobilization and co-ordination of resources, based on scientific knowledge of the family's total needs to: support and encourage healthy family adaptation; to restore dysfunctioning families; and to provide more adequate resources for individuals, particularly for children, whose families are unable to provide for their basic physical and emotional needs.

In relation to the second point, the Research Department of the Community Chest and Councils of Greater Vancouver recently conducted a survey on the attention North American communities are giving to the multi-problem family. Preliminary results of this survey show that over fifty percent of major North American communities are giving serious attention to this problem. Such programs have taken a variety of forms; one is the maintenance of agency structure with more intensive family-centred casework for a few of these multi-problem families, with various devices set up to co-ordinate the programs. Other projects have been established through community centres; generic social services are offered in an effort to establish an

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1 Communities of 100,000 population and over.

2 Proposal for an Area Demonstration Project, May, 1962, Community Chest and Councils for the Greater Vancouver area.
integrated neighbourhood approach. The most outstanding of these projects in North America are cited as: the programs of the Community Research Associates; the St. Paul Family Centred Project; and the Referral Units and Services to Families and Children of the New York City Youth Board.

The St. Paul Study is considered to be the pioneer movement which has developed a methodology to diagnose and measure family functioning and movement in disorganized families. However, this and similar projects have not evaluated whether community treatment programs, which have been set up to promote disorganized families' social functioning, have actually achieved their aim, by comparing them to a control group who have not received such services. "Neither has there been any study in depth of the genetic, biological, psychiatric, psychological and social factors associated with these "hard core" families." Further, no project has established a social service centre which would provide intensive health, welfare and recreation services to multi-problem families.

A service which includes some of these factors, the Area Demonstration Project, is now being planned under the auspices of the Greater Vancouver Community Chest and

1 Proposal for an Area Demonstration Project, p. 5.
Council. Community interest in the establishment of such a project dates back several years. In 1951, discussions began between two neighbourhood houses and a family service agency on the possibility of combining casework and group-work methods; their aim involved provision of a more coordinated service to disorganized families in contact with the group work agencies. This program began in 1955 and has now become part of the regular services of the two houses. In 1959, a report of the Co-ordination of Services Committee under the aegis of the Social Planning Section of the Chest and Council, recommended that a demonstration project be developed in one area of the city. In the fall of 1960, an Agency Advisory Group, comprised of the directors of those agencies whose participation was required for such a project, was formed to recommend proposals for this experiment. The same year, the Research Department undertook a checklist survey of multi-problem families in Vancouver city, to provide the committee with detailed information about the numbers and concentration of these families in the community.

The Advisory Committee has recently submitted its proposal for the Demonstration Project to the Community Chest and Councils. These proposals include administrative structure, treatment and research objectives, and a carefully planned research design. The report states that:
"The uniqueness of the present research demonstration lies in three aspects: a) it incorporates a demonstration service which is a field test of experience so far gained from other experimental projects, and goes beyond this in establishing an integrated casework-group work-community organization approach of major public and private agencies under one administration; b) it includes a carefully prepared control group type of research design, to assess the extent to which the results obtained might have occurred in the absence of the project, and a five-year follow-up study; c) it incorporates a systematic study of the characteristics of problem families." 1

The Project's principal treatment objectives are: "the reduction and ultimate prevention of family breakdown; the improvement of social adjustment, with consequent positive results in family relationships; and the reduction of dependency." 2

This report illustrates the thoughtfulness and interest that key persons in social agencies in this community are taking in the multi-problem family. The report makes it clear that this interest extends beyond the scope of their immediate project, and that their ultimate aim is the prevention of family breakdown. This project represents a pioneer effort in North America in the field of identifying families' needs, providing co-ordinated services for them, and assessing these services with the best scientific methods

1 Proposal for an Area Demonstration Project, p. 5.
2 Ibid., p. 4.
that are available. As such, the Vancouver study will likely make significant contributions in family diagnosis and treatment to this and other interested communities on the North American continent. ¹

The Relationship of the Children's Clinic to the Community

Mention should be made of the Children's Clinic relationship to the community, and its role in the prevention of family breakdown.

There is not as much contact with the community as the writer thinks is desirable. This is reflected in the limited school contact in the sample cases where learning difficulties is one of the presenting complaints. This may be partly the result of the Clinic's geographical isolation from the metropolitan area, but the method of structuring individual client in-office interviews which has been prevalent in psychiatric social work in the last two decades, has likely had considerable influence on the Clinic's detachment from the community. ²

¹ An indication that Vancouver agencies' assessments of problems are more person-centred than family-centred, is found in the results of identified family problems when two or more agencies were active with a case. There was disagreement in 77% as to which constellation of problems were present in the family situation.

² An additional factor may be that psychiatric clinics are often regarded as training grounds for psychiatrists, social workers and clinical psychologists; some protection, therefore, from heavy community commitments is required if clinical training is to be accomplished.
Although staff training is an important function of the Children's Clinic, this and similar settings are committed primarily to the giving of service to the disturbed child and his family who are suffering from psychological and social maladaptation. Simply stated, the basic aim is to help families live richer lives with each other and between their group and society, and to find more satisfying ways of adapting to their life circumstances. In order to help clients towards this goal, social workers need to be aware of living conditions, attitudes and events in the community that influence referred families either positively or negatively. Isolation from the community makes this aim impossible. There is a growing professional belief that social workers should get out of clinic settings more, into the families' homes, the schools, other agencies that have worked with them, with groups of "average" parents in playschool and P.T.A. meetings, in order to familiarize themselves with the reality forces that shape and are shaped by family life. This is an ambitious and long-term plan, but a start could be made through more frequent family, school and agency contacts.

Do Child Guidance Clinics have a role to play in the prevention of family disorganization? The writer believes they can and do, and perhaps more so than any other social agency or psychiatric clinic, particularly when
parents apply for help with a younger child. On the basis of current knowledge and information, it is impossible to estimate how many families have been restored to adequate functioning and in how many, disintegration has been prevented through the work of this Clinic. It has undoubtedly made contributions in these areas. But some way must be found to make the service more accessible to families at points of stress. This setting is an appropriate one to give some leadership to the community on the preventive aspects of family breakdown.

Before any of these goals can be realized, strong administrative leadership from each discipline, and vital interest at every level of staff and line organization, are required. The social worker's role is one part of the total process, but, because of her area of competence, and because of the advances that are being made in theory and practice in the field; caseworkers in Child Guidance Clinics could make a significant contribution to the community in the area of prevention of family breakdown.

1 Although strengthening families and keeping them intact is the major aim of mental health clinics and social agencies, this goal cannot always be pursued. Exceptions may be found where one family member is chronically ill and poses a serious threat to the health of other family members. Another exception is found where children are suffering from severe physical or emotional deprivation, and where the prognosis for rehabilitating the parents is poor.
There is a wealth of reasonably systematized material available on the individual's personality dynamics, but scientific methods of conceptualizing the individual's relationship with the family group are still in their infancy. Dr. Ackerman says,

"...a considerable body of empirical observations concerning family life is now available. But the usefulness of such knowledge is limited. We do not know how far, how accurately, how safely we can generalize. We have no adequate criteria for prediction. Too much is left to chance, and so progress is hindered." 1

What knowledge is required before the essentials of family functioning can be grasped and utilized in treatment? Dr. Ackerman suggests that more definite information is required on the universal elements of family life, how these elements vary from culture to culture, as well as "a clearer definition of the dynamic inter-relations of individual and family group." 2 He believes that these facts may be obtained through research and experience, particularly through the latter medium. Whole families must be described, defined, and classified "on a single continuum, rather than described as parts on many continua." 3 A central challenge, therefore is that of "selecting the more

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1 Ackerman, The Psychodynamics of Family Life, p. 320. (underlining added).
2 Loc. Cit.
3 Ibid., p. 323.
significant variables and respecting the essential inter­
dependence of these variables." ¹ And the approach must
be a holistic-dynamic one to human behaviour rather than
an atomistic, mechanical one. The final test of the validity
of such knowledge is the power of prediction.

Dr. Ackerman discusses the many problems involved
in obtaining accurate knowledge of family dynamics. One is
that families change through time, and that what holdstrue
of their dynamic interaction at one period does not apply
at another time. A further problem is the matter of correct
interpretation of the relations of the part to the whole.
An additional complexity is the paradoxical problem of
injecting exactness into a field of study where clinical
observations are, of necessity, subjective, and where the
observer's presence may bring about significant changes in
family behaviour. A further problem is the poorly defined
descriptive terms which are used in the field of mental health;
in order to communicate the procedures and results of family
studies, concrete, specific, usable definitions are required,
as well as the need to define clearly the bases for judgment
in the analyses of the data. There are many levels to be
considered: biological as opposed to social components;
heredity as opposed to socialization; traumatic experiences
in childhood and adulthood and the individual's capacity to
cope with these experiences.

¹ Ackerman, The Psychodynamics of Family Life, p. 323.
Dr. Ackerman suggests that four levels of behaviour need to be kept in mind in establishing the correlations of individual and family functioning: 1) intrapsychic processes; 2) interaction among family members; 3) the dynamics of the family group as a whole; 4) the relations of the family with the larger culture. It is apparent that a single focus cannot provide the data on family life that is required; each study would require hypotheses related to the particular focus selected, and the data organized according to these hypotheses. The final and indispensable task is the testing of the findings, which, if validated, could contribute to the diagnosis and treatment of family dysfunctioning, and might ultimately promote positive mental health. In order to accomplish such research, Dr. Ackerman believes that the clinician and the researcher must join forces.

That social work is being influenced by, and influencing, the current trend towards research and practice in family diagnosis and treatment is apparent from articles that are appearing in current casework publications. The St. Paul study was extremely significant in this regard because it underscored the need to use the total family as the primary unit for diagnostic study in the planning and co-ordinating of community resources.
This project has provided valuable material for similar experiments in community services for disordered families, which has led to attempts to classify families according to their behaviour patterns. Community Research Associates undertook a family classification study as a companion piece of research to supplement three projects which were undertaken in San Mateo, California, Washington County, Maryland and Winona County, Minnesota. Beginning in 1954 and continuing for a period of three years, the purpose of these projects was to experiment with procedures for organizing community services to prevent and control problems of dependency, indigent disability, and disordered behaviour. A diagnostic classification of disordered family types was thought to be indispensable to the achievement of this goal. C.R.A. accordingly undertook a classification of dysfunctioning families according to their behaviour patterns that had some diagnostic significance as to the causes and treatment of dependency, indigent disability and disordered behaviour. This study attempted to articulate social work concepts of family diagnosis within a framework of healthy and pathological family functioning.

C.R.A. sifted out five major areas of family life as a basis for psychosocial diagnosis: 1. family composition; 2. psychosocial disorders and precipitating stress present; 3. family social functioning including child-rearing and
development, marital adjustment and financial management; 4. individual family members' intellectual, physical and emotional characteristics; 5. family of origin history.

The concept of pathology which was used in this study is a relative one, and distinctions as to health and pathology are based on "which needs dominate manifest behaviour; how many of these needs are urgent; and the behaviour techniques which are used in gaining satisfaction of these needs from the environment; the exaggeration and flexibility of the defenses used; which and how many family members or others are deprived or damaged in the process."

The classification system of families which C.R.A. developed is not based on a series of interaction patterns among family members, but rather on interpersonal relationship patterns according to their fundamental aims; the kind and response elicited between and among family members is evaluated in relation to individual factors and the social tasks the person may be expected to meet in four main areas which are those of the marital relationship; child rearing; child development, and financial functioning. In order of arrangement, the classes represent a continuum in the direction of the family's decreasing capacities for mastering adaptive

tasks. The first category is the "perfectionistic family"; the "unsocial family" is found at the far end of the continuum while the "inadequate" and "ego-centric" families occupy the mid-positions. This range approximates the assessment of ego functioning of individuals who are described as neurotic or "conscience-ridden" at the upper end of the maturity continuum, and as psychotic or totally unable to function socially at the lower end of the scale. Various classifications of character disorders or "impulse-ridden" individuals occupy positions on the mid-range according to their ability to adapt themselves to their social circumstances. Family casework may be facilitated by increased understanding of each family's common and unique strengths and limitations in each category or mixed classification, just as casework with individuals has been enhanced by deeper insights into the differentiation of client's personalities according to neurotic and character disorder classifications. It may be expected, however, that diagnosis of the entire family group will present many more difficulties than individual assessments, which are, in themselves, complex enough. These difficulties could easily lead to rigidity and over-simplification if answers to all the complexities are sought. There are bound to be many variations in each family group which must be respected; some may defy any kind of deep understanding. If this point
is borne in mind, C.R.A.'s classification may provide social work with an excellent foundation for conceptualizing family diagnosis and treatment. These concepts are currently being tested for their usefulness in a variety of agency settings. This would provide an excellent research project for the Children's Clinic.

C.R.A.'s family classifications are outlined below.

1. The Perfectionistic Family: This family is characterized by its overemphasis on "good" social conduct for the group; its goals are very clearly identified with American cultural values, such as achievement, the importance of planning, and responsibility for one's acts. What labels its social functioning as pathological is its overemphasis on perfectionism in the attainment of their goals.
   A) Financial Functioning: This family manages its financial affairs well. The male wage earner gets satisfaction from his chosen work, but he may depreciate his abilities.
   B) Marital Relationship: Each partner has a good sense of his and her sexual identification; good incentive is found in at least one partner to work out differences that engender insecurity, hostility and frustration. Marital problems are often found in the symptom of each spouse feeling unloved and unappreciated by the other.
   c) Child Rearing: These parents provide good material comforts for their children, and at least one partner has
a sense of warmth for them. They teach their offspring the rules of social behaviour and live up to them by example. However, there is usually some aspect of a particular child's development that concerns these parents, and they are overly-critical of themselves as parents.

D) **Child Development**: Children from these families are usually responsive in personal relationships. Frequently a younger child may have neurotic symptoms such as wakefulness, excessive fear of bed wetting etc. In older children, there may be a mixture of provocative, exasperating behaviour and a positive identification with the parent of the same sex. These children aren't prone to anti-social, acting-out behaviour. The diagnostic and prognostic implication of whatever symptoms appear in the children must be interpreted in relation to the parents' response, their acknowledged concern, the realistic steps they take to modify the situation for the child, and their willingness to assume parental responsibility.

There will be a minimum of intellectualizations as a defense in presenting their problems as contrasted to parents of the ego-centric family. Parents tend to seek help early in the history of family disorders, and are able to assume responsibility for them. If correctly diagnosed, the prognosis for this family type is good.
The Inadequate Family

This family's underlying characteristics derive from excessive dependency of each marital partner upon others for encouragement, continued support, guidance, and help in resolving problems which the average family can manage itself. This is usually present in both partners and sets the emotional tone of the family's social functioning within the group, and with the community.

A) Financial: Fathers of these families are not usually very planful in anticipating the needs of a growing family; they may carry the provider role but are not strongly motivated to achieve, and are apt to be satisfied with a mediocre wage. The wife seldom assumes responsibility for income production and is likely to experience trouble in household management. Many of these families require intermittent financial aid. Their foresight in planning for anticipated reductions in income is meagre.

B) Marital Relationship: The couple is drawn together by both wanting satisfaction for dependency needs; this assumes pathological proportions when children are born. Otherwise, the balance may be good but they have strong drives to have children.

C) Child Rearing: They tend to have a large number of
children, with the infant or the defective child having a particular appeal to these parents. Older, normal children are expected to assume a disproportionate amount of responsibility. Limited guidance is given to the children in becoming self-reliant. Parents rarely vent their destructive impulses on their children.

D) **Child Development**: The children are outwardly conforming and imitative; they seldom present serious delinquency problems. They are restricted, however, in forming satisfactory relationships and in performing social tasks.

These families are susceptible to intra-familial disorders in the area of child rearing, marital, financial, and individual disorders. Stress is felt particularly from financial and child rearing problems; the two become fused, but the partners focus on the financial disorders.

The prognosis for this type of family can be good if accurately diagnosed, and if the agency has caseworkers with the time, patience, and teaching ability required for the rehabilitation of family members. Retraining of the woman in her wife and mother roles is particularly important. The caseworker must gain the family's confidence, and make use of the relationship to meet the family's dependency needs. She must gradually encourage more mature behaviour in the various functional areas of family life. Systematic
follow-up is very important with these families to consolidate gains, and to help them cope with new crises before they create more pathology.

3. The Ego-Centric Family

The narcissistic and self-seeking motivations of both partners colour the psychosocial conduct of all family members. They achieve value and importance to one another only as they offer to each other the opportunity for gratification of some self-seeking intention in accordance with their own impulses. People are important as objects of gratification rather than as individuals.

A) Financial Functioning: Good personal achievement and accomplishment is typical of most of the husbands. Their occupations are likely to have prestige values, precision requirements, and opportunities for exhibitionism. Parents are generally capable managers and are self-sufficient in practical matters.

B) Marital Relationship: Parents' motivations for marriage may reveal much self-seeking; their sexual identification is disturbed. There is a tendency towards divorce and remarriage which colours the child-rearing picture.

C) Child-rearing is dominated by narcissistic aims. The family type consists of single (own or adopted) child or composite of own, adopted, and step-children. Although
excellent physical care is given, maternal over-protection and solicitude regarding health, eating and training is frequently prevalent. The parents are seductive with their children of the opposite sex; they restrict their offsprings' social contacts and their expressions of hostility towards themselves. The father may be competitive and harsh with the male children. Family heads set rigid standards of social conduct for home use but may have other standards for behaviour outside the home. Perfectionism in school achievement is demanded.

D) Child Development: Children of these families have a limited capacity to form social relationships. They may be precociously independent, but they may also have food fads and be exclusively interested in the mother. Many have marked phobias by the ages of three or four as well as uncontrollable temper outbursts. In latency, they may be eneuretic, exploitative of parents' weaknesses, and show unusual curiosity about the human body. Avoidance of friendships, and unsocial and aggressive behaviour towards peers, is common.

The prognosis for this family's improvement is guarded. Generally the diagnosis is made too late because parents are often referred for help by a resource outside the family, and only after the child has created serious
problems for the community by his anti-social behaviour. Parents in this group do not recognize the younger child's problems, because they are preoccupied with the gratifications they can receive from him. Out-patient treatment is seldom effective because of the severe pathology in the family, and the parents' very limited ability to use help constructively. Residential treatment for the acting-out child may be indicated, or out-patient treatment of the adolescent once parents have given up their responsibility for him.

4. The Unsocial Family

This family is characterized by both partners' lack of social rapport with other people and with their social environment. Prevalence of delinquent conduct and regression into psychoses mark their social adaptation. Their capacity for interpersonal relationships is very limited. Pervasive problems in all areas of social functioning are evident.

A) Financial Functioning: Mental illness and delinquent behaviour adversely influence parents' ability to provide for their family. A poor work record and illegal methods of obtaining money characterize the male partner. Management of income is poor and continuous receipt of social assistance is common.
B. Marital Relationship: A number of female partners in this group have a history of one or more divorces. Marital disorders associated with financial and social problems are prevalent, and crises are precipitated by events which threaten physical dependency status, or sexual adequacy of a partner.

C. Child-Rearing: Attitudes towards children are frankly rejecting or exploitative. Physical and emotional neglect charges against parents, resulting in state guardianship, occur with frequency because of the children's delinquent activity.

D. Child Development: The children's capacity for relationships is extremely impaired, and acting-out behaviour is prevalent, such as delinquency, truancy and bizarre conduct.

The prognosis for the unsocial family is poor. Little is known about treatment goals and methods to help this type of family with their severe problems. Miss Voiland suggests a more thorough understanding of this group's etiology, needs and treatment methods is required because of the high cost of maladjustment to these families and to society.

A further research project into family diagnosis and treatment should be mentioned because of its attempts to apply and test a new framework within which malfunctioning in interpersonal relationships might be more clearly defined, and treated.

The Midwest Seminar on Family Diagnosis was established in 1960, and will conclude its project in 1963.\(^1\) Delegates from several agencies are represented in the seminar. Its goal is to increase the caseworker's understanding of family dynamics. To accomplish this, each of the seminar members follows a prepared guide in the treatment of one or more cases and brings back the results to seminar meetings. This has resulted in many revisions of the outline and more are anticipated.

The guide suggests areas of family functioning that the caseworker needs to be knowledgeable about, in order to help them with their problems. Understanding is required of the range of family members' needs, the location of major needs, the power positions of individuals that may block the casework effort, the resources of the members that may be turned into assets in the helping task, and the relationships of the family to other institutions in the

community. An understanding of the total family group's adaptation is called for and is obtained by studying the interaction in three sub-systems, the marital relationship, the parent-child relationship and the sibling relationship. Impaired role performance in one sub-system is related to performance in the two others. The two-way process in social behaviour is kept in mind. The influence of individuals outside the group with whom family members come in contact is included for diagnostic as well as treatment purposes. Attempts are made to understand the family's sub-cultural milieu and their attitudes about it.

The seminar attempts to confine their study to the following points:
1. What is the most burdensome problem? 2. Is the problem affected by a deficit or excess in family membership? 3. Is the problem created by the interaction mutually harmful? 4. Does the problem result from external pressures, such as long-term hospitalization or unemployment, or monetary demands that cannot be met by the family income? 5. Is the problem created by the internal pressures of one partner, which would interfere with his capacity for satisfactory relationships, regardless of the characteristics of the other partner? 6. In view of the causative factors, how can the caseworker help the members of this family group change?

Some study has been given to the selection of
appropriate cases to test the family focus described above. Families whose dysfunctioning was so great that little progress could be expected were excluded; generally long-term cases were selected although some interest was expressed in testing this method with short-term cases. Some foster and adoption homes were included because of the total family involvement in placement cases.

Three major casework methods are being used: joint and family interviews, home visits, and partaking of a meal in the home. Although joint and family interviews are given pre-eminence, individual interviews are also arranged, according to the family member's requirements.

In order to set appropriate treatment goals, recognition is given to the developmental stage of the family group. For example, newlyweds may need help in emancipating themselves from their parents, and in strengthening the marital relationship; parents may need to modify their attachments to each other because of their children's needs; when children enter school, parents may need assistance in helping them separate. Clarification of the worker-client role is recognized as essential in establishing collaborative efforts to achieve the treatment goals, as well as a casework focus on immediate and on long-term objectives.
Drs. Otto Pollak and Donald Brierland report that the project thus far has increased the understanding of seminar members in the diagnosis and treatment of family problems.

It may be seen from these studies that social casework is becoming increasingly interested in developing and testing hypotheses relevant to a family focus in casework. These research projects have sharpened up diagnostic elements in family casework, and have endeavoured to systematize the recording so that pertinent facts about family functioning are obtained and used in the treatment process. Other professions, such as sociology, anthropology and medicine, have contributed valuable knowledge of individual and group behaviour which is being utilized and adapted by the social work profession. To date, social agencies have been more active than psychiatric clinics in developing family casework; clinical settings which have a large establishment of social caseworkers, could utilize the findings from these studies as a basis for further research into family casework.

Findings from the Sample Case Records

Judging from many of the recorded assessments, the casework focus in the diagnostic period is oriented to individual family member's emotional problems. How these
difficulties may be influencing the child is not described. It is understood that the child's psychopathology is the result of unhealthy parent-child relationships, but no conjectures are made on the purpose his adaptation fulfills for the family group. Few casework evaluations are recorded on the parents' functioning in the important roles they are called upon to play. Their subjective responses to the behaviour of the referred child are generally described, but casework evaluations of their attitudes towards him are infrequently made. With many parents, it is very difficult to estimate how much acceptance or rejection they do feel for the child, but it should be possible in more cases to make a tentative assessment, and to evaluate parents' motivation in modifying negative attitudes which are contributing to his disturbance. The connection between impaired marital and disturbed parent-child relationships are not recorded. Descriptions of father-child relationships are lacking, as well as information on siblings. The family's functioning was not assessed as to the health and pathology within the group. One way of determining major patterns of family relationships is through exploration of their relationships with their immediate community. Caseworkers could focus more on this aspect of the family's adaptation in interviews, particularly home visits, and through more direct school contact when learning difficulties are one of the child's symptoms.
More explicit recording on internal and external family relationships might contribute to the team a fuller understanding of the child's and parents' problems, and might lead to a more comprehensive assessment of the actual and potential resources that are available for helping the family achieve a more satisfactory adjustment.

It would appear, from the foregoing comments, that social casework in the diagnostic phase in the Children's Clinic emphasizes the "client and his family." ¹ By contrast, Dr. Sherman suggests that family analysis oriented to the "client in his family!" ² is more in keeping with the social work tradition and with the needs of the Clinical situation. With the "holistic" approach, attempts are made to understand the whole family as a condition of comprehending the individual; by contrast an "atomistic" orientation endeavours to comprehend the whole (family) by interrelation and synthesis of its individual members. Dr. Sherman believes that this latter approach places undue emphasis on the problems of the referred family member, rather than viewing the individual's difficulties as a symptom of pathology in the whole group. This is a particularly relevant distinction to bear in mind in the treatment


² Loc. cit.
of disturbed children, for the burden of the problems must be shared by the family before the child can be helped towards a healthier adaptation.

That a holistic focus, is, at times, established and maintained is apparent from some of the sample cases in the treatment period. It is difficult to determine why these cases do not reflect this approach in the diagnostic stage. Lack of time may be a factor, and a history of the child's and parents' problems may take priority; or the family's current functioning may be communicated verbally in conference. Whatever the causes, it would seem advisable to record such information wherever possible, to facilitate clinical and psychosocial diagnoses, and to compare changes in family functioning during and at the end of treatment with the original assessment. Helen Perlman writes

"Our diagnostic concern is to understand those factors that cause or are associated with the (client's) difficulty and those that may be mobilized to cope with it. This will require our closer study and understanding of the dynamics of social interaction and of the psychology of the social." 1

Recording is needed not just for its own sake, but because it will facilitate the formulation of treatment goals. As Mrs. Perlman puts it, concentration upon particular roles

in which the individual is experiencing trouble "will give boundary, focus and direction to the caseworker's activity." ¹

It is therefore recommended that discussion of the Clinic's and the parents' treatment goals be recorded; this can help in the establishment of a focus for parents and caseworkers on the problem-to-be-worked, and will provide a guide for the caseworker, parents, and team to evaluate a family's needs in relation to the Clinic's treatment resources. Such recording would also have a bearing on the decision to terminate, and would enable the caseworker and parents to determine more clearly when the treatment goals have been achieved.

Role confusion on the part of the social worker is apparent in the recording of some of the sample cases. It is likely that this confusion makes it difficult for caseworkers to assess when families have been sufficiently helped by them to work towards termination. However, if the task of the caseworker is understood as helping "the person in interaction with some problematic aspect of his social reality" ²

¹ Perlman, Social Service Review, p. 376.
² Ibid., p. 372.
then termination should be considered when the client's ability to carry his previously impaired social roles and his life tasks have been restored or improved.

The selected files analyzed in the present study are a reasonable sample of the Children's Clinic direct treatment cases in regard to duration of each family's contact with the Clinic, which is approximately one and a half years.\(^1\) It is wondered if the treatment time on some cases might be curtailed if the social worker's role in this setting were clarified. This is an important question in view of the restricted intake at the time this study was being made. Some thought and practice might be given to the establishment of criteria for long and short term treatment. Dr. Caplan hypothesizes that "even a very small influence exerted by a significant person during (family) crisis may be enough to decide the outcome either in the direction of mental health or of mental ill-health."\(^2\) He is referring to those families who are basically healthy but in which a crisis situation precipitates a break-through of family pathology.

The results of this study suggest that social workers might be more secure in their area of competence,

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\(^1\) This includes the total time a family has been in contact with the Clinic.

which has been defined as helping the client enhance his social functioning. In the closed cases, the recording indicates that more improvement in the child's and parents' adaptation was achieved where this focus was established and maintained. The cases in which the social worker concentrated on the client's intra-psychic conflicts without relating these to inter-personal difficulties and to role performance, both within and outside the family, showed the least improvement.

On the basis of the above findings, it can be concluded that the caseworker needs to know how the client's personality dynamics are expressed in his current social relationships and tasks, particularly in the areas where he is experiencing problems, in order to help him achieve a better adaptation to his life circumstances. People's closest relationships take place within the family group, and it is here that basic attitudes towards the self and others are experienced, formed and expressed. The family unit provides a firm or an unsound foundation for its members' relationships and activities that take place outside the group. What happens within the family may influence every sphere of the individual's life outside it. While external circumstances can and do have their impact on the primary group, Western culture recognizes the family as the foundation of society, and as the main influence in shaping
human beings. This particularly true of the child. If the view is accepted that a child's disturbance is an expression of pathology in the family unit, then the way in which the unit functions is the appropriate treatment focus in Child Guidance Clinics.

Much remains to be done to establish role theory, and to integrate psychological theory with it. However, these concepts together seek to understand family relationships and the social functioning of individuals, in the context of their group and of society. Mrs. Perlman states that family diagnosis today "is an effort - not yet achieved for the most part - to assess a configuration of forces, patterned not simply by the personalities involved but also by their roles in relation to one another." ¹ She outlines four aspects of the client's social behaviour that are of primary import to the caseworker. First, there are social activities and tasks involved in the role(s) in which the client is experiencing trouble. What activities does he carry out, and how does he do them? Secondly, the client carries these activities in social interaction with others,

¹ Perlman, Social Service Review, p. 376.
who will be involved in causing or affecting his problem, in its solution and consequences. These others need to be considered both in diagnosis and treatment of the client's problem, and the individual must be viewed not as an entity alone, but as a person involved in an interaction process.

Thirdly, between the client and other people, there are psychologically significant and socially-determined norms and expectations as to the way he and the others perform their tasks. The caseworker needs to learn from him what his ideas of the role norms are, as well as what he has invested in them emotionally, and to compare those conceptions with the range of the community's standards. How a person behaves in a situation is not determined alone by unconscious drives and needs, but is also influenced by his conceptions of the way in which he and others perform their tasks, and what he expects to give and to receive.

Finally, personal attitudes and vital feelings are invested in these social tasks, in the role interaction, and in the client's expectation of the outcome of reciprocal roles. Value judgments of two major sorts are likely to be made here: a) those that are generally agreed upon by the culture at large and b) those that each individual invests in certain roles. The caseworker is concerned primarily with
this latter aspect of feelings. "All or any aspects of personality may be involved in the performance of vital roles. So the role concept carries the constant reminder that feelings, attitudes, personality itself, are the product-in-process of old and current experiences of socially required behaviour (roles), and socially provided rewards and frustrations (role valuations)."

Recommended Changes in the Social History Structure

The importance of the principle that the personality of the client is a product-in-process of old and current experiences is illustrated by this present study's evaluations of treatment. The cases where this principle was kept in mind showed the most improvement in both the child's and the parents' adaptation. This focus should be established in the diagnostic period. One method of facilitating this is to consider revision of the standard social history format. The term "social history" itself might be replaced by another phrase, such as "psychosocial diagnosis of the family" to reflect current social work theory.

In the introduction to the social history outline now in use, (see Appendix C) four broad areas of interest "basic to a psychiatric diagnosis" are outlined: "the

1 Perlman, Social Service Review, p. 380.
problem, family background, personal history, and the referrer's evaluation and plan. The term "family background" does not take into account family functioning, except the parents' feelings about and relationship to other family members, and how the child uses outstanding relationships. In one sentence in the outline, the child's feelings and needs are related to his behaviour in his closest relationships, but which concepts might be used to analyze such a complex process are not mentioned.

This outline was devised several years ago. It cannot, therefore, reflect the current focus of social casework, and the attempts that are being made to integrate the psychological and social components of the client's problem. The family is not viewed as a whole, but rather as a collection of separate individuals - mother, father, and child - and information requested on siblings is sparse. It is apparent that a change in focus from the individual to the individual in his family is called for, and vague descriptions of relationships replaced by more definite concepts. Role theory can contribute towards a more explicit framework within which to describe family relationships.

Regarding personal history, knowledge of the child's

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1 Quoted from the social history outline.
background would seem to be particularly useful in understanding his particular problems, but it is thought that the time spent in gathering information on the parents' separate backgrounds could be more profitably used in learning about their adaptation since their marriage. If more clarification is needed on personality aspects of parents' functioning, individual histories could then be discussed.

The policy of obtaining background information on the parents might make some of them more defensive than necessary about receiving help, and places a responsibility on the caseworker to gather information which may not always be pertinent to the immediate problems the family is concerned about. The historical concentration on parents' backgrounds may contribute to the role confusion of the caseworker and therefore of the parents as clients, for they may become patients before they are really engaged as clients. Such a situation might create a barrier between the parents and the worker in their co-operative efforts to help the disturbed child.

The following revisions are recommended:

**The Problem**

1. A statement of the problem from the parents' viewpoint, the changes they hope for, and a casework assessment of their expectations and motivation.

2. Description of family's current functioning in the following areas: a) economic  
b) marital  c) child rearing d) with the community. Specific areas of difficulty should be identified. 
Description of role performance of parents in problem areas. What activities do they
carry out, and how do they do them? How is each person affected in his role performance by the other(s)? What does each parent expect from himself, his spouse and child(ren)? Are these expectations within "normal" limits in terms of his social milieu, age and personality? What personal attitudes and feelings are invested in these social tasks, in the role interaction, and in the client's expectation of the outcome of reciprocal roles? What is the major source of stress to the parents? What are the areas of strength in the family's functioning? Can any ascendant pattern of family relationships be identified?

History of family's functioning: significant events in the family's life, such as advent of children, which would throw more light on family's current functioning.

3. Individual Factors

a) Assessment of parents' ego strengths

b) Pertinent historical information which could contribute to an understanding of problem areas in parents' functioning.

4. Casework Evaluation: Assessment of the core problem in family functioning to which the referred child is reacting; resources within the family and community which might be mobilized to help the child.

The revisions which have been suggested require the test of time and practice before their usefulness can be determined. The most basic requirement, however, is a change in casework focus in the diagnostic period, from emphasis on each individual's emotional adjustment, to an understanding and recognition of the relationship between
these inner difficulties and inter-relationship problems within the family. And it is only on the basis of much research and experience that social casework will be able to define family diagnosis with any degree of certainty, for at this point, it is only in the stage of tentative formulation.

It should be added that certain families may take much longer than others to disclose to the caseworker those features in their inter-action with each other which are contributing to the child's difficulties. Timing is an important element in fact-finding. Any outline should be used with sensitivity for the client's readiness to discuss those aspects of family relationships that are charged with fear, anger and guilt for them. It will not be possible, with some families, to have all the information relevant to a psychosocial diagnosis by the end of the formal assessment period. This should not be cause for concern, because continuous diagnosis is an integral part of the treatment process until termination. Team conferences can be arranged at the worker's discretion if facts which might alter the course of treatment are disclosed following the diagnostic period.

Another method to describe and measure family functioning is elaborated in the Varwig ¹ and McCallum ²

theses. These studies organized the recorded data on the child's and parents' functioning under three headings according to the extent of impairment. This led to the establishment of a rating scale; the child's and parents' adaptation were measured between two points in time. This kind of measurement would be possible in the Children's Clinic if the files contained more specific information on the family's functioning at the end of the diagnostic period and at specified times thereafter.

**Methods of Treatment**

Another important conclusion related to treatment method. The term "family-focus" is not meant to imply that all family members be included in treatment, or that family-unit cases and interviews should be structured in most cases. Shared cases and individual interviews may frequently be the appropriate treatment method, but the client's feelings, attitudes and behaviour should be related, ultimately, to current family functioning. More definite concepts should be developed regarding unit and shared cases, and individual, joint and family interviews. The key participants in the particular problems for which the family is requesting help should be involved in treatment, and other family members should be included as the caseworker is alerted to the advisability of this in order to relate the family balance
to treatment goals. Dr. Ackerman says:

"Of necessity, the proper sequence of diagnostic and therapeutic interviews involving individuals, family pairs or the entire family group varies from family to family. In the case of a child patient the interviews may, for example, take the following order: an interview with the child and mother together, an interview with the child alone, an interview with child and father, and, finally, an interview with the two parents without the child. It might also entail at an appropriate point an interview with the child and both parents, or the child and sibling together with one or both parents."

Regarding the inclusion of siblings, it deserves exploration whether the earlier involvement of the child who represents the "good" aspect of parents' personalities compared to the referred child's "badness", would expedite diagnosis of the child's problem and shorten the treatment period. This would be an interesting subject for experimentation in the Children's Clinic.

Recording Policy and Methods

This topic is not directly related to family diagnosis and treatment, but it is an important administrative aspect of casework. It also has some bearing on treatment when the social worker shares cases and is part of an inter-disciplinary team. Furthermore, improved recording leads to better measurements of casework skills.

1 Ackerman, The Psychodynamics of Family Life, p. 306.
Recording has long been the bane of the caseworker's occupation; this is possibly due to the elusive nature of the transactions which take place between client and worker. The records studied as a sample are highly individualized; some are lengthy and describe in detail the client's behaviour only; others are pertinent and concise and depict the interaction that took place during interviews; many do not contain an assessment of the client's needs, goals and use of treatment, but seem to meander, without direction, from interview to interview. On many of the closed cases, no attempt was made to compare the client's social adaptation at the beginning and at the end of treatment. Some of the active cases contained no entries for the past several months. The policy of holding progress conferences at least every six months was not adhered to in many of the cases according to the records.

It is questioned whether the recording studied accurately reflects the transactions which took place between clients, caseworkers and teams. Two of the active cases that do not appear to have achieved any treatment goals have, in actuality, made excellent progress despite poor prognoses. It is beyond the scope of this study to evaluate the accuracy of the recording, but certain recommendations can be made about it.

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1 This information was obtained from one of the psychiatrists.
Accurate, concise recording is important for a number of reasons: 1. it can help the caseworker think through the mass of material that is presented, and thus enable her to focus on the core problem; 2. it may help to focus team discussion in diagnostic and progress conferences; 3. it may facilitate communication between workers on shared cases; 4. it can expedite the re-opening and transfer of cases; 5. it would greatly assist research projects, for many studies are conducted from the records in this setting; 6. office management of records would be facilitated.

Because of the apparent lack of recording conventions in this setting, it is thought that caseworkers would welcome a more definite policy. It has been the experience of other agencies that the establishment of recording conventions must be accompanied by caseworkers' continuing interest in using, testing and recommending revisions of these policies.

Conclusions on the Effectiveness of Family Casework

The formulation of definite conclusions from this study is limited by the small number of sample cases, and by the arbitrary nature of the decisions which were made on many of the items in the schedules, particularly in schedule B. An additional impediment to this research
project is that the recording is treatment-oriented and
the files are not organized for research purposes. Furthermore, casework is a highly individualized, creative art, and even the most explicit recording may be unable to cap-
ture the essence of the interaction which takes place between
the client and the worker.

These limitations must be kept in mind in consider-
ing the results of this study. Some tentative conclusions
can, however, be made.

It would appear that some casework which is
practiced in the Children's Clinic is family-centred, while
some is oriented towards the individual's inner conflicts
without relating these problems to his social adaptation.
In these latter cases, it would seem that another important
connection is not made, that of relating the client's prob-
lems to the treatment goals. A third group of cases emerges;
those where the recording is too sparse to evaluate the
focus and outcome of treatment.

Of the sample cases, those which were family-
centred recorded the greatest amount of improvement in the
client's functioning. These files reflected more certainty
of purpose on the caseworker's part than was evident in the
single client problem-centred cases. The caseworker's
professional maturity may have considerable influence on the security with which she can establish, maintain and record the treatment focus and process. Other factors are involved, however, such as educational influences, and administrative expectations and assistance.

The casework focus in any organization will likely depend, to some extent, on the staff's educational backgrounds, and on the particular orientation of its administration. It may be expected that casework will be influenced more by traditional psychiatric approaches in a psychiatric clinic than in other settings. However, each discipline in a clinical team needs to know the extent and boundaries of its professional responsibilities in order to utilize its maximum potential.

A more definite concept of the social caseworker's role in this setting is desirable. Steps are now being taken in this direction. Attempts are currently being made to adapt the social role theory to casework practice in the Children's Clinic; some consultation is available from the University of British Columbia's School of Social Work in this regard. Staff meetings, utilizing the Hawley study  

on role theory which was conducted in 1961, have been held. A growing interest in family diagnosis and treatment is evident. Some caseworkers are beginning to experiment with family group interviewing methods. Administration is giving scope and encouragement for such experimentation to take place, with the emphasis on the creative adaptation to casework, of new theories and techniques. More home visits and community contacts might also be encouraged.

This study indicates that these steps are desirable and necessary if social casework is to adapt new knowledge to what may be a more rewarding practice, both for the caseworker and the client who seeks his help.

Another resource, however, beyond the scope of the Clinic's existing facilities, is required to improve its services. This is the establishment of a research position. Provision of more direct treatment personnel and in-service training programs are also required. But even more essential is a scientific evaluation of the existing program. The needs of disturbed families that the Clinic meets should be identified, as well as those that are not met. More knowledge is required on the reasons for improvement, or lack of it, in the families treated. Such infor-
information could lead to the establishment of treatability criteria. Of utmost importance to caseworkers in Child Guidance Clinics is the identification of methods to help parents improve their relationships with their disturbed child. This thesis has illustrated that concentration on the parents' emotional conflicts does not automatically result in better family functioning, nor in improvement in the child's adaptation. Family-centred casework, in which the overt and subtle inter-actions between family members are studied, identified, and treated, is likely a more effective casework method to help families with disturbed children. This in itself is a broad field for the trained researcher. Classification of family disorders and identification of appropriate treatment methods need further development; new concepts, such as role theory, require testing for their usefulness to family-centred casework, and more study is required to integrate sociological and psychological theories. Dr. Ackerman states that the researcher and the clinician must join forces to accomplish these ambitious goals. It follows that standardization of case records is required as a preliminary step in research into family diagnosis and treatment.
Appendix A

Schedule A. **Suggested Criteria for Evaluation of Emotional and Social Adjustment**

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<tr>
<th>Criteria</th>
<th>Explanation of Ratings</th>
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<tr>
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<td>A. Good</td>
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<tr>
<td>1. <strong>Symptoms of Emotional Disturbance</strong></td>
<td>Predominantly neurotic symptoms, such as phobias, fears, eneurises, tics, accompanied by excessive guilt.</td>
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<td>2. <strong>Physical Development</strong></td>
<td>Within normal limits; no serious illnesses.</td>
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<td>3. <strong>Functioning Level of Intelligence</strong></td>
<td>Superior Intelligence.</td>
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<td>4. <strong>Learning Capacity</strong></td>
<td>Alert and quick in understanding; eager to learn, explore; good attention span.</td>
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<td>Criteria</td>
<td>Explanation of Ratings</td>
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<td></td>
<td>A. Good</td>
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<td><strong>5. Response to New Experiences</strong></td>
<td>Adjusts well to new experiences or change in routine or program.</td>
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<td><strong>6. Ability to Relate</strong></td>
<td>Interested in relationships with others; is actively reaching out for relationships; shows sensitivity to others' feelings.</td>
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<td><strong>7. Emotional Development</strong></td>
<td>Independence and self-assurance appropriate to child's age.</td>
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### Schedule A. continued

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<th>Criteria</th>
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<td><strong>8. Self-Control</strong></td>
<td>Able to postpone</td>
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<td>immediate gratification</td>
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<td>appropriate to age;</td>
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<td>able to accept</td>
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<td>reasonable limits.</td>
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<td><strong>9. Concept of Self</strong></td>
<td>Self-awareness</td>
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<td>appropriate to</td>
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<td>child's age; com-</td>
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<td>fortable acceptance</td>
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<td>of self; strong sense</td>
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<td>of identity.</td>
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<td><strong>10. Relationship with</strong></td>
<td>Warm and relaxed;</td>
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<td><strong>Mother</strong></td>
<td>responds to love and</td>
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<td>affection.</td>
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<td><strong>11. Relationship with</strong></td>
<td>As above.</td>
</tr>
<tr>
<td><strong>Father</strong></td>
<td></td>
</tr>
<tr>
<td>Criteria</td>
<td>Explanation of Ratings</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| **12. Relationship with Siblings**           | **A. Good**  
Appropriate and mutual acceptance and affection. | **B. Fair**  
Obvious ambivalence expressed by over solicitude or frequent resentment. | **C. Poor**  
Extreme rivalry and jealousy; extremely over-towards siblings, or frequent resentment. |
| **13. Relationship with other children in the Community** | **A. Good**  
Friendly, co-operative; able to make friends; leaders or is accepted as leader. | **B. Fair**  
Shy - slow in quarrelsome; relates only to younger children or small group of children; dominating or easily dominated. | **C. Poor**  
Predominantly hostile and aggressive or fearful, withdrawn - seldom plays with other children. |
| **14. School Adjustment**                    | **A. Good**  
Appropriate academic and social performance and adjustment. | **B. Fair**  
Academic performance and/or social adjustment below par as shown by inability to concentrate on school work and/or intermittent social difficulties with classmates. | **C. Poor**  
Reported frequently by school as having chronic academic or social difficulties or child actively rebelling or withdrawing from school. |
| **15. Child's view of his role in family**   | **A. Good**  
Child feels loved and accepted by parents and sibs; is an active participant in family life; has strong sense of belonging. | **B. Fair**  
Child has some question of family's acceptance of him but is able to participate to a moderate degree in family life with some sense of belonging. | **C. Poor**  
Child frequently feels excluded from the family group, feels lonely and scape-goated; is an isolated member. |
<table>
<thead>
<tr>
<th>Criteria</th>
<th>A. Good</th>
<th>B. Fair</th>
<th>C. Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>16. Relation­ship to Adults (Clinic Staff)</td>
<td>Relates well, friendly.</td>
<td>Shy and inhibited or attention-seeking and erratic.</td>
<td>Negativistic; withdrawn; distrustful and fearful.</td>
</tr>
<tr>
<td>17. Range of Emotional Disturbance in Child</td>
<td>Child behaving essentially within normal limits; mild symptoms which don't impair functioning to a pathological degree in any area.</td>
<td>Specific areas of maladjust, i.e. family or peer relationships or achievement impaired while some areas free of disturbance.</td>
<td>Child finds little satisfaction in either relationships or achievement areas; social functioning generally markedly impaired.</td>
</tr>
</tbody>
</table>
# Appendix B.

## Schedule B. **Suggested Criteria for Assessment of the Family**

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Explanation of Ratings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Good</strong></td>
<td><strong>B. Fair</strong></td>
</tr>
<tr>
<td>1. Family’s Income</td>
<td>Steady income, adequate to maintain family’s standard of living.</td>
</tr>
<tr>
<td>2. Employment</td>
<td>Father has good work record; permanent employment with job satisfactions.</td>
</tr>
<tr>
<td>3. Housing</td>
<td>Comfortable, spacious home.</td>
</tr>
<tr>
<td>4. Training of Fathers for Employment</td>
<td>Professional or vocational training, adequate to qualify for and maintain position.</td>
</tr>
</tbody>
</table>
# Schedule B. continued

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Explanation of Ratings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Good</strong></td>
<td><strong>B. Fair</strong></td>
</tr>
<tr>
<td>5. <strong>Socio-Economic Status</strong></td>
<td>High standard of living, recognized social position.</td>
</tr>
<tr>
<td>6. <strong>Marital Relationship</strong></td>
<td>Harmonious, happy marriage, mutual affection and respect, sharing of interests, goals and responsibilities. Ability to maintain communication for resolution of conflicts.</td>
</tr>
<tr>
<td>7. <strong>Financial Management</strong></td>
<td>Both partners plan and manage wisely within a reasonable budget, without excessive concern about financial situation.</td>
</tr>
<tr>
<td>8. <strong>Mother-Child Relationship</strong></td>
<td>Basically sound, warm and close; child receives stability and security; is loved and wanted.</td>
</tr>
<tr>
<td>9. <strong>Father-Child Relationship</strong></td>
<td>As above.</td>
</tr>
<tr>
<td>Criteria</td>
<td>Explanation of Ratings</td>
</tr>
<tr>
<td>----------</td>
<td>------------------------</td>
</tr>
<tr>
<td><strong>10. Relationships Amongst Siblings</strong></td>
<td><strong>A. Good</strong></td>
</tr>
<tr>
<td>Positive emotional ties and mutual identification; conflict within normal limits for ages of children.</td>
<td>Emotional ties weak; frequent fighting in forms of physical or emotional cruelty; reaction formation suspected.</td>
</tr>
<tr>
<td><strong>11. Family Solidarity</strong></td>
<td>Evidence of cohesiveness and strong sense of family identity; members pull together in times of stress; conflict within family dealt with quickly and appropriately.</td>
</tr>
<tr>
<td><strong>12. Parents' View of the Child's Role in the Family</strong></td>
<td>Parents accept child as part of the family group, and make efforts where necessary to support his place in the family.</td>
</tr>
<tr>
<td>Criteria</td>
<td>Explanation of Ratings</td>
</tr>
<tr>
<td>----------</td>
<td>------------------------</td>
</tr>
<tr>
<td><strong>13. Family's Relationship with Extended Family</strong></td>
<td><strong>A. Good</strong></td>
</tr>
<tr>
<td></td>
<td>Parents have harmonious, mature relationships with paternal or maternal relatives; relationships with extended family a source of strength to the group.</td>
</tr>
<tr>
<td><strong>14. Family's Relationships with Community of Residence</strong></td>
<td>Good relationships with neighbours and institutions in community; active participation in community affairs.</td>
</tr>
<tr>
<td><strong>15. Parental Attitudes towards Child's Problems</strong></td>
<td>Parents view child's problems with realistic and supportive concern for him, and continue to show warmth and affection despite symptoms.</td>
</tr>
<tr>
<td><strong>16. Precipitating Factors in Parents' Application</strong></td>
<td>Family crises other than child's problem, such as excessive withdrawal, acting out, intensification of school behaviour, such as economic reverses, severe illness or death of family member, crisis in marital relationship, move to new community.</td>
</tr>
</tbody>
</table>
### Schedule B. continued.

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Explanation of Ratings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>17. Parents' Attitudes towards a Psychiatric Clinic</strong></td>
<td></td>
</tr>
<tr>
<td>Co-operative in keeping and using appointments and in permitting collateral contacts; expectation of being helped; willingness to involve other family members.</td>
<td>Parents show some resistance in keeping and using appointments and in permitting collateral contacts; fearful of psychiatric clinics; unrealistic expectations of helping process.</td>
</tr>
<tr>
<td><strong>18. Parents' Understanding of Treatment Goals</strong></td>
<td></td>
</tr>
<tr>
<td>Understanding of and participation in treatment goals. Help is used constructively.</td>
<td>Has difficulty in grasping treatment objectives, but attempts to follow suggested program, or feels ambivalent about treatment goals.</td>
</tr>
<tr>
<td><strong>19. Movement in Child's and Parents' Adaptation</strong></td>
<td></td>
</tr>
<tr>
<td>Marked improvement in child's behaviour, family relationships and functioning.</td>
<td>Some improvement in child's behaviour and family relationships, but still obvious areas of difficulty.</td>
</tr>
</tbody>
</table>
Appendix C. Social History Outline

INTRODUCTION

"Psychiatric history taking is not merely a process of collecting data. It is a means of getting acquainted with the person who presents the data. It is not a cut and dried 'technique' but a thrilling experience had by two people." This is the way that Dr. Leo Kanner* describes the report which the referror submits in his attempt to convey his understanding of the child, his family, and their problem. It is an organized record of the story which the family pours out to one who, having offered to help, listens in a warm and encouraging manner. From this 'thrilling experience' comes the family's willingness to use the resources of the Children's Clinic.

The intrinsic value of a written case history is determined neither by its volume nor by the mass of detail which it contains, but by its orienting function! Two foolscap size pages of digested data is of more value than three or four such pages of unrelated detail. The rambling story given by the parents can be reduced to a concise, graphic account of the problem as it faces the child, his family, and his community.

The attached social-psychiatric history outline is a suggested means of organizing and focusing data. For the novice it is an instrument in learning of what type of facts to be aware, and for the experienced person it simply serves to suggest the four broad areas of interest basic to a psychiatric diagnosis—the problem, family background, personal history, and the referrer's evaluation and plan. The novice may lean upon this outline as a guide to content, but never as a questionnaire or as a means of interviewing. These four headings should follow in this sequence, providing a universal order to the writer as well as to the reader. If one section is more important than the others, it is the problem; all other data should be relevant to the reason for referral.

* Kanner, Leo -- 'Child Psychiatry'; this is the textbook in this field of medicine.
Appendix C. - continued.

SOCIAL HISTORY OUTLINE

A guide to preparation of Social Histories for the Children's Clinic of the Mental Health Centre.

DATE WRITTEN:
DATE OF EXAMINATION:

NAME:

BIRTHDATE:

STATUS: (Ward, non-ward, etc.)

PARENTS: (FATHER) (MOTHER) (MAIDEN NAME)

BIRTHDATE:

S.S. INDEX:

ADDRESS:

DATE OF PREVIOUS EXAMINATION AT CHILDREN'S CLINIC (formerly Child Guidance Clinic), P.M.H., ETC. (Child or relatives).

FAMILY HISTORY

HOME SETTING: Pertinent and brief descriptive material of present home setting -- economic and community status; housing; persons in home.

FATHER: (1) Identifying information -- name; present age; place of birth; religion.

(2) Social and cultural background -- others in family, ages; father's description of paternal grandparents; father's estimate of his adjustment to family, school, religion, and social groups; extent of education; work record, health; any serious illnesses or operations.

(3) Family relationships -- father's feelings about and relationship to child, to wife, to others in family. Father's attitude and contribution with regard to problem(s); How does he handle it?
Appendix C.—continued.

FAMILY HISTORY: (cont'd)

(4) Paternal relatives—information pertinent to child and parents' adjustment.

MOTHER: Information as for father (1), (2) and (3).

(4) Maternal relatives—information pertinent to child and parents' adjustment.

MARITAL ADJUSTMENT:
When, where and how did parents meet? Courtship; sexual adjustment.

STEP-PARENTS OR FOSTER HOMES:
As above with dates child was with them and reasons for leaving. Indicate and evaluate relationships, adjustment, and the meaning of the experience to the child. (In chronological order)

SIBLINGS: Identifying information—name; date and place of birth; religion. How do they fit into the family, inter-personal relationships?

PERSONAL HISTORY

DEVELOPMENTAL FACTS:

Date, place of birth: Age weaned: Bladder control at:
Toilet training began: Bowel control at:
Teethed at: Walked at:
Talked at (words): (sentence formation):

DESCRIPTION OF DEVELOPMENT TO DATE: Mother's health, attitudes and feelings about child during pregnancy; method of delivery; length of labour; birth injuries

(1) Eating: Method of early feeding. Method of weaning, any early feeding, or present eating difficulties. Food fads or fussiness. Indigestion or any indication of gastro-intestinal disorder.


(3) Sexual development: Interest in sexual information. Any incidents of exhibitionism. Sex play. Masturbation or intercourse (describe, including age and frequency, of such incidents). Extent of sexual knowledge. From whom obtained. Evidence of development.
Appendix C. - continued.

PERSONAL HISTORY (cont'd):

Age of puberty.
Attitude toward it.
If menses established is it regular? Painful?
Has someone discussed puberty and sexual role with child?
Any indication of abnormal sexual behaviour?

(4) Physical development: Has physical growth been normal?
Give incidents of illness, disease (ages) sequelae (disability, etc.)
Reactions of child and parents to serious illnesses.
Disabilities.
Operations and preparation of child for these (age).
Child's attitude to and estimate of present health.
Any over-compensation or over-concern.

PERSONALITY AND APPEARANCE: Physical description -- any indications of nervous habits; fears; disturbances of sleep; recurrent or significant dreams.
General picture of the child's outstanding relationships and how he (she) uses these.
How does he (she) handle feelings and need such as anger, affection, dependency in relation to his (her) closest relationships.
Attitudes to school, teachers, people in authority.

Interest and Recreation; adjustment to social groups, employment, particular friends of both sexes.
Ambitions and goals.
Estimate of child's insight, intelligence, humour.


EVALUATION AND PLAN

Social worker's/public health nurse's evaluation of case from work done by the presenting agency.
What has been done? How frequent are the contacts? How strong is the worker-child relation?
What methods have been tried in working with child and parent(s)?
What has been tried by family members in dealing with problems? How successful?
What possible resources are there in family or community to help meet child's needs?
What are worker's/nurse's suggestions for carrying on from the point?
Questions around which social worker/public health nurse would like discussion.

ALL HISTORIES SHOULD BE SIGNED BY THE SOCIAL WORKER OR PUBLIC HEALTH NURSE AND FOUR COPIES SUBMITTED TO THIS CLINIC.
Appendix D.  - Progress Conference Format

SUGGESTED FORMAT FOR
"SUMMARY FOR CONSULTATIVE CONFERENCE"

(Clinic Direct Service Cases)

1. IDENTIFYING INFORMATION: (brief orientation to the case)
   1. (a) Name of child.
   (b) Age.
   (c) Presenting problem (one sentence).
   (d) Parents -- name and age.
   (e) Address.
   (f) Siblings -- name and age.
   (g) School grade.
   (h) School.

2. Reason for present conference:
   Significant changes and/or crises since last conference (brief).

3. Previous examinations:— dates.
   (a) Diagnostic thinking:
      (1) Clinical findings (brief and pertinent).
      (ii) Recommendations.

4. Initial casework plan: number of workers involved, treatment goals:

5. Statistics: include number of interviews, consisting of interviews, reasons for gaps--e.g., resistance, illness, geographical factors, etc.

11. SUMMARY OF SOCIAL WORK CONTACT:
   Include: new material, casework activity, movement in relation to:
   (a) The individual--changes in his feelings and attitudes.
   (b) The family--changes in relationships within it.
   (c) Adjustments outside the home.

111. POINTS FOR DISCUSSION:
   May include: questions, goals for the future, etc.
   * now called "Progress Conference"
Appendix E. - Closing Summary

GUIDE FOR CLOSING SUMMARY

The Closing Summary is a recapitulation of the Social Worker's contact with a client and includes:— statistical data, factual information pertaining to the client, statement of problems and goals at the point of assignment, evaluatory statements of casework with client, reason for closing, and indication of client's general adjustment at the point of closing. The writing of a Closing Summary is an aspect of Case Recording which is consistent with good professional social work practice.

Uses — (a) Present client.

Writing a Closing Summary calls for critical thinking by the Social Worker prior to termination of contact, and is an aid to the social worker in ensuring that the needs and interests of his client are adequately served or planned for. The Summary may be used by Casework Supervisors in the discharge of their responsibility for the nature, quality and quantity of casework services rendered by the worker. Duty workers may refer to the Closing Summary in reply to inquiries from other agencies who may subsequently serve the clients, and on reopening the same or new file in same family.

(b) Other clients.

There are aspects of learning in the preparation and study of the Closing Summary which further the social worker's knowledge in the interests of the next client.

The Closing Summary is a resource for agency personnel who are engaged in research projects.
Appendix E. - continued.

FORMAT

Date of Application:
Date Intake Conference:
Date Diagnostic Conference:
Date Assigned Continued Service:
Date Closing Summary:

1. **IDENTIFYING INFORMATION:**

   (age and/or birthday; sex; family constellation & economic Status)
   (one sentence probably sufficient).

2. **REFERRAL AND PROBLEM:**

   (referred by whom and through whom?)
   (brief, succinct statement of problem presented at Intake).

3. **DIAGNOSIS, PROGNOSIS, AND TREATMENT PLAN:**

   (refer to findings of Clinic team as they emerge from Diagnostic Conference).

4. **COURSE OF TREATMENT:**

   (includes waiting period in months; division of workers;
   number of interviews; missed appointments; span of contact)

   * (include: effect of waiting period and transfer of workers in terms of resistance, deterioration, progress;
     - continued -

client's use of casework; illustrate degree and direction of movement or change; refer to Consultative Conferences and supervisory or casework conferences re changes of focus).

5. EVALUATION OF PRESENT SITUATION:

(what achieved in relation to problem presented and treatment plan, i.e. #2 and #3; general statement of amount of effort expended, degree of conferring etc.; present factors in clients' external and internal environment; evaluation of clients' present adjustment in relation to his environment).

6. REASON FOR CLOSING:

e.g. client withdrew; "goals achieved"; "referred to--" include relevant anticipatory note or recommendation if client returns, etc.


*See attached presentation by the Research Committee; --"interpretation of Criteria for Measuring Movement in Social Casework".
Appendix F.

BIBLIOGRAPHY

BOOKS


Appendix F. - Bibliography (continued)

Richmond, Mary E., Social Diagnosis, Russell Sage Foundation, New York, 1917.


PERIODICALS


Appendix F. - Bibliography (continued)

PAMPHLETS


THESIS

