MENTAL HEALTH CLINICAL SERVICES

A study of the children between 6 and 12 years of age examined by Mental Health Clinics in Vancouver from 1945 to 1947 inclusive

by

Evelyn Marie Roberts

Thesis submitted in Partial Fulfilment of the Requirements for the Degree of
MASTER OF SOCIAL WORK
in the Department of Social Work

1949

University of British Columbia
ABSTRACT

There are 2 organizations in Vancouver, the Child Guidance Clinic and the Mental Hygiene Division of the Metropolitan Health Committee, which offer services to maladjusted children. No descriptive account of the work of these 2 clinics has been previously written, particularly from the viewpoint of the social worker. Accordingly, this study undertook a review of the clinic records of a particular group of patients, namely, children of elementary school age, to throw light on the problems and needs in this field.

The criteria set for the selection of cases was threefold.
(1) The examination took place within a 3 year period (1945 to 1947).
(2) Patients were those between the ages of 6 and 12 years, with intelligence quotients of at least 80, who had lived with parents or relatives at least until the age of 5 years, or were still living with them.
(3) The children were confined to those residing in Greater Vancouver.

The number of cases which satisfied these criteria was 257. These cases were classified into 4 groups on the basis of "problems" or symptoms of maladjustment which led to clinical examination. The classifications adopted distinguished (1) socially unacceptable behaviour, (2) personality reactions, (3) habit disorders, (4) disabilities in specific school subjects.

The proportion which this group of 257 cases bears to the total number of cases examined by the clinics is examined, and an attempt is made to demonstrate to what extent the clinical population is a cross-section of the general population, but gaps in information in the clinic records make this possible in part only. A further sample was selected (on a one-in-five basis) from each of the four classifications, in proportion to the number of cases examined by each clinic, as well as to the number of boys and girls in the total survey. More detailed information was obtained from the clinic records on the 52 cases which comprised this sample.

An analysis of this material, with the use of case illustrations, throws light on the work of the clinics, and on the factors of disorganization existing within the family and the community which contributed to the maladjustment of the children. The clinical recommendations for the treatment of children are outlined, and so far as possible an evaluation of the outcome of treatment is made.

There is evidence that emotionally disturbed patients might be better served by the clinics if more adequate community resources for mentally retarded children existed, thus reducing the number of clinical examinations of such children. More awareness on the part of parents of the availability of clinic services would undoubtedly lead to the earlier referral of many children requiring this kind of help. Improvement of the working relationships between the 2 clinics and between the Child
Guidance Clinic and the schools would be beneficial. The enlargement of the Mental Hygiene Clinic staff to include social workers would result in a better integrated clinical service.

A third psychiatrist on the Child Guidance Clinic staff would overcome some of the present lacks in clinic services. A treatment and observation centre for emotionally disturbed children is greatly needed in this community. In many instances, staff members of social and health agencies responsible for the preparation of social histories would benefit from brief clinical orientation and discussions with the members of the clinic team on the subject of history taking. The addition of a group worker to clinic teams would enhance the services to maladjusted children.
ACKNOWLEDGEMENTS

I wish to acknowledge great indebtedness to Dr. A.L. Crease, Provincial Psychiatrist, and Dr. C.H. Gundry, Director of the Mental Hygiene Division of the Metropolitan Health Committee for their permission to utilize the clinic records for research purposes. I am also indebted to Dr. U.P. Byrne, Director of the Child Guidance Clinic, and to Dr. C.H. Gundry for their help through interviews regarding clinical services.

Special acknowledgement is made of the helpfulness of Dr. L. C. Marsh, of the Department of Social Work who gave generously of his time and professional advice during the preparation of this study.
<table>
<thead>
<tr>
<th>Chapter</th>
<th>Title</th>
<th>Overview</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>The Clinics in Vancouver</td>
<td>Policies, functions and procedures of the Child Guidance Clinic and the Mental Hygiene Clinic. Work loads of each of the clinics.</td>
</tr>
<tr>
<td>3</td>
<td>The Patients and Their Families</td>
<td>Sources of referral. Distribution of cases according to symptoms presented, and age, sex, intelligence, etc., of patients. Family disorganization factors. Racial origin, religion, residence of parents. Size of families and ordinal position of patients.</td>
</tr>
<tr>
<td>4</td>
<td>Social Histories</td>
<td>The purpose of a social history. Data concerning children and their parents revealed in the histories. Gaps in the social histories.</td>
</tr>
<tr>
<td>6</td>
<td>Unfavourable Personality Reactions</td>
<td>Various age groups showing these symptoms. School and group adjustment of patients. High incidence of harsh or rigid parental discipline. Case illustrations.</td>
</tr>
<tr>
<td>7</td>
<td>Children Presenting Habit Disorders</td>
<td>Various age groups represented. High incidence of patients from larger families. Marked parental discord as a contributing factor. Case illustrations.</td>
</tr>
</tbody>
</table>
Chapter 9. **Recommendations and Results**

Five classifications of approaches to treatment. Results as indicated in clinic records.

Chapter 10. **Future Goals**

Clinic expansions during the post-war period. Need for improved community resources. Public relations of clinics. Social case work in the schools, and in the Mental Hygiene Clinic. Extension of treatment services. Group work representation on clinic teams.

**Appendices:**
A. Mental Health Clinics in Canada
B. Forms in use by the Child Guidance Clinic
C. Forms in use by the Mental Hygiene Clinic
D. Schedule used in collecting information from clinic records
E. Bibliography

**TABLES AND CHARTS IN THE TEXT**

(a) **Tables**

<table>
<thead>
<tr>
<th>Table</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Table 1.</td>
<td>Distribution of Cases by Examining Clinic and Problem Referred</td>
<td>28</td>
</tr>
<tr>
<td>Table 2.</td>
<td>Distribution of Cases by Source of Referral</td>
<td>29</td>
</tr>
<tr>
<td>Table 3.</td>
<td>Boys and Girls in Various Groupings</td>
<td>32</td>
</tr>
<tr>
<td>Table 4.</td>
<td>Distribution of Cases by Age</td>
<td>35</td>
</tr>
<tr>
<td>Table 5.</td>
<td>Distribution of Cases by Intelligence Level</td>
<td>36</td>
</tr>
<tr>
<td>Table 6.</td>
<td>Distribution of Cases by Family Disorganization Factors</td>
<td>40</td>
</tr>
<tr>
<td>Table 7.</td>
<td>Distribution of Cases by Other Contributing Factors</td>
<td>41</td>
</tr>
<tr>
<td>Table 8.</td>
<td>Distribution of Cases by Size of Family</td>
<td>42</td>
</tr>
<tr>
<td>Table 9.</td>
<td>Distribution of Cases by Ordinal Position in Family</td>
<td>43</td>
</tr>
<tr>
<td>Table 10.</td>
<td>Distribution of Cases by Length of British Columbia Residence</td>
<td>44</td>
</tr>
<tr>
<td>Table 11.</td>
<td>Religious Denominations</td>
<td>46</td>
</tr>
</tbody>
</table>
Table 12. Parents' Formal Education
Table 13. School Record
Table 14. Frequency of Types of Recommendations Made at Clinic Conferences
Table 15. Adjustment Status of Patients

(b) Charts

Fig. 1. Distribution of Cases in Both Clinics According to Age
Fig. 2. Proportion of Cases in This Study to the Total Number of Children Examined
Fig. 3. Distribution of Cases by Intelligence Levels
Fig. 4. Theoretic Distribution of Intelligence
Fig. 5. Distribution of Intelligence of Child Guidance Clinic Cases. (All private cases 6 to 12 years - 1947)
CHAPTER 1.

CHILD GUIDANCE CLINICS

Psychiatric clinics for children on this continent have passed through three main phases of development. The first of these was the early work of mental hospitals and schools for the feeble minded. This was concerned chiefly with reducing the number of admissions to institutions. The clinic opened in 1897 under the direction of Dr. Walter Channing at the Boston Dispensary marking the beginning of clinical work with children. Dr. Channing was particularly interested in the problem of feeblemindedness. Other state hospitals began to offer clinic services, and by 1914 in both New York and Massachusetts, provision was made for the establishment of out-patient departments and clinics in each hospital. Each of these was to serve as the mental health centre in its district. However, most of these early clinics regarded mental disorders as organic diseases.

A second development was the opening of clinics for juvenile delinquents. These clinics, which numbered more than 100 in the U.S.A. by 1914, were concerned with the prevention of crime. To William Healy and his associates is given credit for the inauguration of the first coordinated effort in child guidance in 1909. This was in connection with the Chicago Juvenile Court. Healy's work created a wide-spread interest in child life and there was rapid growth in the number of clinics functioning with courts, schools, general hospitals, medical schools and mental hospitals. Most of these in their early years were
little more than mental testing laboratories. Gradually, the procedure
and point of view of these clinics was influenced by clinical psychiatry
and genetic-dynamic psychology, and by 1921 the general public was ready
to respond to the search for better ways of dealing with the health and
conduct of childhood.

In the early twenties, a new stage was marked by the Common¬
wealth Fund's program of demonstration child guidance clinics which was
itself, in part, a fusion of the interests of the two first mentioned
developments. This program was under the direction of the National
Committee for Mental Hygiene, through its Division on Prevention of
Juvenile Delinquency. During the five-year program which was under¬
taken from 1922 to 1927 almost 500 clinics serving about 40,000 children
were set up. These were distributed throughout most of the United
States and one was established in Canada. The plan included not only
the training of members of the clinic team, i.e., psychiatrists, social
workers, psychologists and nurses, but also the promotion of visiting
teacher services in the public schools.

The aim of child guidance today has been stated to be the
offering of help to children who are handicapped chiefly by emotional
difficulties. The delinquent and the potentially psychotic patients
are still served, with varying degrees of success; but children whose
maladjustments are not severe, yet serious enough to hinder them from
the full utilization of their capacities, also come within the scope of
the clinic's services. Psychiatrists, psychologists, social workers
and nurses work as a team in the study of the children. The generally
recognized proportion for a clinic team is: one psychiatrist, two psychiatric social workers, one psychologist and one nurse.

On this continent and in Europe, several scientists studying child psychiatry have contributed much to present-day child guidance. Adolph Meyer's emphasis on the uniqueness of each individual, and the importance of studying his total life history, his intellectual and physical equipment in order to understand his disorder, was an important contribution. To Freud, child guidance owes three important concepts, namely, the theory of the dynamic influence of the emotions (both those of the patient and of his family) on human behaviour; the view that all behaviour is purposive, though its motivation may be unconscious and non-rational; and the belief that each individual has some capacity for self-direction and that therapy and education can only provide a favourable setting for the development of latent abilities. Otto Rank, a Viennese psychoanalyst, elaborated on this last-mentioned concept and gave it a somewhat different theoretical basis. He emphasized the constructive capacities of the human will, but stressed the necessity of working with the patient with regard to his present feelings rather than to his past experiences.

Common to the systems of psychiatry developed by Meyer, Freud and Rank is the concept that behaviour is meaningful. The symptoms of a patient represent his attempts to solve his internal and external difficulties. He may meet conflicts by striking out at himself or at his environment; he may try to deny them by withdrawing from reality and manufacturing a dream world of his own, or he may become over-conforming in
an effort to propitiate the forces which he considers to be the cause of his frustration. Of course, many patients present symptoms which are a combination of two or more of these methods of making life more endurable for themselves. Symptoms, therefore, cannot be regarded as disorders in themselves. Dr. Ernest Jones describes them as "products of an attempt to heal the underlying disease."(1) No diagnosis can be static, since the patient will respond to the new internal situation after each successive attempt to satisfy his needs.

Treatment of symptoms, without alleviation of either the internal or external stress, is of little avail. Therapy must take into consideration not only the relieving of stress, but also the patient's feelings about taking help. There is general agreement in these various schools of child psychiatry that the basic requirement for therapy is bringing to light, and accepting in a non-judgmental way, the patient's feelings about his present situation. Psychiatrists differ in the use which they make of this information after it is obtained.

There are two types of child psychiatry outside of child guidance. One is an out-growth of non-Freudian adult psychiatry. This method, of which Leo Kanner is an exponent, assesses after careful fourfold examination (social, psychological, physical and psychiatric), the patient's strengths and weaknesses, and then sets out to develop and correct them by strengthening the patient's conscious desires. In some

instances the psychiatrist works directly with the child, and in others through information and advice given to the parents. Parents are expected to "do something directly for their offspring or more indirectly work on themselves in their behalf."(1)

The second method, that of psychoanalysis, endeavours to allay unconscious conflict, but leaves the child free to choose his own way of life. Generally speaking psychoanalysts consider the parents either as persons whose cooperation is required in order for the child's treatment to continue or as sources of information.

Early in its development, in contrast to these two approaches to child psychiatry, child guidance began to regard the parents as well as the child as patients. More and more emphasis was placed on services to parents, and this entailed great changes in the role of the social worker, because work with the parents was chiefly her responsibility.

In 1932 a survey of the New York Institute for Child Guidance, revealed that two-thirds of the children under nine years of age classified as "treatment cases" had less than three interviews with a psychiatrist. In two-thirds of the "full-study" cases, the parents were not interviewed by a psychiatrist.(2) A similar survey of the Judge Baker Guidance Centre the next year revealed that treatment there, also, was carried on largely by social workers, through work with parents, teachers, social agencies, and in some cases with the children themselves.


Child guidance was begun with the viewpoint that the social worker's role was that of making the social history as complete as possible, for the psychiatrist's use, and after his examination of the patient seeing that his recommendations were understood and carried out. As it became more apparent that many of children's problems could be traced to unhealthy parental attitudes, the work of treating the parents was left to the social worker. Out of this came the recognition that the principles of dynamic psychiatry apply to parents as well as to children. Social workers then had to learn from psychiatrists about theory and techniques for the treatment of parents.

There are two distinct types of clinics, classified according to the way in which they regard their function of working with parents. In one of the social worker's help is made available to parents because they are likely to be worried about their children, and wish to have an opportunity for discussion of problems with a professional person. This type of clinic makes no attempt to help parents solve their own personality problems. Clinics of the second type see their function as working toward a change in parental attitudes, in particular those of the mother, in order to achieve better mental health for the child. In the first type, the parents' wishes become the focal point of treatment. The social worker becomes the psychiatrist's colleague rather than his assistant, when work with several members of a family is involved.

Dr. Witmer in her study of psychiatric clinics for children describes cleavages within the child guidance field as having two
characteristics. Some may be based on differences of opinion concerning the goal of treatment. Others grow out of differences in the matter of treatment methods and lead to divergent conceptions about the relation of a clinic to the various agencies with which it works and even about the basic function of the clinic itself.

The goal of treatment.

Mental and penal institutions have traditionally operated more for the benefit of society than for their patients. Their social objectives are the protection of society from further inconveniences and damage. Early clinics became another part in the institutional apparatus of schools, churches, courts, etc., which moulds the individual to society's needs.

The first clinics dealing with mentally defective and antisocial patients placed emphasis on those who needed treatment rather than those who wanted it. In consequence, the initial decision to enlist the clinic's help was not left to persons most immediately concerned, namely, the patients and their parents, but came usually from those who found the children troublesome, such as schools, courts, and social agencies. Therefore, many came to clinic under authoritative pressure and consequently were not inclined to be cooperative. The clinic was interpreted in terms of the removal of objectionable behaviour. It is hard for such clinics to reinterpret their objective, because patients and parents still feel that they have no choice as to whether they attend clinic or not.

An alternative point of view about child guidance work is one that sees the treatment process as aiming so to strengthen the patient that he will be able to work out his own kind of adjustment, less handicapped by emotional turmoil. This approach recognizes that there are many ways in which individuals find satisfaction in life. It also recognizes that there are many circumstances beyond the clinic's control which influence the patient's ability to desire professional skills of clinicians and to benefit from them. This is based on the belief that under reasonably favourable circumstances each individual human being contains within himself forces that favour social adjustment.

According to Freud, the demands of society are not alien to the child exposed to favourable conditions, but rather early in his life become an integral part of his personality. Dr. Rank holds that the patient can only be helped to find his own solution to his difficulties, and that the therapist "must refrain from moral evaluation of every kind".

Clinics which accept these theories of individual needs and capacities do not become a part of the network of regulative institutions which attempt to adjust children to accepted social standards. Such clinics seek recognition in the community as the agency of those individuals who desire their help.

Methods of treatment

Four general types of approach have been distinguished by Dr. Witmer. The first is that of clinics whose work centres chiefly around attempting to make the environment an easier or pleasanter place in which the patient may live. These may either provide a new environment by
means of foster homes or institutions, or attempt to remodel the old one; the latter may be done by modifying parental attitudes or relieving their tension, interpreting the child to his teachers and other adults, and ameliorating the school environment.

A second approach is used by those clinics which attempt to find new outlets for the patient's energies or capacities, by the building up of new recreational interests, fostering of undeveloped talents, encouraging of activities in which he is likely to find success. A third method is that of remedying the patient's specific disabilities, physical and intellectual, that is, of removing certain specific internal obstacles so that he is put on a par with his fellows. A fourth procedure is that of direct dealing with the patient's psychic problems, the methods varying with the different therapists. This approach is based on the assumption that the patient can make his own adjustment if he is helped to overcome to some extent his anxieties and his fears. In practice most clinics use a combination of these four approaches. Those who tend to emphasize self-direction for the patient tend to favour psychotherapy.

Clinicians of most schools agree that the first aim in therapy is to create a situation in which the patient is free to express what he will without the usual danger of incurring disapproval. Modifying environment is the traditional mental hygiene method. The Mental Hygiene movement originally aimed at providing a more understanding environment for the psychotic patient, and eventually moved into the field of child guidance because it found that some of the conditions presumably leading
to psychoses were to be found in the misunderstandings and other environmental deficiencies by which children are surrounded.

The educational aspects of clinic work were always stressed by mental hygienists. Early clinics were set up as demonstrations, not only of what they could offer their individual patients, but especially of what the mental hygiene point of view had to offer the professional persons who were responsible for the care of children. Staffs gave numerous lectures and representatives of schools, courts and social agencies were invited to conferences, partly in order that they might learn to handle the problems themselves. This was forced, too, by the recognition that clinics could never hope to serve all the children who were maladjusted.

Clinics basing their work on changing the individuals's environment are necessarily interested in social and educational reform. Each patient may be regarded as a sample of community neglect. The alternative approach of clinics to their work is that of accepting the world as it is (or at least holding that reform of the community does not lie within their function) and concentrating attention upon helping patients make their adjustment to it. Therapy for clinics with this approach is mainly for the patients and not a means of serving society's ends. They do not aim at reforming courts, schools, etc. The help they can give to other agencies is limited to what these clinics consider their specific task - understanding the child's feelings and desires. Members of other professions dealing with children are accepted by such clinics as persons capable of making their own decisions as to what use
they shall put the information given them about patients.

The clinical integration of the contributions of psychiatry, physical medicine, psychology and social work in the study of maladjusted children was instituted in Canada in 1919. The first clinic was established in Toronto through the Canadian branch of the National Committee for Mental Hygiene. It was a part of the Commonwealth Fund program of setting up demonstration clinics. Since then, child guidance or mental health clinics have been established in all provinces in Canada except Prince Edward Island and New Brunswick. (1)

A universal handicap of these clinics was the shortage of staff during the years of World War II. The resulting curtailment of services during a time when many children as well as adults were exposed to greater emotional strains created an increased demand on clinic facilities as the nation emerged into the post war period. Undoubtedly experience of staff members who had been engaged in psychiatric work in the armed services was invaluable in that the results of childhood maladjustments were demonstrated again and again in dealing with service personnel who needed treatment for psychiatric disorders. Rejection as well as discharge revealed a high percentage of severely maladjusted adults. In the words of Dr. J.H.W. van Ophuijsen, Chief of the Psychiatric Clinic of Lenox Hill Hospital "the war has shown with cruel clarity how sick a nation can be and has unmistakably indicated that after the fight against tuberculosis, venereal disease, cancer, etc., our next.

(1) A list of the clinics in Canada, will be found in Appendix A.
enemy is going to be the psychiatric disorder, in the first place in the form of psychoneurosis. "(1)
CHAPTER 2.

THE CLINICS IN VANCOUVER

Mental health has been defined as "the adjustment of individuals to themselves and the world at large with a maximum of effectiveness, satisfaction, cheerfulness and socially considerate behaviour, and the ability to face and accept the realities." (1) The home, the school and the community each have important roles in helping children along the path of mental health to emotional maturity.

In Vancouver, (2) parents and guardians, teachers, nurses, social workers and others, have access to two clinics when children show symptoms of unsatisfactory deviation in mental and emotional development. The Provincial Child Guidance Clinic was opened in 1932. Four years later, the Mental Hygiene Division of the Metropolitan Health Committee, through the appointment of a mental hygienist began serving children whose emotional disturbances were apparent in the school situation. Both clinics have had many patients; at times many more than limitations in number of staff made it possible to serve as adequately as they desired. Other than surveys of work loads for annual reports, there has been no research in either clinic. Directors of both services welcomed a study of clinic cases, and files were readily made available for this purpose.


(2) This refers to Greater Vancouver, throughout this study unless otherwise indicated.
The Provincial Child Guidance Clinic

This clinic was formed in Vancouver after a request by the Provincial Psychiatrist to the National Committee for Mental Hygiene for help in a program for the prevention of mental illness. The Committee was instrumental in obtaining the services of the first psychiatric social worker and paid her salary for one year. A psychologist was added to the clinic team five years later. At first the clinic was open for half-days only. The services have expanded greatly in the intervening period.

The Vancouver Child Guidance Clinic operates throughout the week. Usually 18 complete examinations per week are made. The patients come from Vancouver, North Vancouver, West Vancouver, and Burnaby. Patients from New Westminster, referred by Social Welfare Branch only, are also examined. During the years 1945-47 inclusive the number of patients given full clinical examinations at this clinic was 1,895. Of this number, 1,440 were under 18 years of age.

The children who are given clinical examinations range between the age of 6 months and 18 years. Adults whose maladjustments may contribute to emotional disturbance of children are frequently the subject of consultative conferences between the referring agency and the clinic. In a limited number of cases, such adults are examined at clinic.

The children studied at Child Guidance Clinic can be classified in three groups: (1) The first group is made up of those children who express their lack of adjustment in symptoms of various kinds, in the home, the school or the community. These symptoms may take the form of undesirable habits, personality traits or behaviour. In the second group,

(Eyrne, U.P., "Child Guidance Clinics" typewritten interdepartmental paper.)
are the "dependent" children, who because of illegitimacy, abandonment or neglect of parents, or homes broken by divorce, desertion or death will during their childhood be placed in adoption homes, institutions or foster homes. Lastly, there are children who show retardation in intellectual development such that they are unable to compete successfully in the ordinary types of intellectual work required of them.

The services given by the Child Guidance Clinic are described in the Annual Report of the Social Welfare Branch (1947-48) as (1) treatment (2) diagnosis (3) consultation. Treatment cases are those in which after diagnosis, patients are seen by the psychiatrist on a treatment-interview basis, or by clinic social workers and psychologists under the direction of the psychiatrist. This service is available for the clinic's private patients(1) or for patients referred by agencies on a co-operative basis.(2)

Child Guidance Clinic cases referred to the clinic by social agencies or by medical and health agencies are given diagnostic service. Each "child and his situation is studied in whole or in part, a psychiatric and psycho-social diagnosis is made and possible solutions to problems contained within these areas are then presented. The Child Guidance Clinic, however, has no active part in the subsequent progress of the

(1)Private patients are those referred to clinic not by social or health agencies but by their parents, private physicians, speech therapists, kindergartens, etc.

(2)Cases presented for clinical examination and found to be in need of intensive psychiatric treatment, are in some instances, interviewed regularly at the clinic. The agency making the referral may continue to give other services to the child and his family in such cases.
case. The value of this service depends on the responsible agency adequately equipped to make the social study, to make use of the clinic's findings, and to carry out the clinic's psychiatric recommendations. In the diagnostic service, treatment is delegated by the clinic psychiatrist in conference to the referring agency. (1)

A consultative service is one in which the clinic's services are given to any person interested in the child, but where there may be no actual contact on the part of the clinic with the child. Social and health workers have used the service to discuss the psychiatric problems of their clients with the psychiatrist and the other members of the clinic team. One afternoon each week is set aside at the Child Guidance Clinic for Family Welfare Bureau or Children's Aid Society consultations. Such conferences are arranged for other agencies when requested. (2)

There are five procedures within the Child Guidance Clinic, in the study of patients, namely, the social history, the physical, psychological and psychiatric examinations and the conference.

In the social history a vivid picture of the child living with his parents or foster parents, in his home, school and community is desirable. A psychiatric social history outline (3) is provided by the


(2) During the fiscal year 1947-48, 198 consulting conferences were held at the Vancouver Child Guidance Clinic.

(3) Appendix B (1)
17. clinic as a guide. The clinic requests that four copies of each history (one for each member of the clinic team) should be received at clinic at least 2 days prior to the examination. In compiling the social history, the social worker describes the various aspects of the clinical examination, in order that the parents may prepare the child for the new experience of attending clinic. Private clinic patients, if they are apprehensive about the examination, are shown through various parts of the clinic, and meet the nurse, psychologists, and receptionist several days before their appointment date.

The physical examination\(^{(1)}\) is necessary in recognizing those cases in which the disturbance is due to organic lesion within the central nervous system. In other cases, it frequently aids in understanding the behaviour and may disclose defects such as dental caries, birth marks and other disfiguring features which may have a damaging psychological effect on the child.

The clinic nurse prepares each patient for the physical examination, explaining fully the doctor's procedures, and assuring the patient that nothing discomforting will be done. Vision testing (Snellen Scale), hearing test (speaking voice or audiometer), weighing, measuring, and urinalysis are done by the nurse. Following these tests, the nurse assists the psychiatrist with the physical examination.

The physical room at the clinic is set up to appear less austere than a general hospital examining room. The psychiatrist does not don the traditional white coat and the nurse wears a colored smock, \(^{(1)}\)Appendix B (2)
rather than a uniform. Parents and familiar adults are invited to remain with the child during examination if he appears at all insecure. There are no hard and fast rules regarding lying flat on the examination table, undressing completely, or saying "ah". When treatment of physical defect is recommended, the child's parents or guardians are referred to the family physician or school health services.

The public health nurse makes play room observations\(^{(1)}\) of patients. In preparing each patient for the physical examination as well as in observing him in the play room or waiting room the nurse has an opportunity to see many aspects of his behaviour. These observations which are usually made over a longer period of time and under circumstances different from those of other members of the clinic team and are valuable in supplementing their reports on the child's behaviour.

The *psychological examination\(^{(2)}\)* is concerned with the evaluation of the child's innate abilities, educational achievements and special aptitudes. In making this evaluation the clinical psychologist may use standardized intelligence tests, tests of special abilities, personality schedules and interest blanks.\(^{(3)}\) The results of these tests enable the psychologist to predict within certain limits the maximum school achievement to be expected of a particular child; and the child's chance for success in some vocations. Having discovered any special disabilities, the psychologist may recommend special tutoring and treat-

\(^{(1)}\) Appendix B (3)

\(^{(2)}\) Appendix B (4)

\(^{(3)}\) Appendix B (5) lists the tests used by psychologists at the Child Guidance Clinic.
ment to overcome them. Recommendations regarding school grade placement may be made by the psychiatrist, when the results of the psychological examination indicate that the child is misplaced. A program of remedial reading is carried on by the psychological department of the clinic for a limited number of the children found to be in need of it.

In the psychiatric examination, the psychiatrist through his special training is in a position to view the inter-relationship of the physical and the mental. The psychiatrist's special contribution in understanding the child is the discovery and elucidation of the child's inner motives, as these are revealed by his behaviour in the interview situation. The initial interview paves the way for treatment interviews later on, if these are considered necessary in the staff conference. The psychiatrist also interviews both parents, either separately or together, in all cases in which the parents accompany the patient to the clinic. In many instances the mother only, comes to clinic with the patient. The understanding and co-operation of both parents is considered so important by the clinic that time schedules are adjusted to make possible at a later date, interviews with fathers who were unable to attend clinic at the time of their children's examination.

At the conference which is held after the completion of the four procedures outlined above the psychiatrist acts as chairman. The other three members of the clinic team as well as the worker from the social or health agency participate in the conference. In private clinic cases, if the parents have given consent, the school principal and the patient's teacher, as well as the public health nurse in the school, are
invited to attend the conference. In some instances these persons are invited to conferences on cases presented by other agencies. The aim of the conference is to define reasonable treatment objectives and the prospects of attaining them. This may involve a decision to use direct therapy, treatment of one or both parents, manipulation of the environment or all three. All plans are subject to revision if changing circumstances indicate the need for this. Further conferences may be held in such cases, with the workers responsible submitting additional histories or progress reports covering the intervals between conferences.

The Mental Hygiene Division of the Metropolitan Health Committee

In this division, formed in 1936, much of the mental hygienist's time was at first devoted to the establishment of clinical services for public school pupils. The School Health Service program, which at that time was under the jurisdiction of the Public School Board, was thus supplemented by the Metropolitan Health Committee. The mental health program which developed was curtailed for nearly three years during World War II because the services of a psychiatrist could not be obtained. In January 1946, the clinical work was resumed. During the years 1946 and 1947 the total number of patients examined was 426. Of this number, 9 were adults, 41 were pre-school children, and 376 (88 per cent) were between the ages of 6 and 8. (2)

The following description of the clinics' policy and procedures

(1) The term "mental hygienist" rather than "psychiatrist" is generally used by the Metropolitan Health Committee.

(2) Based on statistics quoted in Annual Reports of The Division of Mental Hygiene, Metropolitan Health Committee, Vancouver for years 1947 and 1948.
The object of the program of the Mental Hygiene Division is the promotion of mental health. Types of problems suitable for study by the clinic are outlined as follows:

"Poor group adjustment - timid, insecure children - the nervous child. Poor attitude toward authority - dependent, unresponsive children, disturbing behaviour. Physical disturbances associated with emotional tension - tics, speech defects, unco-ordinated movements. Presence of neurotic symptoms - tendencies to make use of symptoms to evade challenging situations. Delinquency problems - stealing, lying, truancy, begging, etc."

School nurses are expected to consider that problems of behaviour and signs of undue emotional tension demand attention just as urgently as do physical defects. Early personality problems are to be brought to parents' attention in the same way as other defects, and the correction of early faults is emphasized as a means of safeguarding future health. Parents, school medical officers, teachers, and others as well as nurses may make referrals to the clinic.

Clinics are held in the offices of the Health Units and the schedule of appointments is arranged by the Unit Supervisors of Nurses. Usually one clinic per month is held in each unit. Teachers wishing to have children examined at clinic discuss the matter with their principals.


(2) There are 6 Health Units in Greater Vancouver.
In each case in which a decision is made by the teacher and principal that a pupil requires clinical examination the school nurse is asked by the principal to visit the child's parents to obtain their consent and co-operation. Having done this, the nurse clears the case with the Social Service Index. If the case is under the active supervision of a social agency, an appointment with the case worker is made for the purpose of discussing information for the social and family history.\(^{(1)}\) If the case has been closed by the social agency, the nurse requests a resume of the agency's previous contact. The nurse then prepares the social and family history. The child's teacher prepares the school history\(^{(2)}\) in duplicate, one copy for the principal's records and one for the clinic. Unless there is an individual intelligence test rating or a recent group test score that is consistent with the child's general performance, it is recommended that referral to the Bureau of Measurements be made, before examination at the Mental Hygiene Clinic. The school nurse then makes an appointment with the unit supervisor for the child to be seen at the clinic.

The parents, or one of them, or the person \textit{in loco parentis} are asked to come to the clinic at an appointed time arranged with the Unit Supervisor of Nurses. If a child is under the care of a private physician the Unit Director (School Medical Officer) or the Unit Supervisor consult him regarding the clinic study and invite him to attend the conference.

\(^{(1)}\)Appendix C (1)

\(^{(2)}\)Appendix C (2)
It is the responsibility of the school nurse to notify the parents of the time and place of the child's psychiatric examination. Usually only three patients (2 in the morning and 1 in the afternoon) are examined on a clinic day, the last part of the afternoon being used for conferences. Those persons legitimately concerned with a case are invited to the conference. These might be any or all of the following: school principal, teacher, psychologist (Bureau of Measurements), school counsellor, school attendance officer, social worker, private physician, public health nurse, Unit Director, Unit Supervisor, School Medical Officer (if other than the Unit Director). The school nurse notifies interested parties of the time and place of the conference.

These conferences are considered to be the Division's most important method of teaching mental hygiene. "The Public Health Nurse and Unit Supervisor, should grasp every opportunity to interpret the value of the conference, stressing that members attend not only to secure information, but also to contribute to the round table discussion. The place of the Mental Hygienist should be that of consultant and advisor."(1)

Written reports of clinic study are sent by the mental hygienist to the Unit Director, - (attention of Public Health nurse referring the case) and to the School Principal - (attention of the teacher and counsellor). Written reports are also sent to social agencies and to private physicians in cases in which they are concerned. Six months after the initial examination, the school nurse is expected to submit a progress

(1)Nurses' Manual "Metropolitan Health Committee Facilities for Diagnosis, Treatment or Consultation".
Methodology of this study.

Because this survey is a pioneer in research in these two clinics, it must necessarily be broad in many aspects. Several criteria were set up as a basis for selection of cases. Age limits set were six to twelve years inclusive, the minimum being school beginning age, and the maximum the average pre-adolescent period. Only cases in which patients had intelligence of at least slow normal or above were included.

Children of unmarried mothers were omitted in this survey except where they remained with their mothers, grandparents or other near relatives until they were at least five years of age. Adopted children were also excluded. These groups as well as mentally defective children were omitted not because they are immune to maladjustment or because they are less important than those considered. "Average" children in "normal" families were selected on the grounds that the children in excluded groups showing maladjustment will need all of the services discussed in connection with the "average" children. Besides these they may need additional services.

In the course of the selection of the 257 cases which comprise this study, numerous records of illegitimate, adopted and deficient children were scanned. They are not the main subject matter of this inquiry, but may be referred to where relevant. A detailed study of facilities in use, and additional facilities needed for any one of these
excluded groups might well be the subject of another thesis.

The total number of cases examined by the two clinics during the years 1945-47 inclusive, which met criteria outlined above was 257. In this general survey, the following points were noted: age of child, presenting problem, address, length of child's residence in B.C., source of referral, intelligence rating, number in family, ordinal position in family, racial extraction, religion, and marital status of parents (married, common-law, divorced, separated, deceased), absence of father from home in military service, poor living arrangements, (crowded or bad housing) and presence of grandparents, aunts or uncles in the home whose attitudes contributed to maladjustment.

These 257 cases were classified according to the problems which led to the patients being referred to the clinics examination. The classifications were (1) socially unacceptable behaviour (2) personality reactions (3) habit disorders (4) school disabilities. One out of every five cases in each of the above-mentioned categories was selected at random, and a more detailed study (1) of this 20 per cent sample was made.

(1) The schedule used in collecting data from clinic records of 52 cases (20 per cent) sample will be found in Appendix D.
Figure 1 shows the number of cases examined by each of the clinics. The year 1945 was included in the study in order to make possible some comparison of the cases in which the fathers of patients were still away from home because of war service with those cases in which the fathers had returned. Another reason for considering the Child Guidance Clinic cases of a three year period was to effect a more even balance between the number of cases studied from each clinic. The Mental Hygiene Clinic was not in operation in 1945. Relatively fewer cases per year were examined by this clinic, because the director of the Mental Hygiene Division of the Metropolitan Health Committee was the only psychiatrist in this division and part of his time was spent in giving lectures to students at the University as well as at the Normal School.
Figure 2 shows the proportion of children surveyed in this study to the total number of children examined by both clinics. It shows that only 13.7 per cent of the patients 18 years of age and under, came within the scope of the criteria set for this study.
CHAPTER 3.

THE CLINIC PATIENTS AND THEIR FAMILIES

In the period covered by this study (1945-1947 inclusive) the number of elementary school children of at least normal intelligence who received clinical psychiatric examinations was 257.\(^{(1)}\) Of these, approximately 55 per cent were examined at the Mental Hygiene Clinic. Because the bulk of this clinic's work was concerned with school-age children, it is understandable that in the course of two years, a larger number of children between the ages of 6 and 12 years were examined there than at the Child Guidance Clinic in a period of 3 years. Not only because the Child Guidance Clinic examines children as young as 6 months, but also because much of its time was devoted to "dependent" children, there were comparatively fewer Child Guidance Clinic cases which came within the scope of this study.

Table 1 DISTRIBUTION OF CASES BY EXAMINING CLINIC AND PROBLEM REFERRED

<table>
<thead>
<tr>
<th>Examining Clinic</th>
<th>Socially Unacceptable Behaviour</th>
<th>Personality Reactions</th>
<th>Habit Disorders</th>
<th>School Disabilities</th>
<th>Total</th>
<th>p.c.</th>
</tr>
</thead>
<tbody>
<tr>
<td>M. H. C.</td>
<td>42</td>
<td>48</td>
<td>23</td>
<td>28</td>
<td>141</td>
<td>54.86</td>
</tr>
<tr>
<td>C. G. C.</td>
<td>58</td>
<td>32</td>
<td>16</td>
<td>10</td>
<td>116</td>
<td>45.14</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>80</td>
<td>39</td>
<td>38</td>
<td>257</td>
<td>100.00</td>
</tr>
</tbody>
</table>

In considering these 257 children, it is well to keep in mind

\(^{(1)}\)This number includes only those cases which came within the limits of the criteria for selection outlined in the preceding chapter.
that they represent only the number in whom the need for psychiatric help was recognized. The question then arises: Which persons or agencies saw this need?

Table 2 DISTRIBUTION OF CASES BY SOURCE OF REFERRAL

<table>
<thead>
<tr>
<th>Source of Referral</th>
<th>Socially Unacceptable Behaviour</th>
<th>Personality Reactions</th>
<th>Habit Disorder</th>
<th>School Disabilities</th>
<th>Total</th>
<th>p.c.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parents</td>
<td>20</td>
<td>21</td>
<td>5</td>
<td>7</td>
<td>53</td>
<td>20.61</td>
</tr>
<tr>
<td>Nurse</td>
<td>11</td>
<td>8</td>
<td>12</td>
<td>4</td>
<td>35</td>
<td>13.61</td>
</tr>
<tr>
<td>School doctor</td>
<td>1</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>12</td>
<td>4.67</td>
</tr>
<tr>
<td>Attendance Officer</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>.39</td>
</tr>
<tr>
<td>Teacher</td>
<td>8</td>
<td>20</td>
<td>3</td>
<td>11</td>
<td>42</td>
<td>16.34</td>
</tr>
<tr>
<td>School Principal</td>
<td>7</td>
<td>5</td>
<td>1</td>
<td>6</td>
<td>19</td>
<td>7.39</td>
</tr>
<tr>
<td>B. of M.*</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>3</td>
<td>7</td>
<td>2.72</td>
</tr>
<tr>
<td>Family Doctor</td>
<td>4</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>10</td>
<td>3.89</td>
</tr>
<tr>
<td>Juvenile Court</td>
<td>7</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>8</td>
<td>3.04</td>
</tr>
<tr>
<td>Children's Aid Societies</td>
<td>17</td>
<td>8</td>
<td>3</td>
<td>1</td>
<td>28</td>
<td>11.28</td>
</tr>
<tr>
<td>F.W.B.**</td>
<td>11</td>
<td>4</td>
<td>10</td>
<td>0</td>
<td>25</td>
<td>9.73</td>
</tr>
<tr>
<td>Other Social Agencies</td>
<td>11</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>14</td>
<td>5.45</td>
</tr>
<tr>
<td>Health Agencies</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>.78</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>80</td>
<td>39</td>
<td>38</td>
<td>257</td>
<td>100.00</td>
</tr>
</tbody>
</table>

* Bureau of Measurements.
** Family Welfare Bureau
It is encouraging to note that parents referred 20 per cent of these children. This is the highest percentage among 13 sources of referral. However, if persons connected with the school system, namely, principals, teachers, public health nurses, school medical officers, Bureau of Measurements and attendance officers are grouped together, 45 per cent of all referrals can be credited to this source. Social agencies referred 25 per cent of the children who were examined. Juvenile Court referrals led to 3 per cent of the total number of cases.

Since support of parents is invaluable to treatment, it would be hoped that parents were the instigators in seeking clinical help. Although parents made direct referral for examination in only one out of every five cases, social histories indicate that in a much larger percentage of cases, they were aware that their children were showing symptoms of maladjustment. However, these parents did not know where psychiatric help could be obtained until they had discussed their problem with a doctor, teacher, nurse, or social worker.

There may, of course, be opposition to examination on the part of some parents. A few of the social histories indicated that there was some parental opposition when the schools or social agencies took the initiative in suggesting psychiatric help. Such examinations were not made until parents' consent had been obtained. In private cases at the Child Guidance Clinic parents make direct referrals. In each case of this kind, if one parent is unwilling to accept the services of the clinic, no examination is undertaken until this resistance has been overcome sufficiently that some cooperation from both parents in treatment plans may be expected.
The interpretation of clinic services which is required in such cases is
done by a social worker.

Logically, the next question to be answered is: Why were the
children of this study referred to the clinics for examination? In other
words, what were the symptoms of their maladjustment which led parents,
school authorities, social agencies and others to request clinical exam­
inations for them?

These symptoms may be divided into four categories, as follows:
(1) socially unacceptable behaviour (2) personality reactions (3) problems
in habit formation and (4) special school disabilities.

Symptoms of maladjustment which may be classified as socially
unacceptable behaviour are numerous. Some of these are: temper tantrums,
teasing, bullying, rebellion against authority, cruelty to persons or
animals, destructiveness, bragging or "showing off", seeking bad compan­
ions, precocious sex activities, lying, stealing and truancy. One hundred
of the 257 children examined, (38.91 per cent) presented symptoms of this
kind.

Among the chief personality reactions which are manifestations
of maladjustment, the following may be listed: seclusiveness, timidity,
sensitiveness, fears, cowardliness, excessive imagination and fanciful
lying, "nervousness", excessive unhappiness and crying, stubbornness, rest­
lessness, selfishness, overactivity and unpopularity with other children.
Eighty of the children who were examined, (31.12 per cent) were referred
because of symptoms of this nature.

Problems in habit formation include sleeping and eating diffi-
culties, speech disturbances, thumb sucking, nail biting, masturbation, prolonged bed-wetting and soiling. Thirty-nine of the children examined, (15.18 per cent), were referred because they had difficulties of this kind.

Special school disabilities occur, particularly in reading and arithmetic. "Mirror writing" (writing backwards) is also a special disability. Thirty-eight of the children, (14.78 per cent) were examined because such difficulties prevented their progress at school.

As has been pointed out previously, children frequently manifest symptoms which may be classified under two or more of the 4 categories described above. In this study, cases in which a combination of 2 or more types of symptoms occurred, were classified according to predominating symptoms. For example, a boy who stole, and was untruthful, destructive, and disobedient would be included with the group showing socially unacceptable behaviour, although he may also have presented a habit disorder such as enuresis or nail-biting.

Table 3

<table>
<thead>
<tr>
<th>Mental Hygiene Clinic</th>
<th>Boys</th>
<th>p.c.</th>
<th>Girls</th>
<th>p.c.</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Socially Unacceptable Behaviour</td>
<td>33</td>
<td>78.67</td>
<td>9</td>
<td>21.43</td>
<td>42</td>
</tr>
<tr>
<td>Personality Reactions</td>
<td>31</td>
<td>64.68</td>
<td>17</td>
<td>35.42</td>
<td>48</td>
</tr>
<tr>
<td>Habit Disorders</td>
<td>20</td>
<td>86.95</td>
<td>3</td>
<td>13.05</td>
<td>23</td>
</tr>
<tr>
<td>School Disabilities</td>
<td>21</td>
<td>75.55</td>
<td>7</td>
<td>25.45</td>
<td>28</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>105</strong></td>
<td><strong>74.56</strong></td>
<td><strong>36</strong></td>
<td><strong>25.49</strong></td>
<td><strong>141</strong></td>
</tr>
</tbody>
</table>
Slightly over 70 per cent of the children examined were boys. This higher preponderance of males was more marked in the Mental Hygiene Clinic where boys comprised about three-quarters of the cases. However, two-thirds of the Child Guidance Clinic patients also were boys. There is no doubt that the uneven distribution between male and female patients in the Vancouver clinics cannot be accounted for on the basis of a similarly disproportionate number of boys in the school population.\(^1\)

Moreover, this survey of Vancouver’s clinic patients bears a marked similarity to the findings of two larger studies of clinical populations. In a statistical analysis of 500 cases examined at the Michigan Child Guidance Institute,\(^2\) 78 per cent of the patients were boys. A sample

\(^1\)Canada Year Book, 1947, p. 113-114. According to 1941 census figures in Canada the excess of males over females is 2.56 per 100 of the population. The sex distribution in British Columbia, in 1941 showed a somewhat higher preponderance of males, namely, 6.36 per 100 of the population.

of 500 children examined by the Institute of Juvenile Research in Chicago\(^{(1)}\) included 62 per cent boys.

"Delinquent" populations, as reflected in juvenile court statistics, reveal an even greater disparity between the sexes in social adjustment. In Canada, in 1945, 88 per cent of the children brought before the courts were boys.\(^{(2)}\) The United States Children's Bureau\(^{(3)}\) in its summary of juvenile delinquency cases reported from 28 juvenile courts during the year 1937 found that boys constituted 85 per cent of the "delinquency population".

There are 2 possible conditions for this showing. Either cultural norms tend to protect girls from court appearances; or girls tend toward greater conformity to social mores. The latter condition may account to some extent for the fact that only about 30 per cent of the Vancouver clinical population were girls.

\(^{(1)}\) Ackerson, Luton, *Children's Behaviour Problems*, University of Chicago Press, 1931.


Table 4  DISTRIBUTION OF CASES BY AGE

<table>
<thead>
<tr>
<th>Ages of Patients</th>
<th>Socially Unacceptable Behaviour</th>
<th>Personality Reactions</th>
<th>Habit Disorders</th>
<th>School Disabilities</th>
<th>Total</th>
<th>p.c.</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 yrs.*</td>
<td>10</td>
<td>17</td>
<td>4</td>
<td>9</td>
<td>40</td>
<td>15.56</td>
</tr>
<tr>
<td>7 yrs.</td>
<td>22</td>
<td>9</td>
<td>9</td>
<td>7</td>
<td>47</td>
<td>18.29</td>
</tr>
<tr>
<td>8 yrs.</td>
<td>17</td>
<td>17</td>
<td>7</td>
<td>7</td>
<td>48</td>
<td>18.68</td>
</tr>
<tr>
<td>9 yrs.</td>
<td>18</td>
<td>14</td>
<td>9</td>
<td>6</td>
<td>47</td>
<td>18.29</td>
</tr>
<tr>
<td>10 yrs.</td>
<td>13</td>
<td>13</td>
<td>5</td>
<td>5</td>
<td>36</td>
<td>14.00</td>
</tr>
<tr>
<td>11 yrs.</td>
<td>20</td>
<td>10</td>
<td>5</td>
<td>4</td>
<td>39</td>
<td>15.18</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100</strong></td>
<td><strong>80</strong></td>
<td><strong>39</strong></td>
<td><strong>37</strong></td>
<td><strong>257</strong></td>
<td><strong>100.00</strong></td>
</tr>
</tbody>
</table>

* Up to 6 years 11 months, and similarly for succeeding groups.

Considering the Vancouver patients on the basis of age children between 8 and 9 years constituted the largest proportion, (18.68 per cent). An identical number of children in the 7 to 8 year and the 9 to 10 year group were examined. The age group presenting the lowest incidence of maladjustment was the 10 to 11 year (14 per cent). The above table indicates that the age distribution of patients is fairly even. However, Vancouver (1) Public School Board statistics show that there was an average of over 550 more pupils per year in Grade I than in Grade II during the years under consideration in this study. Assuming that some of these pupils were repeating Grade I, some of the 550 would be 7 years or over. Allowing for this, there would still be a larger number of 6 year olds than of other ages, since there has been a steady increase in the number of births in Vancouver from 1936 to 1947. (2)

(1) Vancouver proper only.
The adjustment entailed in beginning school has long been recognized as a difficult one for many children. The question then arises: Why were there fewer patients of 6 years of age compared with those of 7, 8 or 9 years?

A survey of the 20 per cent sample of 257 cases reveals that the average period of time between the first serious symptoms of maladjustment and clinical examination was 2 years and 10 months. It would appear that early symptoms frequently receive too little attention; too often, not until the child's problem has become intensified to a degree that his behaviour is irritating or even objectionable to those about him, is there any concerted effort made to refer him to a clinic.

Table 5 DISTRIBUTION OF CASES BY INTELLIGENCE LEVEL

<table>
<thead>
<tr>
<th>Intelligence Quotients</th>
<th>Socially Unacceptable Behaviour</th>
<th>Personality Reactions</th>
<th>Habit Disorders</th>
<th>School Disabilities</th>
<th>Total</th>
<th>p.c.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Near Genius (140 &amp; over)</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>5</td>
<td>1.95</td>
</tr>
<tr>
<td>Very Superior (120-139)</td>
<td>9</td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>13</td>
<td>5.06</td>
</tr>
<tr>
<td>Superior (110-119)</td>
<td>6</td>
<td>15</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>8.95</td>
</tr>
<tr>
<td>Average (90-109)</td>
<td>56</td>
<td>41</td>
<td>20</td>
<td>24</td>
<td>141</td>
<td>54.86</td>
</tr>
<tr>
<td>Low Average (80-89)</td>
<td>25</td>
<td>14</td>
<td>12</td>
<td>13</td>
<td>64</td>
<td>24.90</td>
</tr>
<tr>
<td>Not Stated (but apparently average)</td>
<td>2</td>
<td>7</td>
<td>2</td>
<td>0</td>
<td>11</td>
<td>4.28</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>80</td>
<td>39</td>
<td>38</td>
<td>257</td>
<td>100.00</td>
</tr>
</tbody>
</table>
The intelligence quotients of the patients ranged from 80 (the lower limit set in selecting cases) to 161. The 4.28 per cent of the cases, in which the intelligence was not stated, but was apparently at least average, were cases examined by the Mental Hygiene Clinic where routine psychological tests were not always given. In summary then, approximately 84 per cent of the patients had average intelligence.

The distribution of various intelligence levels of clinic cases shown in Figure 3 bears a marked contrast to the theoretic distribution of intelligence as shown in Figure 4.

---

**Fig. 3. Distribution of Cases by Intelligence Levels.**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>160 &amp; over</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>120 - 139</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>110 - 119</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>90 - 109</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>80 - 89</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>not stated</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Legend: 
- Child Guidance Clinic
- Mental Hygiene Clinic

**Fig. 4. Theoretic Distribution of Intelligence.**

<table>
<thead>
<tr>
<th>I.Q.</th>
<th>10 p.c.</th>
<th>20 p.c.</th>
<th>30 p.c.</th>
<th>40 p.c.</th>
<th>50 p.c.</th>
<th>60 p.c.</th>
</tr>
</thead>
<tbody>
<tr>
<td>160 &amp; over</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>120 - 139</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>110 - 119</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>90 - 109</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>80 - 89</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>70 - 79</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Below 70</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The proportion of children of "above average" intelligence to those of "average" and "low average" then is 20:74. The proportion in this study is 16:84. Reducing these figures to percentages, reveals in the clinical population under study the distribution of proportions in the superior range were only 70 per cent of the expected normal distribution.

A comparison of the proportion of children of "low average" intelligence to those of "average" intelligence shows that the former comprise 193 per cent of the number of "low average" cases expected in the theoretic distribution of intelligence.

Therefore, it cannot be said that these patients of the Vancouver clinics represent a cross-section of the general population with regard to intelligence. There is a marked tendency toward a larger-than-expected grouping at the lower end of the intelligence distribution.

A survey of the intelligence quotients of school age patients privately referred to Child Guidance Clinic for examination during the year 1947 reveals a marked contrast to the above findings. These children tended toward both the upper and lower extremes of intelligence, as illustrated in Figure 5.

<table>
<thead>
<tr>
<th>I.Q.</th>
<th>10 p.c.</th>
<th>20 p.c.</th>
<th>30 p.c.</th>
<th>40 p.c.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Below 80</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>80 - 89</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>90 - 109</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>110 - 119</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>120 - 139</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>140 &amp; over</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Fig. 5. Distribution of Child Guidance Clinic Cases. (All private cases, children 6 to 12 years - 1947)
This suggests that children whose problems are apparent to their parents\(^1\) tend toward both extremes of intelligence. Keeping in mind that more than 2 out of every 5 (45 per cent) of the 257 children in this study were referred by school authorities, one reason for the deviation from the normal distribution of intelligence suggests itself. Children of superior intelligence, although maladjusted, are less likely to arouse the concern of teachers than are those of lower intelligence whose maladjustment may show up in poorer academic progress. This theory can be substantiated by the Child Guidance Clinic case records of numerous private patients, in which can be found instances of a principal or a teacher expressing surprise that a child is to have a psychiatric examination. Frequently they make such comments as - "He's not a problem in school", "He's an average student, doing satisfactory work", or "He's in the lower third of the class, but seems to be doing his best". Such pupils often are found to have I.Q.'s which classify them as superior, very superior or above, and therefore have intellectual capacity, if freed from emotional disturbances, to be "better than average" students or in the "upper third" of the class.

Although group intelligence tests are given routinely in grade 1 and grade 6, and sometimes in grade 3 or 4, in Vancouver Public Schools, the maladjustments which cause some children of superior intelligence to make only average academic progress may also operate in the test situation. In one instance, a nine year old girl, doing mediocre work in school, had

\(^1\) The majority of private Child Guidance Clinic cases are referred at the instigation of parents, although actual referral may be through family doctors, speech therapists, public health nurses, etc.
scored 120 in a group intelligence test in the classroom. In an individual test given after several visits to the Child Guidance Clinic, she was found to have an I.Q. of 155.

One of the outstanding features of the study of the families of which the 257 patients were members is that, in one out of every 3 serious factors of family disorganization were considered by the examining psychiatrists to have affected the personality development of patients.

Table 6 DISTRIBUTION OF CASES BY FAMILY DISORGANIZATION FACTORS

<table>
<thead>
<tr>
<th>Factors</th>
<th>Socially Unacceptable Behaviour</th>
<th>Personality Reactions</th>
<th>Habit Disorders</th>
<th>School Disabilities</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marked Parental Discord</td>
<td>7</td>
<td>7</td>
<td>7</td>
<td>3</td>
<td>24</td>
</tr>
<tr>
<td>Divorce</td>
<td>11</td>
<td>4</td>
<td>4</td>
<td>1</td>
<td>20</td>
</tr>
<tr>
<td>Father Deceased</td>
<td>6</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>Desertion</td>
<td>6</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>7</td>
</tr>
<tr>
<td>Separation</td>
<td>3</td>
<td>2</td>
<td>-</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Common Law Marriage(1)</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>-</td>
<td>6</td>
</tr>
<tr>
<td>Mother in Mental Hospital</td>
<td>2</td>
<td>3</td>
<td>-</td>
<td>-</td>
<td>5</td>
</tr>
<tr>
<td>Mother Deceased</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td>Father in Prison</td>
<td>1</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td>Father in Mental Hospital</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>40</td>
<td>27</td>
<td>13</td>
<td>6</td>
<td>86</td>
</tr>
</tbody>
</table>

(1) Only includes cases in which mother's insecurity about this type of marriage affected children.
Leading the list in frequency of occurrence was marked discord between parents. In 9.33 per cent of the cases this factor was noted. In 7.78 per cent parents were divorced. In many of these, there were indications of marked discord preceding the divorce. Families which were incomplete because fathers were deceased represented 3.28 per cent of the cases. In 2.72 per cent desertion, in 2.33 per cent separation, and in 2.33 per cent common-law marriages resulting in mother's insecurity, contributed to children's maladjustment. Other factors were mental illness of mothers, mothers deceased, fathers in prison, mental illness of father.

Table 7 DISTRIBUTION OF CASES BY OTHER CONTRIBUTING FACTORS

<table>
<thead>
<tr>
<th>Contributing to Maladjustment</th>
<th>Socially Unacceptable Behaviour</th>
<th>Personality Reactions</th>
<th>Habit Disorders</th>
<th>School Disabilities</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inadequate housing (poor or very crowded)</td>
<td>16</td>
<td>18</td>
<td>5</td>
<td>3</td>
<td>42</td>
</tr>
<tr>
<td>Father's absence while serving in the Armed Forces</td>
<td>11</td>
<td>12</td>
<td>9</td>
<td>4</td>
<td>36</td>
</tr>
<tr>
<td>Interference by relatives living in the home</td>
<td>18</td>
<td>8</td>
<td>5</td>
<td>3</td>
<td>34</td>
</tr>
<tr>
<td>Total</td>
<td>45</td>
<td>38</td>
<td>19</td>
<td>10</td>
<td>112</td>
</tr>
</tbody>
</table>

Although boys comprised over 70 per cent of the 257 cases, they represented only 56 per cent of the 86 cases in which there was evidence of family disorganization such as marked discord, divorce, desertion and separation. Similarly, boys appeared to be less vulnerable than girls to such environmental factors as the fathers' absence while serving in the
Armed Forces, inadequate housing, and interference of grandparents and other relatives living in the home. Of the 112 cases in which these factors were present, boys comprised only 61 per cent.

According to the social histories, 51.75 per cent of the parents were of Anglo-Saxon descent. In 20.62 per cent of the cases, racial origins were not stated. This high percentage makes it impossible to draw any accurate conclusions as to the extent to which various nationalities were represented in the clinic cases, or to compare this group with the general population. The social history outlines of both clinics suggest that information regarding racial origins should be obtained.

Table 8  DISTRIBUTION OF CASES BY SIZE OF FAMILY

<table>
<thead>
<tr>
<th>Number of Children in Family</th>
<th>Socially Unacceptable Behaviour</th>
<th>Personality Reactions</th>
<th>Habit Disorders</th>
<th>School Disabilities</th>
<th>Total</th>
<th>p.c.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>24</td>
<td>19</td>
<td>8</td>
<td>9</td>
<td>60</td>
<td>23.35</td>
</tr>
<tr>
<td>2</td>
<td>21</td>
<td>37</td>
<td>10</td>
<td>19</td>
<td>87</td>
<td>33.85</td>
</tr>
<tr>
<td>3</td>
<td>28</td>
<td>9</td>
<td>7</td>
<td>7</td>
<td>51</td>
<td>19.84</td>
</tr>
<tr>
<td>4</td>
<td>15</td>
<td>7</td>
<td>5</td>
<td>3</td>
<td>30</td>
<td>11.67</td>
</tr>
<tr>
<td>5</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>-</td>
<td>6</td>
<td>2.33</td>
</tr>
<tr>
<td>6</td>
<td>5</td>
<td>4</td>
<td>5</td>
<td>-</td>
<td>14</td>
<td>5.45</td>
</tr>
<tr>
<td>7</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>4</td>
<td>1.56</td>
</tr>
<tr>
<td>8</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>.78</td>
</tr>
<tr>
<td>9</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>.00</td>
</tr>
<tr>
<td>10</td>
<td>3</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>3</td>
<td>1.17</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>80</td>
<td>39</td>
<td>38</td>
<td>257</td>
<td>100.00</td>
</tr>
</tbody>
</table>
The largest percentage of patients (33.8 per cent) were members of families in which there were only two children. Sibling rivalry, resulting in a feeling of inferiority on the part of the disturbed child occurred in various degrees of severity, in many families, but appeared to be more marked where there were only 2 children. "Only" children represented the second largest group (23.4 per cent). Eighty-eight per cent of all children considered in this study came from families in which there were not more than 4 children.

Table 9 DISTRIBUTION OF CASES BY ORDINAL POSITION IN FAMILY

<table>
<thead>
<tr>
<th>Ordinal Position in Family</th>
<th>Socially Unacceptable Behaviour</th>
<th>Personality Reactions</th>
<th>Habit Disorders</th>
<th>School Disabilities</th>
<th>Total</th>
<th>p.c.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Only Child</td>
<td>24</td>
<td>19</td>
<td>8</td>
<td>9</td>
<td>60</td>
<td>23.35</td>
</tr>
<tr>
<td>Oldest</td>
<td>37</td>
<td>28</td>
<td>8</td>
<td>8</td>
<td>81</td>
<td>31.51</td>
</tr>
<tr>
<td>Middle</td>
<td>27</td>
<td>12</td>
<td>12</td>
<td>4</td>
<td>55</td>
<td>21.40</td>
</tr>
<tr>
<td>Youngest</td>
<td>12</td>
<td>21</td>
<td>11</td>
<td>17</td>
<td>61</td>
<td>23.74</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>80</td>
<td>39</td>
<td>38</td>
<td>257</td>
<td>100.00</td>
</tr>
</tbody>
</table>

With regard to ordinal position, there was a higher incidence of maladjustment in oldest children in families, 81 of the patients (31.5 per cent) being in this group. Youngest children comprised the second largest group. Sixty-one children (23.7 per cent), were in this category; while 60 (23.4 per cent) were "only" children. "Middle" children numbered 55 (21.4 per cent).

Mobility of families does not appear to be a significant factor in the emotional disturbances of children who were examined at clinics.
Twenty-three per cent of the patients were born outside of British Columbia. The population of this province has increased by over 35 per cent since 1939. Allowing for natural increase, within the province, there is no doubt that more than 23 per cent of the increase in population may be attributed to immigration from other parts of Canada and elsewhere.

In one quarter of the cases in which the patients were born outside of British Columbia, the records contained no information about the length of residence\(^{(1)}\) in this province. Table 10 shows the distribution of cases in which the length of British Columbia residence was stated.

**Table 10** DISTRIBUTION OF CASES BY LENGTH OF B.C. RESIDENCE

<table>
<thead>
<tr>
<th>Residence in British Columbia</th>
<th>Socially Unacceptable Behaviour</th>
<th>Personality Reactions</th>
<th>Habit Disorders</th>
<th>School Disabilities</th>
<th>Total</th>
<th>p.c.</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 yrs.(^*)</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>2.33</td>
</tr>
<tr>
<td>3 yrs.</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>4.65</td>
</tr>
<tr>
<td>6 yrs.</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>6</td>
<td>13.95</td>
</tr>
<tr>
<td>5 yrs.</td>
<td>7</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>11</td>
<td>25.58</td>
</tr>
<tr>
<td>4 yrs.</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>4.65</td>
</tr>
<tr>
<td>3 yrs.</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>4</td>
<td>9.30</td>
</tr>
<tr>
<td>2 yrs.</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>6.98</td>
</tr>
<tr>
<td>1 yr.</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>0</td>
<td>11</td>
<td>25.58</td>
</tr>
<tr>
<td>Less than 1 yr.</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>6.98</td>
</tr>
<tr>
<td>Total</td>
<td>24</td>
<td>9</td>
<td>6</td>
<td>4</td>
<td>43</td>
<td>100.00</td>
</tr>
</tbody>
</table>

\(^*\) Up to 10 years 11 months, and similarly for succeeding groups.

\(^{(1)}\) Used in the non-legal sense of the term.
The foregoing table shows that of the patients who had migrated to British Columbia, a high incidence of maladjustment occurred among those who had lived in the province for 5 years. There were children whose families moved to the Pacific coast during the early years of World War II. An equally high incidence was also found among patients who had resided in the province for only 1 year. These were children whose families moved to British Columbia as the war was drawing to a close, or in the first 2 post war years. Socially unacceptable behaviour as a symptom of maladjustment was found in higher proportion (56.8 per cent) among the patients born outside of the province than in the total clinical population (38.9 per cent).

Information regarding the religious denominations of the parents of clinic patients was omitted in 6 per cent of the cases, although in this matter, too, social history outlines of both clinics recommended that it be obtained. The following table compares the religious denominations of the general population with that of the parents of the clinical population.
Table 11

<table>
<thead>
<tr>
<th>RELIGIOUS DENOMINATIONS</th>
<th>Population of Vancouver according to 1941 census</th>
<th>Parents of clinical population</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>per cent</td>
<td>per cent</td>
</tr>
<tr>
<td>Protestant</td>
<td>81.67</td>
<td>86.77</td>
</tr>
<tr>
<td>Roman Catholic</td>
<td>10.92</td>
<td>5.06</td>
</tr>
<tr>
<td>Buddhist and Confucian</td>
<td>3.88</td>
<td>-</td>
</tr>
<tr>
<td>Jewish</td>
<td>.99</td>
<td>.78</td>
</tr>
<tr>
<td>Greek Orthodox</td>
<td>.64</td>
<td>1.16</td>
</tr>
<tr>
<td>Other and not stated</td>
<td>1.90</td>
<td>6.23</td>
</tr>
<tr>
<td>Total</td>
<td>100.00</td>
<td>100.00</td>
</tr>
</tbody>
</table>

1 Based on Table 17 Religious denominations of the populations of 9 cities over 90,000 - Canada Year Book 1945, p. 109.
2 Only the section of the clinical population included in this study.

Immigration laws respecting Orientals have tended to cause the British Columbia population of Asiatic origin to be predominantly adult males. This is a partial explanation for the absence of patients from families adhering to the Buddhist and Confucian religions.

Patients from Roman Catholic families comprised only 5.06 per cent of the clinical population although adherents of this religion comprised 10.92 per cent of the total population of Vancouver in 1941. Of the Roman Catholic patients examined, only one was attending a parochial school. The referral in this case was made by a non-denominational social agency which had contact with the child's family through a request of the Dependent's Allowance Board.

This showing raises the question: Why are children attending
parochial schools not referred for psychiatric examinations? One evident reason is that the services of the Mental Hygiene Division of the Metropolitan Health Committee are not available to parochial or other private schools. Although provincial and municipal funds pay the bulk of the financial costs of Metropolitan Health Services, a grant from the Vancouver School Board restricts the school health services to public schools.

At present, 2 school nurses, whose salaries are paid through Community Cest Funds, are administering to the health needs of over 4,800 children in attendance at more than 30 widely scattered parochial schools. One school dentist attends to these pupil's dental needs. There is no school medical officer. It is understandable, that under such circumstances, emotional illnesses of pupils might be overlooked.

However, the services of the provincial Child Guidance Clinic are available to those attending parochial and private schools. None of the 257 children in this study was attending a non-sectarian private school at the time of referral for examination. Both clinics examined a number of children who had attended private schools earlier.

A study of the addresses of the 257 patients revealed that the maladjusted children came from all sections of Greater Vancouver. The distribution of cases in the various areas was fairly even. School authorities and social agencies referred nearly all of the cases in the parts of the city which on the basis of Juvenile Court reports are classified as "delinquency areas".
In the preceding chapter, which dealt with the 257 cases used as a basis for this study, it was seen that some of the clinic records lacked information which might be considered essential in thorough examinations of maladjusted children. This chapter will deal with 52 cases, which are a 20 per cent sample of the total number of cases surveyed. A more detailed study of the clinic records of these 52 cases was made and reveals that other significant data, about parents, siblings and the patients themselves were also omitted. Not only will these omissions be pointed out, but an analysis of the information contained in the social histories will be made.

A clear picture of the family constellation is important in making an accurate psychiatric diagnosis of a child's illness, and of equal importance in carrying out the clinical recommendations, which frequently involve treatment of the parent-child relationship. All of the children studied in the 20 per cent sample were members of a family group. Nearly all were living with their own families. A very small number were in foster homes with substitute parents, although until at least the age of 5 years they had lived with their natural families. Although social history outlines of both clinics suggest that the age of parents should be stated, in 27 per cent of the sample cases this information was entirely omitted. In another 13 per cent the age of only one parent was stated.
The average age of the mothers of clinic patients was 37 years and 8 months, while that of the fathers was 39 years and 2 months.\(^1\)

The difference in age of parents in this sample group of the clinical population, therefore, was one and a half years. This is a good deal closer than the average situation for Canada.\(^2\)

In the group of children whose symptoms of maladjustment took the form of socially unacceptable behaviour, the differences between the age of parents were most apparent. In 43 per cent of these cases, mothers were older than fathers, the greatest difference being 11 years and the least 2 years. In another 30 per cent of these cases there was a marked difference between the age of the parents, the age of fathers exceeding that of the mothers by from 20 to 9 years.

Whereas a marked difference in the age of a husband and wife does not necessarily presuppose a detrimental effect on their adjustment, in many instances it may be significant in family difficulties. In selecting a marriage partner a woman may have a psychological need for a husband who represents to her a "father person". She may however, in developing emotional maturity later, become dissatisfied with the relationship which originally was a satisfying one. Similarly, a man may outgrow his need for a wife who during the earlier years of marriage had fulfilled a maternal role in his life. The dissatisfaction with marriage and resultant tensions from such situations may occur even when there is little

\(^1\)Based on cases in which this information was available.

\(^2\)The average age of fathers of legitimate children is about 4 years greater than the average age of mothers. Canada Year Book, 1947, p.156.
or no difference in the chronological age of marriage partners. However, this is found much more frequently where there is a marked difference in the age of spouses.

Information about the formal education of parents was entirely lacking in 29 per cent of the sample cases. In 15 per cent of these cases the education of only one parent was stated. The education of both mothers and fathers ranged from grade 3 to post graduate work in university. On the basis of those cases in which information was available, fathers of patients had a slightly higher degree of education than mothers. The average education of fathers was grade 9.8, while that of mothers was grade 9. The following table shows the average education of parents of children of each of the four classifications of symptoms.

Table 12

<table>
<thead>
<tr>
<th>Children's Symptoms</th>
<th>Mothers (Grade)</th>
<th>Fathers (Grade)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Socially Unacceptable Behaviour</td>
<td>8.4</td>
<td>9.5</td>
</tr>
<tr>
<td>Personality Reactions</td>
<td>10</td>
<td>10.5</td>
</tr>
<tr>
<td>Habit Disorders</td>
<td>8</td>
<td>8.4</td>
</tr>
<tr>
<td>Special School Disabilities</td>
<td>9.6</td>
<td>10.2</td>
</tr>
</tbody>
</table>

From the foregoing table it will be seen that parents of children whose maladjustments were classified as "personality reactions" had more formal education than those of children who were examined because of "socially unacceptable behaviour", "habit disorders", or "special school disabilities". The parents who had the second highest degree of edu-
ation, were those of children who had "special school disabilities".

Information about the occupations of the fathers of clinic patients was contained in 92.3 per cent of the social histories. Of the fathers whose occupations were stated, five-sixths were unskilled, semi-skilled and skilled labourers. The other one-sixth were professional and business men. The actual earning capacity of the fathers was stated in only 11.5 per cent of the cases.

The former or present occupations of mothers of clinic patients was stated in less than half (42.4 per cent) of the social histories. Twenty-five per cent of the mothers whose occupations were stated, had been engaged in clerical work previous to marriage while 8.3 per cent had been members of professions. The remaining 66.7 per cent had been employed at unskilled and semi-skilled labour.

In 9.6 per cent of the sample cases mothers were engaged in work outside of the home at the time of patient's referral for clinical examination. More than half of these mothers were working because they were separated from their husbands by divorce or desertion. The other mothers were working to supplement the low incomes of their husbands.

There were many omissions in the social histories with regard to health of parents. The Mental Hygiene Clinic outline does not specifically request this information but there are headings under which it might be included. In 28.8 per cent of the sample cases, there was no mention of the mother's health, while in 59.5 per cent of the cases this information about fathers was omitted. In 17.3 per cent of the cases mother's health was stated to be "good" or "excellent". In a slightly
higher percentage of cases (19.2) the health of fathers was described in the same terms.

In the 53.9 per cent of cases in which illness of mothers was reported, tuberculosis was most prevalent. Other illnesses of mothers listed were: arthritis, asthma, varicose veins, mental depression, neurodermatitis, hysteria, rheumatic fever, cardiac condition and venereal disease.

In the 21.3 per cent of cases in which there were reports of poor health of fathers, arthritis was most prevalent. Other reported illnesses of fathers were schizophrenia, psychoneurosis, ulcers, defective vision, stomach disorder, hemorrhoids and venereal disease.

Besides the diagnosed mental illnesses mentioned above, in 25 per cent of the sample cases, mothers were described in terms which indicated varying degrees of mental disturbance. Such terms as "unstable", "inadequate", "extremely tense", "immature", were used in these social histories. In 19.2 per cent of the cases fathers were described in similar terms. Half of these fathers used alcohol to excess. Several were chronic gamblers.

The social history outline in use for Child Guidance Clinic examinations suggests that information about habits and social behaviour of parents should be obtained. Presumably this would include at least some description of the interests and recreation of parents. However, in the sample cases, there was no information on this subject for 80.6 per cent of the mothers, and 69.1 per cent of the fathers. Social histories indicated that 7.7 per cent of the mothers and 5.8 per cent of the
fathers had no interests or recreation outside of their work.

"Problem" children frequently have "problem" parents. Dr. M. Levine, Professor of Psychiatry at the University of Cincinnati College of Medicine, describes five types of problem parents as follows: (1)

1. The perfectionist parent, whose own neurotic need to be perfect causes insecurity in a child by over-emphasis on prestige and success.
2. The antagonistic or rejecting parent, who arouses fear and insecurity in a child. Such rejection may be concealed under the guise of over-solicitousness, over-protectiveness, and "smother-love".
3. The over-indulgent parent, whose child faces inevitable frustration.
4. The dominating parent, whose attitudes may lead to undue submissions or undue rebelliousness in a child.
5. The identifying parent, who acts as if the child is still a part of her body, making it difficult for the child to learn independence.

Numerous examples of each of these five types of "problem" parents were found in the sample cases. In many instances, social histories indicated the nature of parental attitudes toward the patients. In others, this information was found in the psychiatrist's interview or in the conference notes.

Rejection, with varying degrees of ambivalence, (the combination of the opposing emotions of love and hate) was the most frequently noted negative attitude of both mothers and fathers. Mothers who were "over-protective" were as numerous as those whose rejection was more obvious.

More fathers were "over-indulgent" in their attitudes toward children than were the mothers. On the other hand more fathers tended to dominate their children. "Perfectionist" parents of both sexes were found. There were a few instances of "identifying" mothers. In some cases, one parent was extremely rejecting of the patient, while the other parent was over-indulgent. In other instances, one parent's attitude toward the patient was a positive one while that of the other parent was a detrimental one. In some cases, of course, the attitudes of both parents appeared to be favourable.

Negative parental attitudes such as those described above have their basis in the personalities of parents, which in turn are the result of parents' own heredity and environment. In a later chapter it will be seen that in both clinics the recommendations for treatment are largely in the nature of environmental manipulation. Frequently the most needed adjustment in a patient's environment is that of a changed attitude on the part of one or both parents. It will be difficult, if not impossible, for this public health nurse or the social worker who is responsible for follow-up work to help parents effect this change, if she herself has no knowledge of the etiology of their present attitudes.

The Child Guidance Clinic social history outline suggests that information about paternal and maternal relatives should be included in the family history. In one-third of the social histories of children examined at Child Guidance Clinic, clear pictures of family backgrounds shed considerable light on the reasons for parents being the kinds of persons they were. In the other two-thirds of the cases there were
varying degrees of information of this kind.

In marked contrast to this, in only one-quarter of the Mental Hygiene Clinic social histories was there information about the parents' family backgrounds. A small number of these were fairly detailed. In the remaining three quarters of the Mental Hygiene Clinic cases, no information whatever was available about factors which might account for the parents' personality traits. Another important aspect in the study of families is that of interpersonal relationships between patients and their brothers and sisters. Other than data on age and education, information about siblings was lacking in more than half of the social histories.

While all of the social histories of Child Guidance Clinic patients in this sample of cases were prepared by social workers, only 17 per cent of the Mental Hygiene Clinic cases were prepared by members of this profession. Public Health nurses were responsible for the preparation of the remaining 83 per cent of the social histories of the Mental Hygiene Clinic patients.

A partial explanation of the difference in this matter between the social histories prepared by social workers and those prepared by public health nurses may be that more emphasis is placed on family history in the Child Guidance Clinic outline. The work of the Mental Hygiene Clinic according to its stated policy "is to be considered a field of prevention rather than treatment", and "cases found to require repeated treatment sessions are referred to a private physician, Child Guidance

(1) The Case of Tom Z. described in Chapter 5, illustrates this lack of background information about parents.
Clinic, etc., following study by the Mental Hygiene Clinic." This may, in part, account for the less detailed social history outline of the Mental Hygiene Clinic. However, in actual practice, this clinic has assumed a treatment role greater than was evidently anticipated at the time the above-quoted policy was formulated.\(^{(1)}\) It would appear, therefore, that the social history outline of the Mental Hygiene Clinic should be extended in order to serve more adequately its expanding functions.

Another explanation for the greater emphasis on family background on the part of the social workers, is that by nature of their training, they are more aware of the meaning of behaviour and the importance of intrafamilial relationships in the development of personality. The acquiring of skill in the science and art of interviewing is also an important part of the training of social workers.

A good social history, whether prepared by a social worker or a public health nurse should aid members of the clinic team to see the child from his earliest life up to the present time. "The social case history supplies to the clinic staff a revealing story of the child in his social setting. The plot centres around his difficulties, which often come about through friction between his growth process and the demands of his environment. It is evident that whatever affects this

\(^{(1)}\) No cases studied in the 20 per cent sample were referred to the Child Guidance Clinic by the Mental Hygiene Clinic, although in a number of instances children who had been examined by the latter became patients of the Child Guidance Clinic when referred by their parents or social agencies.
growth process or the environment is of significance in the story."(1)

The eliciting of an accurate medical history has been described as demanding "care, courtesy, time and patience". (2) This is particularly applicable in preparing a social history, where informants may have feelings of resentment, suspicion, apprehension, or guilt. Care, courtesy, time and patience are required if parents are to be expected to give an accurate picture, as they see it, of the child in the family constellation. Parents, in giving information about the child, often indirectly give much information about themselves. A skilled interviewer learns to obtain and utilize this material. On her ability to assess parental attitudes depends much of the success of the treatment plans which follow the clinical examination of the child.

The social worker or the public health nurse is in most cases, the person who helps parents in the carrying out of the clinic recommendations. Gordon Hamilton in her recent book *Psychotherapy in Child Guidance* calls the parent the social worker's "partner in treatment". (3) With this in mind, it behooves the interviewer, whether social worker or public health nurse, to aim toward establishing rapport between herself and the parent during their first contact. Not only will this promote a


good working relationship in the carrying out of treatment plans, but it
will also insure a more complete social history. There will be less with­
holding of information if the interviewer can help the parent realize that
her opinions are respected, and that her relation to the clinic will be
a participating one, a joint attempt to work out a clearer understanding
of the problem.

When a child is referred to clinic by a social agency, the
school or the court, there is particular need to help the parent as well
as the patient, to understand that the purpose of the clinic is to con­
sult with her and help her in the care of her child. The interviewer,
will have difficulty in establishing rapport if she lacks time and is
over-anxious about obtaining in one interview, all of the information
suggested by the social history outline.

Frequently parents are so concerned with the immediate situation
which has arisen that they emphasize present symptoms rather than earlier
ones and give no consideration to an underlying cause. Such parents have
not thought in terms of a gradual process culminating in a group of
symptoms. An opportunity to talk about the symptoms often has therapeutic
value for these parents. At the same time the public health nurse or
social worker may glean significant facts about both parents and patients.

Gordon Hamilton in her previously quoted study, writes thus on
this subject:

"The history tells when some deviation started, and
knowing when it started, and under what circumstances
we are in a better position to know what it is today.
The history seeks knowledge of the past because it is
a part of the present structure."
One can only treat "current" personality in its present circumstances, but one can understand the person best by knowing when deviations and fixations occurred and what were the traumatic incidents which are now scars and to which he is still reacting. It is the inappropriate persistence of the past into the present which largely occasions treatment."

A clear picture of the onset and development of the child's difficulties as well as the precipitating cause of his coming for the clinic's help is an important part of a social history. Skilful interviewing is necessary in order to obtain this information. It may be necessary for the person preparing the history to direct the interview toward discussion of earlier symptoms. In 15.4 per cent of the sample cases, there was a complete lack of information about the onset and development of the patients' difficulties. In 46.1 per cent of the cases social histories gave some information on this subject, while in the remaining 38.5 per cent a clear, detailed description was given.

Certainly "care, courtesy and patience" are required in order to gain the cooperation of parents so that they will unfold the detailed picture of their child's development from birth to the time of the clinical examination. Parents may need help in understanding the significance of the questions put to them before they are prepared or able to give a valuable account of their child's personal history.

In giving this information parents may gain some understanding of the strains and stresses which have contributed to the creation of the patient's maladjustment. Parents may, for the first time, look at

the total picture of their various methods of attempting a solution of the difficulty and arrive at some evaluation of these methods. At the same time the interviewer may gain information as to whether parental discipline has, on the whole, been sound and rational, or whether it has been harsh, unreasonable, inconsistent or weak.

Ideally, parents should be given some opportunity to talk about their child's problem soon after a referral is made for clinical examination. This is equally important whether parents have taken the initial step in seeking the clinic's help, or the school, court or a social agency have made the referral. In actual practice, at Child Guidance Clinic particularly, there is frequently a delay of one or two months between the referral and the first interview.

Such delay, although unavoidable, often exposes the patient to parents' frenzied search for other methods of dealing with the problem. An enuretic child who has already received corporal punishment, disapproval and ridicule may be forced to launder his own linen, eat salty sandwiches or to endure some other ineffectual or harmful "remedy". The large caseloads and manifold duties of social workers and public health nurses appear to be one of the chief reasons for this delay. Another reason is that with the existing clinical facilities, appointments for examination are frequently filled for several months in advance.

In 28.8 per cent of the social histories information was given about birth, feeding, weaning, toilet training, walking, talking, and teething. In 34.6 per cent of the cases, social histories gave fairly detailed information about most of these factors. Information was very
meagre in 13.5 per cent of the social histories. In some of these cases, mothers stated that they could not remember details of the child's early life. In 23.1 per cent of the cases, no early developmental information was given. In a number of the social histories in this group the whole subject of developmental history was summed up in two words, "apparently normal".

Social histories which lack information in whole or in part of the early development of patients necessitate the examining psychiatrist devoting a portion of his interviews to this subject. In many instances significant factors such as feeding difficulties, sudden weaning, early and rigid toilet training were revealed to the psychiatrist.

In nearly all of the sample cases, the medical histories of patients were carefully written. The majority of the patients had had one or more serious illnesses. Over one-third (34.6 per cent) had undergone tonsil and adenoid operations. Several of these children had this operation twice. A small number of patients had had appendectomy and mastoidectomy operations. Over 12 per cent of the children had suffered fractured limbs. The age at which a child is hospitalized for an operation, his psychological preparation for it, and his reaction to it, are of importance in a social history. In over half of the histories one or more of these items of information were omitted.

Pneumonia and bronchitis were reported in 15.4 per cent of the cases. Other severe illnesses mentioned in histories were rheumatic fever, eczema, nephritis and rickets. In nearly all cases children had had one or more communicable diseases. A number of children appeared to
be "accident prone".

The health history of Tim J., although somewhat extreme, will be quoted in Chapter 5, because it illustrates the inter-relationship between physical and emotional factors.

Another essential topic in the thorough study of clinic patients is that of formal education. The age at which these children entered school, their attitudes toward this new experience, their punctuality and attendance, their special interests, their difficult subjects as well as their academic achievements may be of significance in the clinical diagnosis and subsequent treatment plans. Both clinics, recognizing the importance of this aspect of children's lives request considerable detail in the educational histories of patients.

In the Mental Hygiene Clinic a separate report, designated as the school history is prepared by the teacher and school principal jointly, or by either of them separately. On the whole, the school reports of the Mental Hygiene Clinic cases gave a clearer picture of the patients as pupils than did the education section of the social histories of the children examined at the Child Guidance Clinic.

Another advantage of the use of the school report at the Mental Hygiene Clinic is that in many instances, teachers' attitudes toward "problem" pupils are evident. In the sample cases these attitudes ranged from the positive "He's an unhappy maladjusted child. Why? What can we do to help him". to the negative "She's a thief. I can prove it." In one case, a school principal's report (four type written pages in length) was devoted entirely to giving evidence in police court fashion, of a
Information about the school's attitude toward patients was given less frequently in Child Guidance Clinic cases. However, in this clinic's social histories, the parents' attitudes toward the school and toward their children's academic progress or lack of it were more clearly delineated, than in Mental Hygiene Clinic cases. The marked tendency to omit such information in the school clinic's social histories may be attributed, in part, to the absence of any specific reference to school in the outline.

Table 13 is a summary of the school histories of the sample cases in both clinics and shows that the percentage of patients whose school records were good was only slightly higher than the percentage who had failed in one or more grades.

Table 13

<table>
<thead>
<tr>
<th>School Record</th>
<th>p.c.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent</td>
<td>3.85</td>
</tr>
<tr>
<td>Good</td>
<td>26.92</td>
</tr>
<tr>
<td>Fair</td>
<td>17.31</td>
</tr>
<tr>
<td>Poor</td>
<td>21.15</td>
</tr>
<tr>
<td>Failed in one or more grades</td>
<td>23.07</td>
</tr>
<tr>
<td>No report</td>
<td>3.85</td>
</tr>
<tr>
<td>Not in school</td>
<td>3.85</td>
</tr>
<tr>
<td>Total</td>
<td>100.00</td>
</tr>
</tbody>
</table>
This summary also indicates that less than one-third of the patients who were in school were making satisfactory academic progress.

Although there was a wide range in the quality of the descriptions, all of the social histories in this sample gave some account of the patient's current personality traits. In some instances it appeared that the persons preparing the history had had little or no direct contact with the patients. Those histories which included the interviewers' own observations of the patients as well as the statements made by parents and others, contained more distinct portrayals of the children as persons.

Interests and forms of recreation are significant in the study of maladjusted children. In the choice of recreation each individual seeks to satisfy some inner need. S.R. Slavson, a recognized authority on group therapy, describes play in the following terms:

"To the child, play is of utmost importance, for it is through his play that he learns the world. Play is the means whereby the child in fantasy, comes to know reality. The child scales down the world around him to simpler patterns that he can understand and master, gaining greater security and acquiring power as he does it. The adult world is to the small child threatening and forbidding, and in play he reduces its complexity to the level of his powers and understanding. As he grows and is able to deal with this world, his play activities gradually fuse with reality, until the latter becomes predominant. Through play, also, the child diverts his aggressions, which are part and parcel of his biological heritage. Instead of attacking someone, he bangs an object or throws a ball. This draining (sublimation) of basic aggressiveness is of extreme importance in socializing him. Where there are no sublimations or substitutions, the child antagonizes other children and adults; and as a result of their rejection and punishment, he grows resentful and maladjusted."(1)

In less than two-thirds (63.46 per cent) of the social histories mention was made of the patients' interests and recreation. Very few of the histories outlined the opportunities for the pursuit of interests or for play, provided in the patient's environment.

On the subject of group adjustment, (socialization in situations involving other children) there was more adequate coverage by the social histories. In 9.6 per cent of the cases, however, no reference was made to this important aspect of development. The summary of the reports on this topic indicates that group adjustment was "poor" in 63.8 per cent of the cases, "fair" in 27.7 per cent and "good" in 8.5 per cent. In other words, in the cases in which group adjustment was described, at least 9 out of every 10 children had some difficulty in this area, and that for more than 6 out of 10 the difficulty was marked.

The conclusion reached, through this study of social histories is that in many instances there was inadequate information about both the past and present aspects of the patient's development. More information about the child himself should be available, and in order that the social and cultural atmosphere in which he is being reared may be considered in relation to his problem, social histories should contain information about the parents' nationality, religion, age, education, intelligence, occupation and earning capacity, habits, attitudes toward family and patient. Past and present physical and mental health of parents may also have an important bearing on the patient's development and should be assessed if possible. The patient's brothers and sisters should also be described, particularly with regard to their attitudes toward him.
CHAPTER 5.

SOCIALLY UNACCEPTABLE BEHAVIOUR

One hundred of the 257 children given psychiatric examinations were referred because of socially unacceptable behaviour. This number represents almost 39 per cent of the total number of cases. The highest incidence, (22 per cent), of this type of problem occurred in the 7 to 8 year old group. The second highest number of cases, (20 per cent), occurred in the 11 to 12 year old group. The other age groups are represented in decreasing order as follows: 9 to 10 years - 18 per cent; 8 to 9 years - 17 per cent; 10 to 11 years - 13 per cent; and 6 to 7 years - 10 per cent.

The 7 to 8 year old boys and girls whose behaviour was socially unacceptable represented 46.8 per cent of all the children of this age examined. The 11 to 12 year old children in this group comprised 51.28 per cent of all patients of this age.

"Only" children represented 24 per cent of the clinic patients showing socially unacceptable behaviour. Patients from families of 2 children comprised 21 per cent of the cases in this classification of symptoms, while those from families of 3 children represented 28 per cent. In summary, more than seven out of every 10 boys and girls who were referred to clinic because their behaviour was socially unacceptable came from families in which there were not more than 3 children. Larger families were represented in this group of patients as follows: 4 children - 15 per cent, 5 children - 1 per cent, 6 children - 5 per cent,
7 - 2 per cent, 8 - 1 per cent, 10 - 3 per cent. In the matter of patients' ordinal positions in families, "oldest" children comprised the largest group (34 per cent) "middle" children comprised the second largest (27 per cent), "only" children the third largest, (24 per cent) and "youngest" children the smallest group (12 per cent).

In 40 per cent of the cases in this group there was evidence of family disorganization. The single factor most prevalent, divorce, was present in 11 per cent of the cases. Marked discord between parents was noted in 7 per cent, father deceased in 6 per cent, and desertion by one parent in 6 per cent of the cases. Other circumstances, such as separation and parents in mental hospital were less frequent.

In 45 per cent of the cases in this group there were factors contributing to maladjustment of children other than those which constitute "broken families". These unfavourable circumstances, in decreasing order of incidence were: interference by grandparents and other relatives living in the home (18 per cent), poor or very crowded housing (16 per cent) and fathers' absence while serving in the Armed Forces (11 per cent).

Findings based on the 20 per cent sample of cases.

Judging from the sample of cases showing symptoms in the form of socially unacceptable behaviour, 6 out of every 10 children had difficulty in their group adjustment. Some of these children refused to

(1) Table 6, p. 40.
(2) Table 7, p. 41.
(3) The information in the remainder of this chapter, and corresponding sections in subsequent chapters is based on the total clinic study of each case, and not as in Chapter 4, solely on the social history.
participate in group activities if they were not "captains" or "leaders". Others had few friends because of their aggressive behaviour.

Ralph, (1) (aged 8 years 11 months) was completely ostracized by children in the neighbourhood because his violent temper tantrums at home and on the street (he struck and bit his parents, broke windows, swore profusely, etc.,) had gained for him the reputation of being "a holy terror".

Some of these patients preferred playing with children much older or much younger than themselves. A brief sketch of one boy's attempts to find satisfactions in his relationships with others follows.

George, who was examined when 11 years 11 months of age was referred to the clinic by the Juvenile Court. The boy had been involved in theft several times. At school he was unpopular with children of his own age. Classmates considered him "a cheat and a tattle-tale". For some time George had relied on younger children for companionship, but this brought more ridicule from his own age group. He turned later to teen-aged boys but was rebuffed by them. In his search for recreation and friendship George found transitory satisfaction in his association with a vaudeville group. He was used as an hypnotic subject (faked) by M----, the Magician.

A girl whose chief symptom of emotional disturbance was stealing, had increasing difficulty in her group adjustment while the underlying causes of her maladjustment remained untouched. Her efforts toward group adjustment are outlined below.

Dorothy, an 11 year old girl, referred for examination because of repeated thefts over a period of more than 3 years, was called "robber" by her classmates. She was "polite and well liked by adults", but had no friends of her own age. Frequently, with stolen money, she bought things to share with other children, and so the vicious circle continued. She liked to play "cops and robbers", and football with the boys in the neighbourhood. On rare occasions when the boys accepted her in their games, Dorothy was subjected to further rejection by girls of her own age, who called her "tomboy".

(1) All names, of course, are fictitious.
In the case of Dick, described below, the boy's poor group adjustment was obviously a reflection of the treatment he himself had received in his home.

Dick was nine and a half years of age when he was referred for clinical examination. His symptoms were "bullying, lying, firesetting, stealing and negativism". In school, Dick's attitude to authority was unsatisfactory. He was described as "only reacting to force". Dick was the seventh child in a family of 10 children. He had 5 older brothers. Dick's father was "arbitrary and rigid" in his attitude toward his wife and children. The older boys, four of whom had had "some contact with an underworld crowd", imitated their father. They dominated younger members of the family, particularly Dick. Dick played only with children young enough or small enough for him to bully. He said that he had "a devil inside", which made him cruel and disobedient.

In 34 per cent of the sample cases of children whose behaviour was socially unacceptable, patients' school reports indicated that they were not making satisfactory progress in their academic work. Compared with the three other classifications of symptoms, children in this group had the least difficulty in meeting with the school's standards.

Ralph, was repeating Grade 3 when he was examined by the school clinic. His symptoms at that time were "swearing, poor application at school, poor group adjustment and poor control of temper". Frequently he refused to attend school. In the group test given by the Bureau of Measurements, Ralph's intelligence quotient was 109.

Five months later Ralph became so unmanageable at home that the parents sought help from the Child Guidance Clinic. On an individual test at this clinic, Ralph's intelligence quotient was rated as 121.

However, in all of the other cases in which school progress was unsatisfactory, the children in question had "low average" or "average" intelligence.

Sibling rivalry was apparent in 70 per cent of the sample cases. In some instances this seemed to be closely related to the mother's
rejection of children of an earlier marriage. An illustration will be given.

Marlene was referred to Child Guidance Clinic at the age of 6 years by her mother on the advice of the family doctor. The little girl was "disobedient, slapped back threatened to run away, and cruel to her half-brother". To the mother the child was a reminder of her first husband whom she had divorced. (This had been the father's fourth marriage). Each unfavourable trait of the child's personality was said by the mother to be "just like her father".

The mother's second marriage was a satisfying relationship for her. The child of this marriage, 3 years younger than the patient, was preferred by the mother. She realized that Marlene's behaviour antagonized the step-father and feared that her marriage was being jeopardized by the presence of the little girl in the home. Marlene felt insecure in this situation, and openly showed her resentment of the step-brother who received so much of her mother's affection.

In several other cases, parents openly promoted sibling rivalry by such remarks as: "Wait till your brother starts to school. He'll get out of Grade 3 before you do." (to a girl who had just failed in Grade 3). "Girls are so much easier to bring up. I was very disappointed when Jack was born. I had hoped for a girl. It was a happy day when Angela came" (said in the presence of Jack, whose resentment of his younger sister was marked.)

In one half of the sample cases, one or more siblings of patients showed some form of maladjustment. This is more marked than in any of the three other classifications of symptoms.

One mother, a widow with 4 sons, requested clinical examination for Mike, her third child, who was truanting from school and stealing. She had found the clinic helpful when her oldest son had been examined 4 years before. The symptoms shown by the first boy had been "nightmares, facial tics, inability to make friends".
Norman (aged 10 years) was referred for examination by the Juvenile Court because of "breaking and entering and petty thievery" had one sister who was an unmarried mother, and another sister who had been a "pickpocket" and a truant.

Dick (previously mentioned with regard to group adjustment) had 4 older brothers who were not able to make satisfactory work adjustment. They tried to "make an easy living" by contact with "an underworld crowd".

Arthur, an 11 year old boy examined at the request of the Juvenile Court, because of his stealing had a sister who had spent a year in a Girl's Industrial School on a charge of sexual immorality.

Leslie, a boy (aged 10 years and 8 months), was said by his mother to be incorrigible. His symptoms were stealing and truancy. This boy's sister (10 years older) became an unmarried mother at the age of 16, became involved with youthful criminals of both sexes, and later was imprisoned because of drug addiction.

In 80 per cent of the sample cases in this classification of symptoms, patients had experienced unfavourable circumstances in the period between birth and the end of their second year. This is a higher percentage than was found in any of the other three classifications of symptoms. The cases of Ralph and Bill will illustrate some of the kinds of unsatisfactory circumstances described in the clinic records.

Ralph, (previously mentioned) was cared for part of the time during infancy by his elderly paternal grandmother who had lived with his parents from the time of their marriage. There was considerable tension in the home. The child's father was not a well adjusted person. He said that he had had several "nervous breakdowns". He had always been dominated by his mother who was showing signs of senility before Ralph was born. The father was not able to help his wife withstand the domination of her mother-in-law. The baby had "cradle cap" during the first 6 months of his life. His hands were frequently tied to keep them away from his head. When Ralph was 5 months old, the mother became pregnant, and was at times very ill during the pregnancy. The second child died shortly after birth. Soon after this the mother worked in an office half-days, leaving Ralph with his grandmother.
Bill, the product of a forced marriage, was deserted by his father shortly after birth. The mother left the baby with relatives during the day while she worked. The baby's legs were "weak and crooked". He had difficulty in learning to walk, and was under a doctor's care for several months. Meanwhile, the father's infrequent visits were occasions of bitter quarrels between the child's parents. They obtained a divorce before the little boy was 3 years old.

In other cases one or both parents were disappointed because the child was not of the sex they had hoped for. In some instances parents said that children were not wanted because of poor financial circumstances, poor health of parents, crowded housing and other similar reasons.

Sudden weaning, nutritional deficiencies, early and rigid toilet training, over-concern about thumb-sucking and masturbation, and illnesses such as bronchitis, whooping cough and eczema during the first 3 years were noted in other cases.

Negative factors such as some of those described above were present in 85 per cent of the sample cases in the period of patients' lives from 3 to 6 years. Severe illnesses, falls resulting in fractures or concussion, tonsil, adenoid and mastoid operations, or frights, were also experienced by some of the children during this period. For some children the birth of a sibling at this time appeared to be a threat to their security.

In 35 per cent of the sample cases of children whose behaviour was socially unacceptable, there was evidence of harsh or rigid parental discipline. For example, the case of Margaret, (aged 8½) will be described.
This child lived in a good residential district. She was the eldest child in a family of 3 children. A children's agency received several complaints from neighbours that the mother was whipping the child severely. The mother frankly admitted that the reports were true. She told of Margaret's temper tantrums and fluctuating behaviour and readily accepted the agency's offer of clinical examination for the child. In the course of the study of this child it was learned that the mother had used this method of punishment for several years.

Another mother, said that her daughter, (aged 11 years 10 months) was incorrigible. A study of the case (also referred by a children's agency) revealed that the mother, a hard-working embittered woman was in need of psychiatric help for herself and that the girl's adjustment was fairly good.

The mother had a deep-seated hatred of the girl (her first child); she tried to keep her daughter busy with household duties and homework, refusing to let the girl go to friends' homes or have friends visit her. When the girl rebelled at this injustice she was beaten, verbally reprimanded in a destructive manner, and threatened with police, industrial school, etc.

Earlier in this chapter it was pointed out that the highest incidence of patients showing socially unacceptable behaviour occurred in the 7 to 8 year old group. The case of Peter G. aged 7 years 9 months is one in which the diagnostic and consultative services of the Child Guidance Clinic were used by a social worker in a family agency.

Peter was brought to Child Guidance Clinic when his mother expressed concern to a social worker in a family agency about his defiance, disobedience and "whining". The social worker in this agency, to which the mother had gone for help with a marital problem, prepared the social history.

Peter's home was a small, crowded, dirty apartment, but in a good neighbourhood. His father, aged 35 years, had had Normal School training, but at the time Peter was examined, aspired to a position of public accountant in the U.S.A. and was trying to get American citizenship papers. The mother, on
the other hand, had refused to sign the necessary form for citizenship papers. The father seldom lived with his family but when he did come home, Peter was witness to bitter quarrels between his parents. The father wanted a divorce, but the mother flatly opposed it. Peter remembered clearly that his father had gone away for quite a while before his baby brother was born. Perhaps Peter remembered too that his father had left the family for a long time before the birth of his sister when the little boy was only 4 years old.

Peter's mother was 2 years older than his father. She had finished Grade 8, and had later become a clerk in a small store. Peter was Mrs. G.'s first child, and she said that she had wanted a baby very much. She told of her illness during pregnancy, of the severe nausea which was followed by extreme hunger. Her husband was described as "unsympathetic" during this period. Family finances had never been very good, but they were particularly bad at that time, and often there was no food in the house when the mother felt like eating.

Mrs. G. had breast-fed Peter for only 2 weeks. She changed to bottle-feedings when the baby seemed to be "always hungry". The story of when and how he was weaned from the bottle wasn't told but the mother did say that Peter had been a "problem" ever since he was 3 years old. He was "slow" in learning toilet training, and mother was not very successful with this until Peter was over 3½ years old. A few months before the little boy was examined at Child Guidance Clinic, he had begun soiling under the bed. Mother thought that this was sheer "spitefulness". The soiling continued.

Besides Mother, sister, brother, and Father, who came and left again, there was also a maternal grandmother living in the small, crowded dirty apartment with Peter. Grandmother said that her husband, living in Manitoba, was a successful business man. She did not say why she was not living with him. In grandmother's eyes Peter was a bad little boy. Everything he did was "wrong". Her chief complaint was "He has no more manners than an animal". He threw things at her, and once had threatened her with a knife.

The social worker in the family agency was not the first person who had tried to help Peter. When the little boy had failed in Grade 1 his teacher and the school principal had conferred about him and decided that "special class" might offer this pupil better opportunities. They had reached this decision after taking into consideration the boy's score
on a group intelligence test.

The special class teacher reported that Peter was not a "problem" in school, and that he seemed happier than when he was in the regular Grade 1. Mrs. G. said that she had to "force him to go to school every day" though.

Although Peter was defiant and at times sullen with his mother, he always "sided fiercely" with her against his father during the parents' frequent quarrels. The father thought that there was "nothing wrong with the boy except his mother's spoiling". The boy had had severe bronchitis 4 months before he came to Child Guidance Clinic. This had recurred frequently; in fact, it had not really "cleared up" during the 4 months.

The physical, psychiatric, and psychological examinations as well as the nurse's observations of Peter in playroom with his mother all revealed that the boy was immature and anxious. He was frail and looked undernourished. Peter tested in the low average group of general intelligence. His I.Q. was 87. The mother was emotional and inconsistent in her handling of him.

At the conference which followed Peter's examination at Child Guidance Clinic, case work with mother was recommended. Peter needed more security and more consistent handling. Eventual foster home placement seemed indicated, and it was recommended that another conference should be held in 2 months, with a representative of a children's agency present unless there was an improvement in the family situation.

The second conference (consultative), was held and a social worker from a children's agency was present. The family agency's supplementary history covered the 2 month interval, between the conferences and was as follows:

Peter had been in hospital twice during the 2 months. Each time he had had severe bronchitis. He seemed to enjoy being in hospital. His grandmother had said that the little boy "did not get proper rest". He was frequently up until 11 p.m. There had been constant quarrelling whenever father returned to the home. Peter's mother became "upset and hysterical" after each of father's visits. Grandmother complained that she was ill and wanted to leave British Columbia.
The family agency worker reported that she had been unable to help the family to any extent. Both Mr. and Mrs. G. had engaged lawyers. Besides, Mrs. G., who was an ardent member of a religious sect was getting additional advice from the church president.

Child Guidance Clinic recommendations at the second conference were "(1) Try admission to Solarium (2) If this cannot be arranged, the possibility of Peter going to live with his aunt in Saskatchewan should be explored (3) Foster home placement of 1 year or longer, since the mother seems unlikely to respond to case work."

That this little boy, caught in the maelstrom of parental immaturity and discord, should become maladjusted is not surprising. The social work implications in this case are numerous. Perhaps the outstanding one is the limitations of a social agency when the problem has existed for many years before it is referred. Had the family agency been brought into the picture at an earlier phase of the marital difficulty the outcome for parents might have been more favourable. Peter and his siblings might have had a richer soil of healthy family life in which to take roots and grow. If the problem had been detected and referred to the family agency during Mrs. G.'s pregnancy or confinement it is highly probable that the personality strengths of each parent might have been released and utilized.

Another time at which the problem might well have been detected was during attendance at Well Baby Clinics. Later, but still before the difficulty had reached the serious proportions described, a teacher in a nursery school or kindergarten might have noticed that Peter was unhappy. Through discussion with the mother, the teacher could have directed her to a source of help. In Grade 1, a public health nurse, or school social worker, making a thorough investigation of the reason for the boy's lack
of progress, might have considered placement in a special class a necessary, but only partial, solution of his problem.

When the family agency arranged to have Peter re-examined at Child Guidance Clinic 1 year and 4 months after the conference, the value of continued case work with the G. family was apparent.

Following the second conference at Child Guidance Clinic, the social worker had suggested that Mrs. G. should discuss with the family doctor the possibility of Peter's admission to the Solarium. Mrs. G. readily accepted this suggestion. The doctor examined Peter again and made a diagnosis of bronchial asthma, but did not consider the little boy eligible for care in the Solarium. The mother carefully administered the medication which the doctor prescribed, and the improvement in Peter's physical health was encouraging to her. Mrs. G. told the social worker about Peter's increasing appetite. Later she told that he was sleeping well. There were discussions between the mother and the social worker about consistency in dealing with Peter and his siblings.

The grandmother left the G. home. The mother gradually faced the reality of her husband's loss of interest in her and in the children. She obtained a judicial separation from Mr. G. and he was required to pay a substantial sum of money each month for the support of his wife and family. With less anxiety about family finances (Mrs. G. had been totally dependent on her parents for support for 2 years before) the mother's own health improved and her ability to care for her children increased. Mrs. G. no longer became upset when her husband urged her to consent to a divorce. She was even able to face the same suggestion frequently from the young woman Mr. G. wished to marry.

Mrs. G. discussed her children's problems with the social worker as they became apparent to her. She was able to accept the case worker's explanation that her small daughter's masturbation indicated a need for greater security rather than punishment. When the family doctor told her that her youngest child needed a serious operation urgently, Mrs. G. discussed with the social worker her unwillingness to increase her already large debt to the doctor. The social worker, utilizing her knowledge of community resources, told the mother about the out-patients' department of the Vancouver General Hospital. As a result of this, arrangements were made for the necessary operation, the postponement of which might have had serious effects on the little boy's health.
Peter's second examination at Child Guidance Clinic revealed that his physical health had improved a great deal. His emotional adjustment showed even greater improvement. The examining psychiatrist noted that Mrs. G. was less anxious and less worried about the future than at the time of her first interview at Child Guidance Clinic. She showed improved health and her whole attitude toward her family was better. The psychiatrist advised that although marked progress had been made, the mother needed continued contact with the family agency.

Much of the progress in this case may be attributed to the fact that throughout a difficult 2 year period, Mrs. G. had a continued supportive relationship with one well-trained and experienced social worker. This non-judgmental, helpful relationship was in marked contrast to Mrs. G.'s relationship with her mother and her husband. It enabled her to utilize her own abilities with advantage to her children and herself.

The case of Peter is not an extreme example. As pointed out earlier in this chapter, in 40 of the 100 homes from which patients showing socially unacceptable behaviour, there were known factors of family disorganization such as desertion, separation, divorce, and marked discord. Eighteen of the 100 children were affected by the interference of grandparents, aunts, uncles or other relatives living in their homes. There were 16 instances of extremely poor or crowded housing.

An example of a case in which none of the above mentioned factors were apparent is that of Tom Z., aged 7 years.

Tom was examined at the Mental Hygiene Clinic because of marked disobedience at school. He also told many lies. He was referred for examination by a public health nurse.

Tom's mother said that he was very jealous of his brother who was 4 years younger. There were no other children in the family. Mr. and Mrs. Z. were born in Central European countries. The social history did not state when either parent had emigrated to Canada. The father had attended university for 1 year and was
regularly employed at semi-skilled labour. The mother had a Grade 9 education. She said that she liked to write stories and thought that Tom's imagination was like her own. The family lived in a good house in a middle class neighbourhood. The public health nurse thought that "family relationships seemed good and social standards seemed normal". The age of neither parent was stated.

The mother's attitude toward Tom was described as one of "sympathetic understanding". The father ignored the boy. The information about Tom's early development was meagre. The examining psychiatrist elicited the information that as a baby Tom had been "hard to wean". He had to be fed until 2 years old. Tom had eczema, and a "wheezy chest". He was also subject to hay fever. His mother said that he had "always" been restless. He seemed to care little for his own safety or that of others. Mrs. Z. said that for the past 4 years Tom had been indifferent to discipline. She had found making tom "sit still on a chair" the best form of punishment because it was "so irksome to his nature". Some corporal punishment had been used at times too.

Tom's intelligence was rated as low average. He had a good singing voice and liked to sing. He preferred playing with older children. He was quick tempered and rather rough in his play at times.

The examining psychiatrist gave advice to Tom's mother and his teacher. He recommended that an outlet for Tom's musical and imaginative tastes should be provided. Tom's mother was advised to avoid anything which would promote sibling rivalry.

There is no progress report on this boy, during the 2 and 1 half years which had elapsed since his examination at the clinic. In the brief social history there are indications that this mother has not been very wise in her care of Tom in the past. One might question her ability to carry out the clinic recommendations, without help from a public health nurse, or a social worker.

The case of Tim M. illustrates the importance of learning about the parents as well as the child. It also illustrates the use of a family agency's help by the Child Guidance Clinic in the treatment of a private case.
Tim was 9 years old when he was referred to the clinic by his mother, on the advice of his teacher and a children's agency. Tim's symptoms were stealing and lying. The mother had learned that corporal punishment, (suggested by a clergyman) did not produce the desired results.

Tim was born prematurely, and spent the first 2 months of his life in a hospital incubator. He was at home only 1 month when feeding difficulties became so severe that he was hospitalized for 6 months. Again he returned home, but only for 1 months. This time, Tim was in hospital for 6 months, because of pneumonia and impetigo. After another brief period at home, Tim returned to hospital and remained there for 8 months being treated for rickets. Again he was home for only a few months when he returned to hospital to have his tonsils and adenoids removed. The week after he went home, Tim drank half of a bottle of his mother's medicine, had a convulsion and was taken to hospital to have his stomach drained.

After this episode, Tim had measles, numerous colds and impetigo, but did not return to hospital until he was four and a half years old, when he suffered a broken collar bone. When Tim was 5, he became very disturbed because his mother underwent an operation and he thought that she was going to die. Shortly after this Tim was found to be anaemic and was treated for this condition by the family doctor.

When the clinic social worker in preparing the history conferred with the school principal, the latter reported that Tim liked to be the centre of attention and boasted a great deal about his illnesses. In view of Tim's medical history this was quite understandable.

Three days before the date set for clinical examination, Tim had an appendectomy operation, necessitating postponement of the clinic appointment.

A casual observer of this history might consider that there was a large element of neglect on the part of Mrs. M., and might call her "a careless mother". What did the clinic social worker learn about the mother which would throw a light on the reasons for her being the kind of person she was? What did the worker learn which would help her to understand the mother's unmet emotional needs?
Mrs. M. was one of the younger members in a family of 13 children. There was a great deal of marital discord between her parents. Her father, who was described as "very strict", seemed to reject his daughters.

When Mrs. M. was 14, she developed tuberculosis. In talking with the social worker this mother appeared to realize that she was extremely anxious about health matters, and thought that this anxiety dated from her illness during adolescence.

Mrs. M. married before the age of 19, partly to escape the domination of her father. However, she soon found herself involved in difficulties with a dominating mother-in-law. Mr. M. was 21 years old when he married. He had a Grade 7 education, and was frequently unemployed. During the first 3 years of marriage Mr. and Mrs. M. lived with or near this mother-in-law. There was constant bickering between Mrs. M. and her mother-in-law in this period. Mrs. M. thought that the basis for this was racial prejudice (she was French-Canadian, and the mother-in-law was Irish).

When Tim started to school, at the age of 6, his mother was working, so he was sent to a boarding school for a year and a half. When he returned home, there was discord between the parents and separation was threatened.

The social history contained less information about Mr. M.'s early life, but he too, had many illnesses.

At one time of Tim's referral to the clinic, Mr. M. was in a military hospital suffering from what his wife vaguely described as "war trouble". For years he had been on a diet (to which he rarely adhered), because of duodenal ulcers. He had had pneumonia several times, and he had been very ill following an appendectomy.

Obviously, in much of his illness, Tim had followed the pattern of the 2 adults nearest to him. There was undoubtedly an inter-relationship between the little boy's physical neglect by his sick parents and his identification with these parents in their retreat into illness. Apparently both parents were over-dependent persons, and this was taken into consideration in the casework services of the clinic.
The mother, whose dependency needs had not been met in her youth, responded well to the sympathetic understanding and emotional support given her by the caseworker. Mrs. M. was encouraged by the knowledge that Tim was not mentally retarded. (His I.Q. was 129). She was able to gradually learn a new approach to the training of her son. She began to recognize the importance of consistency in handling Tim. Tim's stealing and lying which had caused the mother so much concern, ceased as his environment became more stabilized. These symptoms recurred however when the mother became pregnant and again grew concerned about her health. During the third month of the pregnancy, the mother fell while leaving a street car.

At this point, the clinic sought the help of another agency for Tim and his parents. A family agency provided the services of a visiting homemaker, a kind and motherly person who remained with the M.'s until after the birth of the second child. Again the dependency needs of this family were met. Mrs. M., with this help was able to give Tim a greater sense of security and his former symptoms disappeared. Mr. M., relieved of some of his responsibilities at home, found steady employment. He was able to pay partially for the visiting homemaker's services. Shortly after the birth of the baby, the family moved to another province (not the one in which the mother-in-law lived) to take advantage of a better work position offered to the father there.

It would be presumptuous to predict that there would be no more difficulties in this family which would require help from social agencies. It can be said however that casework services while the family were in
this city were a step in the right direction because the unmet needs of this family were recognized.

Based on the cases in which the information was available, the average period of time between the appearance of first symptoms of maladjustment and referral to clinic was 3 years. This does not include cases in which there were indefinite statements such as "early", "a long time" and "always". The importance of early recognition of symptoms and prompt action in seeking to eliminate, or alleviate the underlying causes of these symptoms cannot be overstressed. The undesirable methods of dealing with these "problem" children had, in many cases, aggravated the situation which was already intolerable for them.
CHAPTER 6.

UNFAVOURABLE PERSONALITY REACTIONS

Eighty of the 257 children given clinical examinations were referred because of personality reactions which were indications of maladjustment. This number represents 31 per cent of the total number of cases. The highest percentage of children showing symptoms of this kind were between the ages of 6 and 7 years and between 8 and 9 years. Each of these age groups comprised 21.25 per cent of the 80 children examined. In the order of decreasing percentages the other age groups were represented as follows: 9 to 10 years - 17.5 per cent, 10 to 11 years - 16.25 per cent, 11 to 12 years - 12.5 per cent, and 7 to 8 years - 11.25 per cent.

The 6 to 7 year old children whose symptoms were personality reactions comprised 42.25 per cent of all the patients of this age group. The 8 to 9 year old children showing these symptoms formed 35.41 per cent of all the patients between these ages. An equal percentage of the children between 8 and 9 years showed symptoms in the form of socially unacceptable behaviour.

Almost one quarter (23.75 per cent) of the children examined who were manifesting unfavourable personality reactions, were "only" children in their families. Patients from families of 2 children comprised 46.25 per cent. In other words 7 out of every 10 children examined came from families in which there were only 1 or 2 children. Larger families were represented in this group of patients as follows: 3 children - 11.25 per cent, 4 children - 8.75 per cent, 5 children - 2.50 per
cent, 6 children - 5 per cent, 7 children - 1.25 per cent, and 8 children - 
1.25 per cent.

With regard to ordinal positions in families, "oldest" children comprised the largest group (35 per cent) "youngest" the second largest 
(26.25 per cent) "only" children the third largest (23.75 per cent) and 
"middle" children the smallest group (15 per cent).

Turning now to findings based on the 20 per cent sample, in 96.75 per cent of the cases children had difficulty in their group adjust­ment. There were varying degrees of maladjustment in this area. Several of the patients, though of high average average intelligence, did not play with children of their own age. Some who associated with younger children only, were aggressive and at times cruel in their play, while others had no friends near their own age and relied on adults for companionship.

A specific example of another form of unsatisfactory group ad­justment is that of Bill, aged 8 years 11 months.

Bill had suffered from severe headaches and nausea inter­mittently for a period of 6 years. His I.Q. was 116. This boy had no friends, and used to sit outside alone for hours. He liked knitting, sewing, and cooking. Bill's mother commented "He should have been a girl." Bill had no interest in outdoor sports.

Denise, aged 10, with average intelligence, referred to clinic because of her daydreaming, "ugly moods" and awkward gait, told the social worker this story:

"George is my only friend. I wish he could be in my grade at school. (George was a 7 year old mentally retarded Hindu child). I hate all the kids in school. I don't like chocolate milk very much either, but I get some every day or recess time. I drink it real slow so I won't have to go into any games. None
of the kids like me. They call me "stupid" and "slow poke".

When the worker made inquiries about what Denise liked to do most her reply was immediate and vehement.

"I like to "crab" at my mother. She "crabs" back and we get madder and madder. That's the most fun. Kids don't like me when I "crab" at them, but I don't care. I hate them all 'cept George. Nobody else likes him. Sometimes I fight with him, too, but he comes back again in a few days."

In 37.5 per cent of the sample cases of children showing unfavourable personality reactions, patients had difficulty in keeping up with the school standards of academic work. In most cases this could not be attributed to lack of intelligence, as the 2 illustrations of Patricia and Sam show:

Patricia, aged 8 years 10 months, was referred to clinic by her parents, because of her lack of self-confidence and constant quarrelling with her twin brother. Patricia showed little interest in her work at school, and her progress was slow. She complained about being taller than the girls in her class, (she was not as old as many of her classmates but was very large for her age). She said that she could not do better work because she was "too dumb". Her I.Q. was 129.

Sam, aged 10 years 7 months, was referred to clinic by his mother because he had "no sense of responsibility" and was "full of fears". Sam's school report indicated that he had a negative attitude toward learning. He seldom completed his work and showed no interest in new lessons. Sam's I.Q. was 150.

In half of the cases in this sample, marked sibling rivalry was apparent. Examples of some of the forms of this are illustrated in the two following cases.

Roger, aged 8 years, the eldest of 3 children, was referred to clinic by his mother on the advice of the family doctor. Of Roger's numerous physical complaints of several year's standing, bilious attacks were the most severe. He occasionally had violent temper tantrums. Usually he showed
little animation. Roger's father, whose employment had kept him away from home for months at a time spoke harshly to the boy during his short periods with the family. Often the father added to his reprimand the statement: "You're the oldest. You should have better sense." The mother, in the absence of her husband, expected Roger to assume many chores around the home, particularly the responsibility of "keeping an eye" on his brother and sister. Roger had no time to make friends or pursue any of the usual boyish interests. Most of his small allowance was saved to buy gifts for his 2 siblings. It appears that by this gesture Roger was trying to gain the approval of his parents. Their single favourable comment about him was: "One good thing about Roger is that he's very unselfish. He's always buying gifts." This "unselfishness" may have been Roger's outward denial of his resentful feelings toward his siblings, which were only rarely exhibited by aggressiveness toward them.

Sam, the boy previously referred to in the discussion of poor school achievement, showed his feelings of rivalry toward his brother more openly. Sam's mother said that she had tried to "bring him up scientifically" which to her meant "no cuddling or picking up".

When the second child, John, was born 3 years after. Sam's birth, the attending doctor told the mother that she would not be able to have any more children. The mother said that this had caused her to "lavish attention" on the younger boy. Both parents had found John "more lovable". Sam showed his resentment of his brother with increasing vehemence. Before John was 5, one of his ear drums was punctured when Sam struck his head several times with part of a mechano set.

In one quarter of the sample cases, the siblings of patients showed varying degrees of maladjustment.

Patricia's twin brother, Jack, was examined at clinic too. Like his sister this boy had very superior intelligence (I.Q. 127). The symptoms which led to the examination at clinic were defiance, cynicism, and marked aggressiveness.

In 68.7 per cent of the sample cases in this group, patients had experienced unfavourable circumstances in the period between birth and the end of their second year. Three examples will show the serious-
ness of some of these experiences.

Albert, breastfed from birth, was suddenly changed to bottle feedings at the age of 1 month when his mother was hospitalized for several weeks. Feeding difficulties arose and he became very frail. At the age of 2 years, this boy barely survived when pneumonia developed.

Denise (whose poor group adjustment was previously described) was rejected before birth by both of her parents. The mother aged 45, "wished for death" during the pregnancy. The father consumed alcohol excessively during the pregnancy, and for several months afterwards causing many hardships for the family whose income at best was only marginal. The mother said that she was so busy with her other 6 children that she ignored the baby. Besides parental rejection, Denise had the frightening experience of being badly bitten by a dog before the age of 3 years.

Harold, as an infant, was "held by the neck and beaten" by his father. The mother stated that the father would "throw him into the crib" and refuse to let her go to comfort the baby.

Negative factors in the period from the 3 to 6 years were present in every case in this sample. In none of the other three classifications of symptoms were such factors apparent to this degree. As was pointed out in the previous chapter 85 per cent of the children whose behaviour was socially unacceptable had met with difficulties or unfavourable circumstances during this period.

Jimmy, at the age of 4, suffered concussion as a result of a fall. The year before this child was old enough to attend school, the father, discontented with his work was unusually irritable. Part of the home in which the boy lived was sub-let to tenants who were noisy. The mother had many disputes with the tenants and the boy was constantly reminded to "be careful about noise".

Several children had tonsils and adenoids removed before they began attendance at school. Some were inadequately prepared for this operation, being told "it won't hurt a bit".
Mary, aged 4½ years, was suddenly separated from her mother who was sent to a sanatorium. She was not told why her mother had left and was not given an opportunity to say good-bye to her. For over a year before the mother had left, she was run-down and apprehensive, and was afraid at night when left alone with the child while the father worked. The child imagined that she heard footsteps and could not sleep. Not only did the little girl lose her mother, but she was also separated from all of her maternal relatives because her father feared that they, too, might have tuberculosis. She was passed from one to another of the father's relatives and friends.

Another factor which was more prevalent in the sample cases of this group, than in the other three classifications of symptoms is that of rigid or harsh discipline of children by their parents, older siblings or relatives. In 81.25 per cent of the cases, this factor was evident.

One boy's mother said that the only remedy for his "sauciness" was a "good slap in the face". The father's method of discipline was that of "commanding" the boy in a loud tone of voice. The mother's comment was "He just wilts when his father scolds him."

Another boy's father, a periodic deserter of the family, encouraged the child to disobey his mother. Frequently this father had temper tantrums during which the boy was severely beaten.

Discipline came from several sources for the 8 year old Jack who was "taciturn at school and aggressive in an impulsive way".

Jack lived in a home in which there was considerable friction among the adults in the family. During the brief periods when the father was at home (the parents separated frequently) he ignored the boy. The maternal grandmother, an invalid, lived in the home, and frequently criticized the boy and his mother's training of him. A maternal aunt who also lived with the family, worked in an office. She was tense and irritable after work, and constantly "nagged and scolded" the boy and his 3 siblings. Besides using corporal punishment to discipline the boy, the mother frequently
threatened him with "a visit from the devil who might take him away at night".

It has been stated previously that the highest percentages of patients showing unfavourable personality reactions were found in the age groups from 6 to 7 years, and from 8 to 9 years - (21.25 per cent each). The case of David S., aged 6 years 2 months is an illustration of early detection by the school of a child's maladjustment. This case also illustrates in a particular way, the mental hygienist's vigilance in discovering opportunities to stress the aim of the clinic's program, the promotion of mental health. It demonstrates too, the value of careful 'follow-up" work by the public health nurse.

During the first few days of David's attendance in Grade 1, his teacher observed his extreme distractability, his fear of new experiences, and his use of tears in meeting whatever constituted for him a difficult situation. These symptoms were brought to the attention of the school nurse, and the boy was examined at the Mental Hygiene Clinic before the end of his first month in school.

In addition to the above-mentioned symptoms, the school history revealed that the patient was excitable, wanted to run home from school at times, was "bossy" with other children, and almost constantly rubbed his fingers against his sweater sleeve. The social and family history revealed that the patient lived in an excellent home in a good neighbourhood. David's parents were well educated, economically secure, and seemed well adjusted. David was the first child in the family. The only sibling, a sister, 3 years younger, appeared to be a healthy, normal child. The parents had noticed that David was afraid of new experiences, excitable and sensitive. They said that for several years he had liked to rub fuzzy objects between his fingers. This habit was first noticed when he rubbed the crib blanket before falling off to sleep. The parents also commented on David's dawdling over his food, and his disobedience at home. Bladder and bowel control had not been established until David was 3 years old.

At the age of 2 years, the boy had been severely burned with boiling water. This had necessitated medical attention for several months.
David had not been in school long enough to have been tested by the Bureau of Measurements. He had not yet been examined by the school doctor.

The examining psychiatrist diagnosed David's case as "immaturity" and described the rubbing of fuzzy objects as a fetishism which was a regressive attempt to escape from conflict. The psychiatrist considered David's intelligence to be normal, but at the conference recommended having an individual test done by the Bureau of Measurements.

Further recommendations arrived at during the conference were:

1. Discussion with the mother regarding encouraging maturation. The mother should show less anxiety, ignore the fetishism, and prevent the child's use of behaviour to get out of difficult situations.
2. Encouragement of more companionship with the father.

Four months after this conference, the school nurse reported that the case had been closed because of the attitude of the parents and teacher. A summary of this report follows:

All recommendations except that of having a psychometric test, had been carried out. An individual intelligence test had not been done because the teacher did not consider this to be necessary. The parents and teacher felt that the boy should not have been referred to the mental hygienist before more serious symptoms had developed. David's progress in school was slow, he did fairly good work while closely watched. He no longer cried in school and did not want to run home.

Following this report, a letter from the mental hygienist to the director of the health unit was instrumental in clarifying the function of the clinic, and subsequently in the reopening of the case. In this letter the clinic director suggested that "in the interests of good education and public relations" an attempt should be made "to get an understanding of the discrepancy between the original attitude of the parents and teacher and the present one". The mental hygienist further
emphasized the importance of all public health workers stressing the aim of the clinic program which is "to promote mental health", and not to wait until the development of serious symptoms.

In less than a month there was a second progress report from the school nurse in which it was revealed that the teacher had not seen the mental hygienist's report containing the conference recommendations, at the time she had said that a psychometric test was unnecessary. Arrangements were now being made to have this recommendation carried out. The teacher said that David's parents had been most cooperative with the school in its attempts to help the boy. The school nurse reported that she would again have interviews with the mother.

Later, another progress report was made. This summary of the report is as follows:

The results of the individual test given by the Bureau of Measurements showed David's intelligence to be "average". (This test was given 8 months after the above-quoted letter from the mental hygienist). At school David had been placed in the "A" class. He was repeating Grade 1. He was still somewhat immature and excitable, but there had been considerable improvement in this area. The parents and teacher were well satisfied with the progress made by David.

The final progress report was sent to the mental hygienist, 6 months afterwards. It was a much more favourable report than the previous ones.

David was progressing well. He was in the "A" class in Grade 2 and able to keep up with his school work easily. At home, the parents had been able to help the child assume and enjoy more responsibility. His former symptoms had disappeared. The case was closed.

Evidently, the teacher though instrumental in having this boy examined at the clinic, was unable to attend the conference which followed the examination. Although a letter containing the recommendations was sent to the principal, apparently the teacher had not seen it. Presum-
ably in the "follow-up" of the case of a pupil, the teacher and nurse confer from time to time. The duties of principals are manifold, as likewise, are those of public health nurses. (1) The addition of psychiatric social workers to the Mental Hygiene Clinic staff, and social workers in the schools should lighten the responsibilities of nurses, and principals and make for closer cooperation among the various persons concerned with the welfare of the pupils. This closer cooperation and consequent better understanding, together with the special skills of social work would undoubtedly result in more adequate services to emotionally disturbed children.

The case of Sam G., aged 10 years 7 months, illustrates the need for close contact between the parents and the clinic if the recommendations made after examination are to be of value.

Sam was referred to the Child Guidance Clinic by his mother because he had "no sense of responsibility" and was "full of fears". This boy's poor school achievement, although he had high intelligence, as well as his aggressive behaviour toward his brother have been referred to previously in this chapter.

Both parents had high school education. Mrs. G. was 6 years older than her husband. The parents had several mutual interests such as athletic sports, reading, entertaining, and community activities. The father was not seen by the social worker who prepared the history, nor did he come to the clinic when Sam was examined. However, the mother gave the impression that the marriage was a happy one. The family lived in a comfortable home in a good neighbourhood. The father was a successful business executive.

(1) Besides her work in the school, each public health nurse spends some time in Child Health Centres (Well-Baby Clinics), visits tuberculosis cases in her district, and assists with the program for the control of communicable diseases.
Sam was breast-fed for 2 months, and weaned from bottle feedings at 9 months. As an infant he had severe eczema and a "nervous stomach". He was not handled unnecessarily by the parents as the mother wished to "bring him up scientifically". According to the mother toilet training presented no difficulty and was completed before Sam was 1½ years old. At an early age (about 2 years) Sam plucked at his clothing, pulling out the threads. Shortly after this thumb sucking, head scratching, and picking at his ears, nose and fingernails were "annoying habits" developed by Sam. These habits persisted up to the time of the clinical examination with the exception of thumb sucking which had ceased when Sam began biting his fingernails.

When Sam was 3, a baby brother was born. Because the parents had been told that this would be their last child, they "lavished attention" on the baby. From the beginning Sam seemed to resent this. The mother said that she felt that Sam had "suffered through lack of affection and attention". The brother John was described by the mother as "a perfect boy".

At the age of 8 years, Sam had missed 4 months of school, when he had impetigo. Soon after he returned to school, he became ill and was hospitalized for a month because of nephritis.

The mother said that Sam had not entered into active sports. "He always seemed to be afraid of hurting himself. He's too cowardly to catch a baseball. His father and I are so disappointed. We were both athletic." Mrs. G. said that Sam had wanted his own way since infancy, had always been "fussy", and a "lone wolf". Mrs. G. also commented on Sam's fear of water, both at the beach and in the bath tub. He did not even like to wash, and insisted on being bathed by his mother. The mother considered these "problems" more acute since Sam had had nephritis.

Sam's interests were "mechanics, riding his bicycle, making model aeroplanes, and boats." He was very interested in science, especially electricity. He played the piano and violin well. He seemed to prefer being alone while he pursued these interests. He did not have any friends of his own age. The mother attributed this to his "bossiness".

The parents had considered sending Sam to a private school for boys. It was chiefly for advice about this that the mother sought the help of the clinic. They thought that this might be of help in solving many problems, particularly the constant quarrelling between Sam and his brother.

Sam was examined shortly before the end of the school term. At the clinic, Sam was uncommunicative concerning his feelings
about his home and family, and about school. His I.Q. was 150.

The recommendations of the clinic were given directly to the mother by the examining psychiatrist. It was noted by the psychiatrist that the mother appeared to be very intelligent. She was somewhat tense, and had prepared a list of questions to ask the psychiatrist. She carefully wrote down all of his recommendations. These were as follows:

1. Attendance at Y. Camp for a period during the summer holidays.
2. Private boarding school for at least a year.
3. The boy should be given electrical apparatus to work with.
4. Parents should not expect Sam to play with boys of his own age. They should not expect the younger brother to keep up with Sam.

This boy was referred to the clinic in 1945, when staff short-ages were acute. No follow-up work was done by the social worker. In 1948, after there had been some enlargement of the clinic staff, inquiries were made about the adjustment of some of the patients who had been examined during the war years while the clinic services were curtailed. Sam was one of these patients. The mother's reply to the initial inquiry was as follows:

Following the clinic examination of Sam, both boys had been sent to a private boarding school in the interior of British Columbia. They had remained there for 2 years. They were now at home and attending the public school in the neighbourhood. Rather bitterly the mother said "Sam is worse than ever, and John is just about as bad. They fight more than ever, and neither of them have any sense of responsibility". Mrs. G. said that Sam was now in Grade 8 but was doing very poor work. He still was without friends and did not enter into active sports. His interests were said to have dwindled to "only electricity and radios".

The mother commented on how much money had been spent in sending
the boys to private school and how discouraged she and her husband were with the results. Mrs. G. said that she would discuss with her husband the clinic's offer of further service. The following day she phoned stating that the parents would like to have the help of the clinic. This case was assigned to a male social worker and a summary of his contact with the mother and patient follows.

Mrs. G. was interviewed at home. She described the strict routines within the home to which the boys were expected to adhere. She did not seem to understand how Sam could learn to evade this routine or be unhappy in accepting the "more normal interests" which the parents tried to impose upon him. She refused to see that environment had anything to do with the problem.

Three weeks later, Sam was interviewed by the social worker. The boy was described as "small for his age". Sam remarked that his father had told him that he would probably "turn out to be a tramp radio man". The boy would not bring up any negative feeling in regard to the limitations set by his parents. The worker went over the reasons why he was wondering if Sam had sometimes been rather unhappy at home, and whether perhaps the members of the family did not understand one another. Sam showed very little response to this except in terms of everything being "all right". It was noted that the boy was extremely polite.

A month later the worker visited the home again. Mrs. G. said that her husband was "much too busy" to see the worker. She wanted to know whether worker had "anything definite" to tell the parents. Mrs. G. quoted Sam's remarks after his interview with the social worker: "What is that Child Guidance Clinic? A recruiting centre for Essondale?"

During this interview with the mother the worker pointed out that the parents methods of training and their reactions to their children were natural ones arising from the parents own experiences. He tried to give the mother reassurance that the parents had done everything, as they saw it, to give the boys what they needed in home life and training.
The mother suggested that perhaps she and her husband had expected too much of the boys and had placed too many responsibilities upon them.

Mrs. G. accused Sam of being self-centred and "working in reverse". At this point the worker pointed out what Sam by his negativism and by passively working against the parents was showing strong resentment inside himself and real feeling that he could not compete equally with other children. He said that the clinic might help the parents find out how Sam's resentment and pent-up feelings could be changed and particularly how the parents' handling might change to meet this special situation. The mother then said that perhaps her husband would have time in the next month to see the worker. She said that she would phone later and let the worker know about this.

The social worker during his visits to the home had observed the mother's negative methods in handling the one and a half year old boy (a third child had been born while the 2 boys were attending the private boarding school). Mrs. G. shouted at this child, and constantly followed him saying "No, no", "Don't touch", etc. She said that she was determined that this child would learn the meaning of "no".

When Sam came home from school, he showed the worker his room and "radio lab". Again the boy was exceptionally courteous but completely uncommunicative on the subject of his feelings about the home situation.

One month elapsed, and there was still no phone call from Sam's mother. The worker recognizing the seriousness of Sam's problem decided that another attempt should be made to offer the clinic's help. He phoned the mother and suggested that a plan to alleviate the situation might be discussed. The mother said that at the moment she was busy with the baby but she would phone back in a few minutes. The mother did not phone.

Two months later this case was closed. The closing summary ended with the following comment by the worker. "It appears that Sam's parents are not really willing to look at the problem or at their own approach to it, and it seems to be a situation where their negative and rather destructive methods cannot be changed at this time."

The extent to which these parents would have been willing to look at the problem in 1945 cannot be estimated. However, it seems safe
to say that had it been possible for a social worker to maintain contact
with the family immediately after Sam's examination, the clinic recommenda-
dations might have been carried out in a more satisfactory manner. The
parents might have been helped to recognize the advantages of their ori-
ginal plan of sending only Sam to the private boarding school. They might
have decided, too, that a school near enough to permit more contact with
his home would have been more in keeping with Sam's needs. Casework
services with the parents might have been beneficial to the other children
in the family as well as to Sam.

At best Mrs. G. might have been a somewhat rigid and unrelenting
person. However, during her early contact with the clinic she was not
given an opportunity to demonstrate whether or not she would be amenable
to casework services. Obviously the mother's resentment of what she con-
sidered the clinic's failure in the past was a large obstacle to her
ability to use casework services when they were offered.

There was a higher percentage of girls in this group than in
other classifications of symptoms.

The case of Denise describes a girl whose problems were
of long standing. Denise was aged 7 years 2 months at the time
of her referral by the teacher to the Mental Hygiene Clinic and
aged 9 years when referred by her sister to the Child Guidance
Clinic. The symptoms described in the social histories of each
clinic are similar, namely, lack of concentration, day dreaming,
awkward gait, poor group adjustment.

Before Denise was studied by the school clinic she had
been examined by a private psychiatrist. This had been done
because her older sisters urged the parents to do something
about the child's maladjustment. The family finances, however,
did not make it possible for more than 2 interviews with the
psychiatrist. The school teacher's report prepared for the
clinic revealed that she had observed the child closely and was
interested in understanding the meaning of her behaviour. She was particularly interested in knowing how she could help Denise in the class room. The teacher described the child as "always seeming exhausted". Her speech was slow and forced, her gait was awkward. The child dawdled in getting ready to go home from school. On the few occasions when the teacher had seen the mother and child together it appeared that the patient tried to "bully" her mother. Denise showed little or none of this attitude toward the teacher.

Denise had started school when she was 5½ years old. She was left handed and had done mirror writing during the first year. At the time of the examination Denise was in special class. In neither her first nor second year at school had she shown very much progress.

The social history revealed Denise was the last child in a family of 7 girls. Her mother had said that she was busy with older members of the family and had not spent very much time on the child during infancy.

At the age of 3, Denise began pulling out her hair. Facial twitching began about this time too. She was described as a "very restless" child, with a marked tendency to become "so stiff and clumsy when excited" that she was hardly able to walk. The mother said that Denise was "slow, forgetful and usually disobedient" and that she only obeyed "when afraid of punishment".

The recommendations made at the conference were as follows:
1. In the training and management of this child the parents should be guided by the general principles of habit training and the establishment of good emotional attitudes.
2. The child should be encouraged to do things for herself at home.
3. The mother should avoid nagging. (The above recommendations were discussed with the mother by the mental hygienist).
4. The child has normal intelligence and should be restored to regular class soon.

The psychiatrist pointed out the possibility of slight brain damage at the patient's birth.

The progress report 6 months after this conference described improvement in Denise's adjustment. She appeared to be more self-reliant. Her gait was less awkward and better group adjustment was noted. Her speech had improved and she was making fairly good progress in school.
The increased understanding of the child on the part of the teacher undoubtedly contributed much to this improvement. The mother's interview with the mental hygienist and home visiting by the nurse may also have helped. There was only one progress report, however. Apparently there was enough improvement in the school situation that this case was closed.

About 2 years after this progress report the case was referred to the Child Guidance Clinic by one of the patient's older sisters who said that her mother wanted the clinic's help.

Not only were the symptoms still present but in many respects they were intensified. The mother's anxiety about the child was increasing. In giving the information for the social history there were many things about the child's earlier development which she could not remember. She mentioned her own tendency to cry at the least thing and dried her eyes almost continuously during the interview. Mrs. C. said that Denise was "just an entirely different child" from her other daughters and that she worried about her future.

In her interview with the psychiatrist the mother questioned whether Denise would ever be self-supporting. She complained that the father had not given this child any attention.

Psychological tests revealed that Denise had average intelligence. She appeared to be very withdrawn throughout the test. In the play room she seemed shy and immature. She spoke baby talk to her mother but dropped it when speaking to others. She was rather childish and awkward with play things dropping toys and falling on the floor.

At the conference it was felt that there was a definite element of rejection of this child and an accompanying oversolicitousness. Home relationships were considered poor and the family in need of a good deal of help in order to understand this child. The mother herself appeared quite disturbed and possibly tended to be rather hypochondriacal. It was the opinion of the clinic team that the child had assets within herself if she could be better understood and her self-confidence and recognition of herself as an integral part of the family could be built up. It was recommended that continued casework
should be given to the child and the parents.

This case was transferred to another social worker after the clinical examination. Rather early in her contact with the second worker the mother revealed that she had only agreed to come to the clinic for help because there had been so much pressure from her older daughters to do this. One daughter in particular (the one who had made the initial contact with the clinic) was very interested in what the mother termed "this new psychology stuff".

In the weekly interviews which followed Mrs. C. poured out her feelings about the daughters who had been very critical of her and who still demanded so much attention from her.

At first she seemed to try to test the worker to determine whether she would be like her critical daughters. "What would new psychology say about that?" she would ask rather tauntingly at times. The worker tried to interpret simply and gradually what "new psychology" would say, and the mother began to recognize that intellectually at least this was not so "new" to her. "Do you think it's all right for me to go to ----- meetings?" (religious sect not approved of by the husband and daughters) led to a brief discussion which apparently resulted in the mother's feeling that she was accepted by the worker. The following week Mrs. C. remarked "I've been thinking that this psychology and my religion have a lot in common. They both try to give a person the chance to build up the good things in themselves and they both say that people can help one another."

Having released some of her resentment and fears, Mrs. C. slowly began to look for the positive things which she might do to help Denise. She was easily discouraged, however, and needed help in understanding that evidences of improvement might be gradual. No longer did she make such remarks as "She's a queer one. None of the psychiatrists can figure her out." This mother finally developed the courage required to face a serious surgical operation which she had postponed for a long time. For 13 years she had suffered from a physical condition which caused almost complete lack of bladder control.

There was an equal number of interviews with Denise during this time. Through play at first (she was too withdrawn to talk) this child
showed indications of her feelings of rejection.

All of the toy furniture associated with babies (high chairs, play pens, cradles, etc.) were thrown into a room in the doll house which Denise called the attic. "These people don't want any more kids. The mother says she's had enough babies" was her first remark while playing. Another day, repeating this game, Denise said "That woman is going to have another baby. She doesn't know it, but the doctor does." Later, "She's going to have twins." The child finally placed 7 baby dolls on the window sill saying "Boy, she's going to have 7 kids. Let's clean up that baby furniture and get the bedroom ready for all these babies."

Another time she arranged the farm animal toys on the desk, and taking a gun said "Let's kill this old grandfather horse" (she frequently called her mother "Grandma"). The next week Denise asked "Did the grandfather horse die?" and taking the toy from the box said "If I had a band-aid and stuff I could fix him up so he'd live." She was given a toy nurse's set and while she administered first aid talked about what a good old horse it was and how hard he had worked. She said that she had shot him because "just sometimes he's so mean".

At first Denise used the term "one of my mother's daughters" rather than "my sister". (The mother referred to her children as "my oldest daughter", "my second daughter", etc.) The child's nieces and nephews, several of whom were older than herself, were spoken of as "one of my mother's daughter's children". This gave the worker an opening for discussion of Denise's place in the family group. The child appeared not too sure of her position. There were indications that she felt on the fringe of the family constellation rather than a part of it. She learned to say "sister", "niece", "nephew", "cousin", etc., and seemed both surprised and pleased when the worker referred to her as "mother's youngest daughter".

This child's gait became less tense when she visited the clinic. At first she scowled or gave what she called "dirty looks" at others she met in the clinic corridors. Occasionally now she smiles at them. There is less faltering in her speech at times. She is still finding it difficult to make friends and she daydreams a great deal. The mother sees a slight improvement in Denise's attitude toward small responsibilities at home and in her ability to get along with her nieces and nephews.

There still remains much to be done in helping this child and
her family. The father and 3 of the older sisters were each interviewed once. Possibly more interviews will be held with them. Neurological tests may be recommended later. The examining psychiatrist with whom the worker consults frequently about this case doubts whether a satisfactory adjustment can be made by the child in this home. The father's continued lack of interest and the mother's poor health and emotional disturbance are viewed as serious obstacles. In the process of helping Denise find the satisfactions which she has missed in earlier years, and the consequent facilitation of her movement into a stage of development more in keeping with her age, a treatment and observation centre might be of great benefit. Lacking this, a boarding school or foster home may be the means used.

In the case of Denise, the school recognized the maladjustment early, but the study made by the Mental Hygiene Clinic did not take into full consideration the intrafamilial relationships which had such an important bearing on the child's maladjustment. Closer follow-up or referral of this case by the clinic to an agency which might have given case work services would undoubtedly have led to better results than were obtained.

For children showing unfavourable personality reactions the average period of time between the appearance of the first symptoms of maladjustment and referral to clinic was the same as for the children showing socially unacceptable behaviour, namely, 3 years. There were fewer omissions in the social histories regarding this subject and no indefinite statements such as "always" and "a long time". Therefore,
the average period of 3 years may be considered a more accurate indication of the duration of symptoms previous to clinical examination than it was in the case of patients showing socially unacceptable behaviour. The lack of awareness on the part of parents of the availability of clinical services was in many instances one reason for the delay in seeking help.
CHAPTER 7.

CHILDREN PRESENTING HABIT DISORDERS

Thirty-nine of the 257 children given clinical examinations were referred because of habit disorders. This group of patients represented 15.17 per cent of the total number of cases. The highest incidence of this type of problem occurred in children from 7 to 8 years and from 9 to 10 years, each of these age groups comprising 23.08 per cent of the number of children whose chief symptoms were habit disorders. The other age groups are represented in decreasing order as follows: 8 to 9 years - 17.95 per cent, 10 to 11 years - 12.82 per cent, 11 to 12 years - 12.82 per cent, 6 to 7 years - 10.25 per cent.

Not only within this classification of symptoms were the 7 to 8 year old children and those from 9 to 10 years represented in the same proportion, (23.08 per cent) but also in relation to the total number of patients in each age group the proportion was identical (19.14 per cent). In other words, almost 1 out of every 5 patients between the ages of 7 and 8 years, was referred to clinic because of disorders in habit formation. Likewise, in the 9 to 10 year old group, about 1 out of every 5 patients were referred for this reason.

Patients from families of 2 children represented the highest percentage of patients with habit disorders (25.64 per cent). The second highest incidence was found in families with one child (20.51 per cent). Patients from families of 3 children comprised 17.95 per cent. Larger families were represented in this classification of symptoms as follows:
4 children - 12.85 per cent, 5 children - 7.69 per cent, 6 children - 12.82 per cent, 7 children - 2.57 per cent.

Comparing these percentages with those found in the other classifications of symptoms, this group will be seen to have a greater proportion of patients from larger families than did the other groups. Whereas 35.9 per cent of the children with habit disorders came from families of 4 or more children, 27 per cent of the patients showing socially unacceptable behaviour, and only 18.75 per cent of those with unfavourable personality reactions were from families of this size. In Chapter 10 it will be seen that only 7.9 per cent of the patients with special school disabilities came from families of 4 children, and none of the patients in that classification were from families of more than 4.

"Middle" children comprised 30.77 per cent, "youngest" 28.21 per cent, "oldest" 20.51 per cent and "only" children 20.51 per cent of the patients showing disorders in habit formation.

Marked discord between parents was evident as a factor contributing to maladjustment in a larger proportion of cases in this group than in the other three classifications of symptoms. This was noted in 17.95 per cent of the cases, while divorce was a factor in 10.26 per cent.

In almost one quarter of the cases (23.08 per cent) the father had been away from the family while serving in the armed forces. In over an eighth of the cases (12.82 per cent) housing was poor or very crowded. In the same percentage of cases there had been interference in training and care of the patients by grandparents or other relatives living in the home.
Turning now to the 20 per cent sample of patients showing disorders in habit formation, the clinic studies indicated that in only one out of every 4 cases of this kind children had difficulty in group adjustment. In this respect children in this group showed less maladjustment than those in the other classifications of symptoms.

One example of poor group adjustment is described below.

Walter, aged 8 years 7 months was referred to the school clinic because of "soiling, enuresis, timidity and quarrelsomeness". He complained that the boys of his own age teased him and were "too rough". He cried easily and usually sought the companionship of younger children. He insisted on being the "leader" with these children and was inclined to be cruel, when his playmates opposed his leadership.

Poor progress in school was more apparent in this group of patients than in the two classifications previously described. In 75 per cent of the sample cases, reports indicated that the patients were not keeping up with the school's standards of work.

The boy whose poor group adjustment was described above, had repeated Grade 1, and was sullen and uncooperative in school. His progress in Grade 2 was slow. His intelligence was "average". Another boy who was referred to the school clinic by a family agency because of enuresis and soiling was doing Grade 1 work for the third year. His intelligence was "low average".

Sibling rivalry was apparent in 37.5 per cent of the sample cases. In comparison with the other classifications of symptoms, the proportion of children with disorders in habit formation showing sibling rivalry was lowest. Evidence of maladjustments in patients' siblings was
found in 25 per cent of the sample cases.

Seventy-five per cent of the patients in this group had met with unfavourable circumstances in the period between birth and the end of their second year.

Harry, aged 6 years 9 months was referred to the Child Guidance Clinic by a children's agency because of "soiling, enuresis, masturbation and destructiveness". This boy was the third offspring of a common-law marriage in which there were many quarrels and periodic desertions by the father. The mother was described as having "an uncontrollable temper". Harry was abruptly weaned from bottle feedings before the age of 10 months. The mother complained that although she had attempted to toilet train Harry "early" (7 months) and had used every method of which she had ever heard, she had not succeeded.

Negative factors during the period from 3 to 6 years were also found in 75 per cent of the sample cases.

Jane, aged 9 years 3 months (a ward of a children's agency since the age of 5½ years) was referred to the Child Guidance Clinic because of enuresis and excessive masturbation. Jane, the second child in a family of 4, had lived during her first 5 years in poor, crowded quarters in a low-standard district known to the police as "a hotbed of vice". The father had spent some time in prison for vagrancy and drunkenness. The mother, a promiscuous woman of borderline intelligence had deserted her children for several months when Jane was 4. Before Jane was 5 years old, an elderly man had attempted to rape her. Jane became a ward at the age of 5½ years, when the mother was sentenced to prison on a charge of "contributing to juvenile delinquency" because of drunkenness and promiscuity in the presence of her children.

In 75 per cent of the sample cases, there was evidence of parental discipline which was harsh, rigid or inconsistent.

Herman, a 7 year old boy whose chief symptom of maladjustment was soiling lived with a mother who entered into a common-law relationship when her husband deserted her. This boy who had received much blame and punishment from his own father met with harsh criticisms from his step-father and frequent deprivations
as well as "beatings" from his mother.

The case of Hubert S. illustrates the importance of a careful physical examination.

Hubert was 11 years 11 months of age when he was referred to the school clinic by the nurse. His symptoms were enuresis and choreaform movements.

Hubert was the second child in a family of 5 children. His mother, 43 years of age, was 8 years older than his father. The family's economic situation had fluctuated a great deal, and there were many debts. The family had lived in several parts of Canada, and in Alaska. Hubert had been in Vancouver for only 1 year. The home was a fairly large house in the city suburbs. The furnishings were scant. There were no boys' clubs or community centres in the neighbourhood.

This boy had suffered a stomach injury as a result of a car accident when he was only 18 months old. He had severe diarrhea for a short time after this. The food fussiness which had developed around this time had persisted. When he was about 3 years old Hubert had fallen off a dredge injuring his head and remaining unconscious for several hours. The enuresis had begun shortly before the boy was 9 years old. His father was in the Navy and away from the family when this symptom developed.

During the year previous to Hubert's examination at the clinic, the father's employment had kept him away from the family for months at a time. The mother, a cook, worked at night and Hubert's brother aged 14 was in charge of the family during the mother's absence from the home. Hubert strongly resented the authority given to this older brother.

In school Hubert's work (grade 6) was average. His poor speech was observed by the teacher. The boy's group adjustment at school appeared to be fairly good, but he had no friends outside of school. Notations from the school medical card contained in the social history were as follows: "complains of deafness", "choreaform movements" and "enuresis-sores on buttocks".

The social history made it obvious that Hubert's environment was such that emotional disturbances might be expected. One of the most favourable aspects in the family situation was that the father had recently
returned to Vancouver and was seeking employment in the city which would make it possible for him to live at home.

The mental hygienist's interview with the mother revealed that she was "an excitable, dependent person".

The recommendations arising out of the conference were:
1. The nurse should see the boy's father and form an opinion about his responsiveness to advice. The father should be encouraged to offer the boy more companionship and encouragement.
2. An ear, nose and throat investigation should be made in order to discover the cause of Hubert's deafness.
3. The boy should be given an opportunity to join the Y.M.C.A. or the Boy Scouts.
4. Although the enuresis might be based on anxiety, a urinalysis should be made.

The progress report 6 months after the clinical examination was brief and did not indicate the extent to which the above recommendations were carried out. It did reveal however the validity of the recommendation for urinalysis. Information contained in the report was as follows:

Hubert had been severely ill about 1 month after his examination at the clinic. He was taken to a hospital where a diagnosis of diabetes mellitus was made. Diet and insulin were prescribed. Some improvement was noted in Hubert. He was now less excitable.

Mrs. S., "an excitable, dependent person", evidently had needed more help than the nurse had had time to give. The urinalysis had not been done until Hubert was hospitalized. It appears probable that the recommendation regarding ears, nose and throat investigation was not promptly carried out, either.

Judging from the 20 per cent sample, it appears that children showing disorders in habit formation are referred for clinical examinations earlier than those having other symptoms of maladjustment. However, the average period of time between the first occurrence of symptoms
and examination was 2 years and 5 months, and there are indications that most of the patients were exposed to faulty methods of "curing" the disorders. In most instances, during this period no attempt was made to seek for underlying causes. These patients would undoubtedly have been spared much discomfort, had they been referred for clinical examinations earlier.
Of the 257 children given clinical examinations, 38 were referred because they appeared to have disabilities in specific school subjects. This number represents less than 15 per cent of the total number of cases. The highest incidence (23.67 per cent) of this problem was found in the 6 to 7 year old group. An equal percentage of cases (18.41 per cent) were found in the 7 to 8 and 8 to 9 year old groups. As might be expected the occurrence of this type of problem diminished in the higher age groups. The other age groups are represented as follows: 9 to 10 years - 15.78 per cent, 10 to 11 years - 13.13 per cent and 11 to 12 years - 10.52 per cent.

The 6 to 7 year old children who were referred because of disabilities in special school subjects comprised 22.5 per cent of all the patients in this age group. Reading was the school subject with which the majority of these patients as well as those in other age groups had difficulty. Arithmetic was second on the list, while mirror writing was the reason for examination in only one of the cases.

One half of the patients with specific school disabilities were members of families in which there were only 2 children. "Only" children represented 23.68 per cent of the patients in this classification. Patients from families of 3 children comprised 18.42 per cent, and those from families of 4 - 7.9 per cent of the cases in this group. None of the patients came from families of more than 4.
A markedly high percentage (44.71) of these patients were the "youngest" member of families. In no other classification of symptoms as well as in no other category of the ordinal positions in the family was such a high percentage found. The nearest percentage to this was in the "socially unacceptable behaviour" classification in which 37 per cent of the patients were the "oldest" in their families. "Oldest" children in the school disabilities group formed 21.04 per cent of the cases, while only half as many (10.52 per cent) were "middle" children.

Although in 1 out of every 3 of the 257 children examined there were factors of family disorganization which appeared to contribute to the patients' maladjustment in this particular group such factors were evident in less than 1 out of 6 cases. Marked discord between the parents was the most frequently found factor of family disorganization, this being apparent in half of the cases in which such influences were found.

Similarly, the three other factors contributing to maladjustment, namely, absence of the father while serving in the armed forces, inadequate housing, and interference of relatives living in the home, were less frequently found in this group than in other classifications of symptoms.

A comparison between the intelligence levels of the children who had disabilities in specific school subjects and those of children who were referred because of other symptoms reveals that in the first-named group the intelligence quotients were "average" and "low average". In only one case (2.63 per cent) in this group was the intelligence "superior", and in no cases were the test results indicative of "very superior" or "near genius" intelligence, although such results were found in each of
the other classifications of symptoms.

Turning now to the 20 per cent sample of cases in which patients had specific school disabilities, slightly more than 6 out of 10 children (62.5 per cent) had not made satisfactory group adjustments.

Floyd, aged 6 years 6 months showing no ability to learn to read, ate crayons and paste in the classroom, and used scissors to cut books. He preferred girls' toys and tried to get into the girls' games when the other boys shunned him.

Edna, aged 11 years 10 months who was unable to grasp number concepts, was usually quiet and listless and had no companions of her own age outside of school. When she entered into games with her classmates she was "rough and awkward".

Arising out of nature of the symptoms presented by this group of children, there were reports of unsatisfactory school progress in all cases. Of course, as previously pointed out, there was a high incidence of poor school progress in the cases of habit disorder where 75 per cent of the patients were not keeping up with the school standards of achievement. In cases of children showing socially unacceptable behaviour poor school adjustment was found in 35 per cent, while in those in which there were unfavourable personality reactions lack of progress in school was evident in 37.5 per cent.

Sibling rivalry was apparent in half of the sample cases in this group. This is the same proportion as was found in cases where the symptoms were unfavourable personality reactions. As in the children in other classifications sibling rivalry in patients having school disabilities appeared to be attributable to a multiplicity of factors. In this group however, parents in their efforts to urge the children to do better
school work, frequently promoted sibling rivalry by attempting to arouse competition between patients and their siblings. An illustration of this follows.

One boy who had failed in 2 grades chiefly because of poor reading was told "Wait till Jeannie starts to school. She'll learn quickly and will soon be able to read the comics to you."

In 37.5 per cent of the sample cases, siblings of patients showed maladjustments.

In the case of an 11 year old boy, his 13 year old sister had also been examined at the school clinic. The diagnosis was "adolescent personality difficulty".

In another case, an 8 year old boy had a sister, aged 6, who was described as "destructive, and high strung". (Clinical services were later requested by the parents for the younger child).

In 75 per cent of the sample cases, patients had experienced unfavourable circumstances in the period between birth and the end of their second year.

Gerald, a 7 year old boy, who was examined because of a reading disability, was born into a family where neither parent wanted a second child. The mother was quite ill during most of the pregnancy and remained in bed for 6 months after his birth. The infant was cared for by relatives, friends and the father during this time. Feeding difficulties arose. Toilet training was begun early, and the mother was quite rigid and demanding in the methods she used to establish bladder and bowel control. This child was severely ill with whooping cough in his second year.

Eileen (aged 11½ years) was referred to the clinic because of reading disability, had been suffocated at birth. The mother had not had medical assistance during confinement. When 10 months old this child had an abscessed jaw. During her second year she had pneumonia. In her first 3 years, as well as later, this child had lived in a family where there were many stresses such as discord between the parents, unemployment, and frequent changes in residence.
Negative factors in the period from the third to the sixth year were found in 37.5 per cent of the cases. This showing bears a marked contrast to the findings in the other classifications, as described in previous chapters. One hundred per cent of the children showing unfavourable personality reactions had experienced difficulties during this period. In 85 per cent of the cases in which patients showed socially unacceptable behaviour, and in 75 per cent of the cases in which there were disorders in habit formation, such factors were present during the third to sixth year period.

Roy (aged 8 years) referred to Child Guidance Clinic because of inability to learn to read, had met with unfavourable experiences during his first 3 years (strong resentment at the birth of a sibling, asphyxiation, and injury in a car accident). It was in the period between his third and sixth years however, that he encountered other experiences some of which he remembered and feared. The family moved from place to place in his third and fourth year. Each time he was "train-sick". He had tonsils and adenoids removed when he was about 4 years old. Soon afterwards the family went to live in the maternal grandfather's home. The grandfather insisted on quietness in the house, and refused to permit other children in the house or the yard. He was critical of the boy and compared him unfavourably with the younger sister.

Shortly after the boy was 5 years old he injured his head when he fell from a swing. He was hospitalized for a short time. A few months later he stood by and watched with terror, artificial respiration applied to his younger sister when she had almost drowned. At the age of 6 this boy started to school reluctantly, not wanting to leave his mother who had been in bed for several weeks because of rheumatic fever.

Harsh, rigid or inconsistent parental discipline was found less frequently in the cases in which children had school disabilities than in any of the other classifications of symptoms. This was evident in only 25 per cent of the cases in this group, whereas in 81.25 per cent of the
cases of children showing unfavourable personality reactions, 75 per cent of the cases showing disorders in habit formation and 35 per cent of the cases showing socially unacceptable behaviour such discipline was apparent.

Roy, referred to above, met with harsh words from his grandfather. Some of his threats were: "I'll break your neck," "I'll knock the head off you," and "I'll turn you over to the police". Sometimes when the boy spoke at meal time the grandfather would say: "Shut up. When I was your age children were seen and not heard."

The parents, although resenting the grandfather's attitude, felt obliged to remain in this home because of the difficulties involved in finding living accommodation for a family with children. They tried to compensate for the grandfather's harshness by being over-indulgent with the boy and his sister.

Eleven year old Sylvia, who had difficulty in reading, had been frequently given corporal punishment by her father who had temper tantrums and was abusive to his wife and children. Occasionally bribes were used by the mother in handling the child.

In the clinical study of almost all of the sample cases, disabilities in special school subjects were attributed to social and emotional factors and the recommendations stressed the alleviation of the adverse influences in the child's environment. Progress reports of such cases indicated that as the environment became more stabilized, the disabilities in special school subjects diminished or disappeared. In the case described below, however, the clinical diagnosis was "severe reading disability" and the clinical recommendations centred around obtaining for the child direct help in reading.

Stephen W. (aged 7 years 2 months) was referred to the Child Guidance Clinic by his mother on the advice of the school principal. The symptoms presented were "unable to read, and slow in school".
Stephen's father was at first reluctant to have the boy examined. He had thought that the clinic was "only for feeble-minded children". The boy was the younger of two children. His sister aged 11 had great difficulty in learning arithmetic.

The family lived in a comfortable home in an average neighbourhood. This appeared to be a united family group and both parents seemed eager to give their children emotional security. They were concerned because Stephen had been teased by his classmates when he had failed in Grade 1, and had since that time frequently referred to himself as "stupid".

Stephen was said to have "not much energy" in play but he entered fairly well into the games in the school yard. He wore glasses.

At the age of 3 months Stephen had had measles, followed by whooping cough. The mother seemed anxious about the child having had a serious fall when only a few months old. She wondered too about a head injury Stephen had received when he was 2 years of age. She mentioned that the child had always been "rather slow". He had had many colds and frequent nose bleeds.

The physical examination at the clinic revealed that Stephen had enlarged tonsils and adenoids. The tonsils were badly infected. Psychological tests indicated that the boy's I.Q. was 101, and that he had a reading disability. The psychiatrist's interviews with the mother and child did not reveal anything negative.

The clinic recommendations were:
1. The child should be examined by the family doctor as his tonsils and adenoids require attention.
2. Social worker should confer with the school principal re special tutoring daily for the boy.

The mother had already made an appointment for Stephen with the family doctor before the social worker's first visit following the clinical examination. Both parents were encouraged by the knowledge that Stephen had normal intelligence. The parents expressed willingness to provide help for the boy in the form of tutoring in reading and asked for the social worker's assistance in finding a suitable tutor.
When the social worker conferred with the school principal and teacher about this she learned that there were no remedial classes in the school. However, the teacher said that she would give Stephen special remedial reading every day in individual work with him.

Three months later, this case was closed. Stephen's tonsils and adenoids had been removed and already an improvement in his health was noted. With the special help from his teacher, Stephen had made considerable progress in reading. Both the teacher and the parents observed that Stephen was developing normal aggressiveness. He said that he liked school better and this was quite apparent to his teacher and parents.

Two years later an inquiry about Stephen's adjustment was made by the clinic. The mother said that the boy had passed into a new grade each year and was making good progress. She further reported that the special tutoring which Stephen had received had been so valuable that the parents had obtained similar help in arithmetic for his sister. The results of the special lessons for the girl had been good. She, too, had been promoted each year and was enjoying school.

The successful outcome of this case may be attributed in part to the school's recognition of the problem and to the clinic's diagnostic services. However, neither of these would have been effective if there had not been close cooperation between the school and the clinic in the follow-up work. Undoubtedly, the greatest asset in the case was the two adequate parents who saw the problem also and cooperated with the school and the clinic in doing something about it.

The lack of early recognition of maladjustment was more apparent in the sample cases in this group than in the other three classifications of symptoms; the average period of time between first appearance of symptoms and clinic referral, being 3 years and 4 months. In these cases as well as in those of children showing socially unacceptable behaviour, unfavourable personality reactions, or disorders in habit formation,
earlier recognition of the problem and thorough investigation of underlying causes would have benefitted the patients.
CHAPTER 9.

RECOMMENDATIONS AND RESULTS

The major objective in the clinical study of each child is the strengthening of the patient so that less handicapped by emotional disturbance he will be able to work out an adjustment, which will no longer necessitate his formation and use of unhealthy symptoms.

In both of the Vancouver clinics the conference is used for the formulation of plans which offer the child help. Frequently the forms of assistance which his home, school and community might give are delineated. Besides these indirect methods of helping the child, the direct treatment of his psychic problems may be included in the plans for his welfare. These plans for treatment, direct and indirect, are based on what is known of the child through the clinic’s study of him as an individual and as a member of his family group and society. His unmet needs in the past and his methods of attempting to meet these needs are taken into consideration by the persons formulating the plan.

The four general types of approach to treatment as already outlined in Chapter 1, bear repetition here. These were (1) promoting changes in the patient’s environment (2) the finding of new outlets for the patient’s energies or capacities (3) remedying of the patient’s specific physical and intellectual disabilities and (4) dealing directly with the patient’s psychic problems. Such approaches to treatment were found in the recommendations made by the Vancouver clinics. In the samples of case studies given in the preceding chapters specific recommendations of the
examining clinic were given in detail. In the accompanying table based on the 20 per cent sample (52 cases), five classifications of treatment recommenda-
tions are used, a separate category having been utilized to classify proposals for educational adjustment.

Table 14  FREQUENCY OF TYPES OF RECOMMENDATIONS MADE AT CLINIC CONFERENCES (Total of 52 cases.)

<table>
<thead>
<tr>
<th>Rank</th>
<th>Recommendation</th>
<th>No.</th>
<th>Rate Per Case</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Adjustment of the home situation</td>
<td>98</td>
<td>1.88</td>
</tr>
<tr>
<td></td>
<td>(a) Social or educational work in the home</td>
<td>40</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(b) Advice regarding methods of training</td>
<td>22</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(c) Suggestions regarding sibling relationships</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(d) More companionship with father</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(e) Consideration of placement</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Social Adjustment</td>
<td>44</td>
<td>.84</td>
</tr>
<tr>
<td></td>
<td>(a) Development of recreation and other specific interests</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(b) Opportunities for adequate social relationships</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(c) Summer camp</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Educational Adjustment</td>
<td>27</td>
<td>.54</td>
</tr>
<tr>
<td></td>
<td>(a) Advice to teacher regarding handling of patient</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(b) Adjustment of grade placement</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(c) Change of school</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Improvement of physical health</td>
<td>22</td>
<td>.42</td>
</tr>
<tr>
<td></td>
<td>(a) Referred to physician for treatment</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(b) Supplementary examinations</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Direct treatment of the patient</td>
<td>15</td>
<td>.28</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>206</td>
<td>3.96</td>
</tr>
</tbody>
</table>

Clearly, many aspects of children's needs are recognized in the clinics' efforts to facilitate the adjustment of patients. It will be noted that almost half of the recommendations involved work with the patients' families. This indicates the clinics' acceptance of the theory
that "the chief supports or hindrances for the individual in his struggle to adjust himself are found in the family. Whether he develops emotional maturity depends very largely upon his home and his parents."(1) In the preceding chapters statistical data and case illustrations have demonstrated the multiplicity of socio-economic factors which impinge upon the personality development of children. But diagnosis alone is of no avail if definite co-ordinated efforts are not made to alleviate the stresses which have created unhealthy symptoms.

Although recommendations concerning social adjustment ranked second in frequency, progress reports and case records did not indicate that careful attention had been given to this. For example in only 2 of the 13 cases in which summer camp was recommended, the workers conferred with the camp director before and after the patients attended camp.

In a few instances, social histories made such statements as "This boy spends most of his free time at X--- House (Community Centre)" or "June belongs to a girls' group at ----". In only one of the sample cases had a visit been made to the Centre named and inquiries made about the child's participation in group activities, and his adjustment as observed by the group workers in the agency. In none of these cases was there any evidence of a group worker or recreation leader being invited to or attending a clinic conference.

The extent to which recommendations for educational adjustment was carried out was difficult to determine. It is probable that the con-

ferring of nurses and teachers was more frequent than progress reports indicated. The adjustment of grade placement was not approved by school principals in 4 out of the 11 cases in which the consideration of this was recommended. These 4 were cases in which pupils' intelligence quotients indicated that they would be able to make progress in a higher grade.

If the school principal's had been present at the conferences in which these recommendations were made, in all probability they would have given their reasons for not considering this a suitable plan. Such discussion by the principals might have been valuable to members of the clinic team and others at the conference, in clarifying the school's point of view. At the Child Guidance Clinic, where the schedule is such that usually 4 patients per day are examined, it is frequently difficult to arrange the conferences at such a time that it will be convenient for the principals or teachers to attend. They are invited, however, whenever such action appears feasible except where parents are not willing to have their child's problem discussed with representatives from the school.

Conferring with the principal or teacher about the patient's school record, attitudes, group adjustment, etc., from time to time after the clinical examination as well as before has shown good results in the cases in which this was done by the Child Guidance Clinic social workers. (1) Frequently, however, the only contact with the school was prior to the clinical examinations.

The extent to which recommendations concerning the improvement of physical health were carried out was indeterminable from the information

(1) The case of Stephen described in Chapter 8, pp. 117-119 illustrates this.
contained in the clinic records. One instance in which this was not carried out was referred to in Chapter 7.

Direct treatment of the patients was recommended in 15 (28 per cent) of the sample cases. "This child should be in a treatment and observation centre if one were available" and similar statements were found in 6 out of the 15 cases in which recommendations for the direct treatment of the patients were made. The examining psychiatrists made this comment to stress the seriousness of the patient's problems as well as to provide a means of determining in part at least the number of children requiring a period of time in a treatment and observation centre. In these 6 cases as well as others in which direct treatment of the child was recommended the social workers in the clinic or in family and children's agencies were given direction by the examining psychiatrist. Opportunities for consultation with the psychiatrist were provided for the social workers in the course of their intensive case work with the children and in some instances the patients were re-examined by the psychiatrist.

The case of Ralph B., aged 9 years 3 months when he was referred to the Child Guidance Clinic, illustrates the role of the worker in the practice of "social work undertaken in direct and responsible working relation with psychiatry". It illustrates, too, some of the many community resources which may be of vital importance in helping a child whose maladjustment is serious, and whose home is unable to meet his needs. Some of Ralph's symptoms and some of the underlying causes of these have

(1) Psychiatric social work as defined in the By-laws of the American Association of Psychiatric Social Workers. Article VI, Section 1A.
already been mentioned in Chapter 5.

Five months before Ralph came to the Child Guidance Clinic, he had been referred to the Mental Hygiene Clinic. At that time, his mother and teacher had described his symptoms as "swearing, poor application at school, poor group adjustment and poor control of temper". The Mental Hygiene Clinic had found that there were many unfavourable conditions in the home and considered that it was "doubtful if the home environment could be materially changed". One of the outstanding difficulties in the home at that time was the presence of the elderly paternal grandmother, who was senile and had marked paranoidal tendencies. The father who did not appear to be able to cope with family difficulties had broken 2 appointments for an interview with the mental hygienist.

Ralph's parents referred him to the Child Guidance Clinic, on the advice of the social worker from the Provincial Mental Hospital who had visited the home to prepare the social history of the grandmother who had been committed to the hospital. The parents told of Ralph's aggressive behaviour at home. He sometimes kicked his mother and frequently struck, kicked and bit his father. He had broken windows and the glass in doors by striking with his clenched fists. The symptoms which had led to his examination by the school clinic persisted.

The history of Ralph's earlier years revealed that as a baby he had cried a great deal, he had "cradle cap" in infancy and his hands had been tied to prevent him from scratching his head. There had been feeding difficulties during infancy. He had had many colds, high fevers, and running ears. When Ralph was 14 months old, a second child was born, but died shortly after birth. During this pregnancy, and after childbirth, the mother had been seriously ill.

The paternal grandmother had lived in the home from the time of the parents' marriage until Ralph was over 9 years old. There were many family tensions as a result of this. The grandmother who frequently criticized the mother's handling of the boy was left to care for him at times while the mother worked outside of the home. The grandmother made threats of physical injury to the child and frequently told him that his habit of masturbating "would ruin him".
The paternal grandfather had died in a mental hospital before Ralph's birth. He had been hospitalized for many years because of manic-depressive psychosis. The father was very much concerned about the possibility of his own mental breakdown because of hereditary factors. When younger he had voluntarily consulted a psychiatrist. His reaction to the patient's violent behaviour was frequently that of weeping and saying "This will kill me." The mother sought release from the difficult situation in which she found herself, by gradual withdrawing.

It was hardly surprising that the complete examination of Ralph by the clinic revealed that the boy was severely disturbed. His intelligence was superior. At the conference the examining psychiatrist pointed out that the possibility of schizophrenia must be considered. The intensive case work treatment of the child as well as work with the parents was recommended by the psychiatrist. In the course of carrying out this recommendation the social worker frequently consulted the psychiatrist.

The patient was interviewed by the psychiatrist 3 times after the first examination and a diagnosis of severe psycho-neurosis was made. During the first 6 months of the social worker's contact with the parents and patient, 72 hours were devoted to this case.

If the resources of a treatment and observation centre for emotionally disturbed children had been available, some of the temporary measures which had to be used would not have been necessary. Lacking this, however, other community resources, some of which were not designed for such purposes, were marshalled to help this boy and his parents.

Interviews with the parents, some jointly and others with each parent separately were held frequently. There were also play periods and interviews with Ralph. The school was visited and the worker conferred with the school principal, the nurse and the teacher on several occasions.

A final assessing of the inability of the parents to take their place as "partners in treatment" with the clinic was made. The father, an anxiety-ridden person for many years, was on the
 verge of a mental breakdown and asked to have the child re-
moved from the home. The mother too made this request. It
had been difficult in the past for her to maintain equilibrium
while she endeavoured to support and strengthen her emotionally
disturbed husband and son.

At this point a conference between the clinic and a child-
ren's agency was held. The outcome of this conference was that
Ralph was placed in the Receiving Home of the child placing
agency. This was a temporary measure, as the Receiving Home was
set up and financed to serve a different group of children.

While Ralph was living at the Receiving Home, arrangements
were made for a 2 week period in camp. This, too, was a tempor­
ary measure and from the point of view of the clinic and the
child placing agency was expedient.

Although recognizing that Ralph was too emotionally disturbed
to derive much benefit from camp experience, the clinic saw this move as
providing an opportunity to work more closely with the parents. The camp
was not geared to deal with boys whose maladjustments were as severe as
Ralph's, but the camp director, aware of the urgency of clinic's need
for time to help the parents in their decision, accepted the boy as a
camper.

Soon after camp, Ralph expressed the desire to return to
his own home. This was arranged but again his parents were un­
able to deal with his extremely aggressive behaviour. On one
occasion Ralph and his parents became so disturbed that the
clinic psychiatrist advised that the worker should recommend
that a private psychiatrist should be called by the parents
for the boy.

This was carried out and the psychiatrist who came to the
home recommended that Ralph should be removed from his parents
immediately. Mr. and Mrs. B. agreed that this was necessary
and the psychiatrist took Ralph to the Receiving Home of the
child placing agency.

Again the clinic looked for community resources acceptable
to the child and parents. Ralph wanted some of his home; the
parents did not want to relinquish their guardianship and custody
of the boy. A lack of recognition of either the boy's or the
parents' desires might have precipitated the further breakdown of each member of this family. A private boarding school seemed to be the best solution. However, the earlier evaluation of the financial status of the family had revealed that outside help was needed.

A suitable private boarding school was sought, and at the same time possible community resources for the financial support of such an arrangement were investigated. At this time, the case was transferred to a male worker, because it appeared that the boy whose relationship with his father was so poor, might benefit by this.

The social worker found a private boarding school, the principal of which was interested in trying to help Ralph. The boy's difficulties and needs were carefully discussed by the social worker and the principal. The social worker also found a service club which was interested in financing the boy's education. Here, too, it was necessary for the social worker to outline the nature of Ralph's difficulties and possible ways of alleviating these. This club was prepared to assume full financial responsibility for the school fees until such time as the parents were able to contribute toward this.

During the period of more than 2 years which Ralph has been in the private school, case work has continued with the boy and his parents. The first year, Ralph was interviewed at least once a week by the social worker. During the second year interviews were held once every 2 weeks. During the current year the same frequency of interviews continues.

The mother returned to part time employment, and the parents have gradually been able to assume greater financial responsibility for Ralph's attendance at the school. Meanwhile, the service club has been kept informed of Ralph's progress.

Summer placement in a rural foster home, with brief periods at home during school holidays have been arranged. Both the boy and his parents are aware that for all concerned longer visits are not yet advisable. Throughout Ralph's period in the school, there have been frequent discussions between the principal and the social worker about his development.

Ralph, whose group adjustment had been extremely poor, has for some time been enjoying a boy's satisfaction of being able to make friends with his classmates. He has been able to
contribute to the group in both studies and sports. His school reports describe excellent progress and he received the Junior Athletic Award at the end of his second year in the school.

Ralph has become more aware by his own problem, and is gradually recognizing that the almost complete inability of his father to assume the role of a parent is likely to be permanent. At present, it appears that this boy and his parents will desire and need the continued help of the clinic over a period of several years.

The grave proportions which this boy's maladjustment had grown before treatment began, necessitated a great deal of activity on the clinic's part to prevent the total disintegration of this family.

Accurate evaluation of the outcome or the after-effects of follow-up is very difficult. Not only is it impossible to gauge the effect of influences other than those of the clinic or other agencies, but also the reports of results of the work with and for patients varies with the judgment and experience of those who make the evaluation. The likelihood of inaccuracies in the estimations of the adjustment status of children must be kept in mind in considering this compilation of results, based on reports of adjustment as found in the clinic records.
### Table 15  ADJUSTMENT STATUS OF PATIENTS

<table>
<thead>
<tr>
<th>Results</th>
<th>Socially Unacceptable Behaviour</th>
<th>Personality Reactions</th>
<th>Habit Disorders</th>
<th>School Disabilities</th>
<th>Average^1</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>per cent</td>
<td>per cent</td>
<td>per cent</td>
<td>per cent</td>
<td>per cent</td>
</tr>
<tr>
<td>No follow-up or progress report</td>
<td>20.0</td>
<td>31.25</td>
<td>25.0</td>
<td>37.5</td>
<td>27.0</td>
</tr>
<tr>
<td>No improvement</td>
<td>5.0</td>
<td>6.25</td>
<td>12.5</td>
<td>12.5</td>
<td>7.7</td>
</tr>
<tr>
<td>Partial Adjustment</td>
<td>15.0</td>
<td>12.5</td>
<td>12.5</td>
<td>37.5</td>
<td>17.3</td>
</tr>
<tr>
<td>Marked Improvement</td>
<td>60.0</td>
<td>37.5</td>
<td>50.0</td>
<td>12.5</td>
<td>44.2</td>
</tr>
<tr>
<td>Satisfactory Adjustment</td>
<td>-</td>
<td>12.5</td>
<td>-</td>
<td>-</td>
<td>3.8</td>
</tr>
</tbody>
</table>

^1 Based on the total sample of 52 cases.

In over one third of the sample cases examined by the Mental Hygiene Clinic there were no progress reports although such reports are requested by this clinic. In the Child Guidance Clinic cases referred by health or social agencies for diagnostic services, there were no progress reports, unless patients returned to the clinic for repeat examinations, or consultative conferences were held. This is in keeping with the Child Guidance Clinic policy which does not request progress reports except as in the above-mentioned cases. The cases in which there were no follow-up or progress reports comprised more than one quarter (27 per cent) of the total number of sample cases from both clinics.

According to the above table, the percentage of patients showing satisfactory adjustment (3.8 per cent) was only half as large as the percentage showing no improvement (7.7 per cent). However, clinic records
indicate that in more than half of the cases (51.5 per cent) varying degrees of improvement were noted.
CHAPTER 10.

FUTURE GOALS

Some of the limitations of the clinic services which have been indicated in cases described in the preceding chapters have been remedied to a certain extent during the years under consideration as well as in 1948 and the current year. It might be well to review briefly some of the recent expansions in each of the clinics before pointing out further needs.

During most of 1945, the first year included in this study, the psychiatric examinations were made by psychiatrists from the Provincial Mental Hospital. There were staff shortages at the Mental Hospital too, during this period and consequently there were limitations in the time which the psychiatrists could spend at the Child Guidance Clinic.

At the beginning of 1946, 2 psychiatrists were appointed. One was the clinic director, who, when not engaged in the work of travelling clinics, acts as psychiatrist at the consultative conferences in which social and health agencies seek help in understanding the psychiatric implications of the problems of some of their clients. The director also examines a number of patients. The other psychiatrist works full time at the Vancouver clinic.

There has also been a gradual expansion in the social work staff of the clinic. During half of 1945 the clinic supervisor's time was divided between the clinic and the social service department of the
Provincial Mental Hospital. Later in the year, one social worker was employed for full time work at the clinic.

In 1947, a clinic supervisor was appointed. At the present time there are 6 social workers (including the supervisor) on the clinic staff. One social worker spends part time as a member of the travelling clinic team.

The number of clinical psychologists has increased from 3 in 1945, to the present psychological staff of 5. Two psychologists are engaged in travelling clinic part of the time. The nursing staff, too, has been enlarged. In 1945 there was one nurse at the clinic; at present there are 3 nurses. More office space and diagnostic equipment has also been provided to keep pace with staff expansion.

Through the federal health grants, 4 members of the clinic staff (one from each profession of the clinic team) have each completed one year's advanced university training.

In the Mental Hygiene Clinic, too, there has been an enlargement of staff. An assistant mental hygienist was appointed in 1948, facilitating the extension of clinical services to include the examination of children under school age. In the same year a psychologist was also added, to the Mental Hygiene Division, making possible the psychological examination of patients who attend school in areas not served by the Bureau of Measurements, as well as children of pre-school age in Greater Vancouver. The appointment of a psychiatric social worker is included in this clinic's proposed plans.
Turning now to the 257 cases which are the subject of this study, it was noted earlier that they comprised only 13 per cent of the total number of children(1) examined by the 2 clinics. In other words approximately only 1 patient out of 8 was an elementary school child of normal intelligence living with parents or relatives. Two reasons for this showing were revealed in the course of the selection of cases which came within the limits of the specified criteria. The first of these reasons is that many patients between the ages of 6 and 12 years and living with their own parents and relatives had intelligence quotients below 80. Some of these were brought back to the clinic, 2, 3 and even 4 times, because the parents did not accept the fact that their children were mentally retarded. Not only did these children in many instances not derive any benefit from the examinations, but the clinic time spent on such cases might have been used advantageously for emotionally disturbed children. In some of these cases, the patients lived at too great distance from public school special classes to attend, although their intelligence was not too low for such classes.

The early detection of mental deficiency in Child Health Centres, and interpretation of this to the mothers would be beneficial to both children and parents. With this help, many mothers would be able to face the situation, and plan accordingly. Too often, mothers try to register in Grade 1, children with I.Q.'s below 50, who to all except the parents are obviously defective.

Frequently family tensions are increased and siblings become maladjusted when the community lacks resources for children whose intel-

(1) Patients up to 18 years of age.
lectual limitations are great. The 2 clinics as well as social and health agencies might furnish information as to the extent which this problem is apparent in their cases, which might in turn give impetus to more adequate planning for severely retarded children. In Winnipeg, the Child Guidance Clinic(1) was instrumental in the forming of 3 "occupational" classes for feebleminded children with I.Q.'s of approximately 50 or below.

In Vancouver, St. Christopher's School (under private auspices) is a boarding school for boys of limited intelligence. There is no such school for girls, but many parents have made inquiries about such resources. The only other institution available for mentally defective children is the Provincial Training School in New Westminster. There are so many demands for such an institution that with the present facilities of this school it is sometimes necessary for children to wait in the Provincial Mental Hospital at Essondale for several months before entering it. Many parents find this a difficult situation and some remove their children from the hospital. Anxiety during this waiting period sometimes increases the family tensions rather than lessening them.

Another reason for the small proportion of children in the category surveyed in this study, is that disturbed children are frequently not brought to the clinics for help unless the disturbance shows up in the school situation or family difficulties are sufficiently acute that a social agency is called in. Parents' lack of awareness of the availability of clinic services is apparent in many records.

(1) This clinic is jointly sponsored by the City Health Department and the Winnipeg School Board.
In one case, a mother's comment on how she had learned about a clinic is significant "I had been worried about Frank for over 3 years. I tried everything I could think of, and just about everything anyone suggested. I was desperate. One day, my neighbour noticed that I had been crying. She suggested that the Child Guidance Clinic might help us. She said that she had heard something about the clinic at a banquet once."

Another mother, whose daughter had been involved in small thefts commented thus when she terminated her contact with the Child Guidance Clinic: "More parents should know about this clinic. I had noticed in the newspapers that Juvenile Court cases are sent here and I thought that maybe the clinic could help us with Peggy, even though she had not been in court yet."

Parents sometimes learn of the clinic services through their friends. From one city block in less than one month came 3 severely disturbed children. The first patient came to clinic as a result of referral by the family doctor. Through his parents another boy's mother learned of the clinic and referred her child for clinical examination. This mother, in turn, told the parents of another child about the clinic and a third patient was referred for examination. In a number of other cases, parents of patients were informed of the clinical services by the parents of former patients who had felt that they had benefitted by contact with the clinic. Recent newspaper publicity about the Crease Clinic as well as one short article in a city paper about the Child Guidance Clinic have brought a deluge of requests for help with problems of long standing. The importance of early treatment for disturbed children, and of the value of
parents taking the initial step in seeking help for these children, is recognized by the clinics. In view of this it appears that some investigation on the part of these clinics into the ways and means of acquainting the general public with the availability of their services would be advantageous.

There are indications in some of the Child Guidance Clinic records that some of the school principals, nurses and teachers lack information about the Child Guidance Clinic. There appears to be some feeling on the part of persons in the schools, that if a child is a pupil he should be examined by the school clinic. The rights of parents to seek help for their children from whichever clinic they choose is not always recognized. At times, too, there appears to be the attitude "He's a good pupil. Why should he be examined?", which overlooks the fact that boys and girls are members of a family too and that parents may observe symptoms at home which are not apparent in the school.

Such attitudes may in part be attributable to a lack of close cooperation between the school and Child Guidance Clinic in the past when staff shortages made frequent contacts with school personnel almost impossible. These misunderstandings are not insurmountable, and may in the future be overcome to a certain extent by the more frequent conferences between school and clinic personnel which staff expansions have made possible. A spirit of mutual understanding and cooperation might be promoted more readily however, if by some means, the functions and procedures of the Child Guidance Clinic were made known to the School Principal's Association and other similar groups.
There are indications that a more satisfactory working relationship between the 2 clinics is being sought. In February of this year, a meeting between the Supervisor of the Metropolitan Health Nurses, the Child Guidance Clinic Director and Supervisor, and the Executive Directors of several social agencies was held. At this meeting some of the misunderstandings regarding relationships between the 2 clinics and between the school clinic and social agencies were discussed and some agreements about overcoming these were reached. An illustration of one type of misunderstanding which has occurred frequently is shown in the case of 10 year old Sally whose parents became concerned about her temper tantrums and suicidal threats.

In July, the parents arranged for Sally's examination at Child Guidance Clinic which was to take place a few days after school re-opened. Sally was to begin Grade 5. The school was closed at the time of the preparation of the social history but the mother had saved all of Sally's report cards including those from kindergarten. Sally herself talked very favourably about school, her only complaint being that she was "no good in arithmetic". All of this information was embodied in the education section of the social history, and there was discussion with the mother about seeing Sally's teachers when school re-opened. The mother, a very tense and extremely talkative person, gave numerous reasons why she did not want the school to know that Sally had been examined at Child Guidance Clinic. It was obvious to the social worker that the mother was so concerned about her own contribution toward Sally's maladjustment that she wanted to keep the child's problem concealed from the school. To the worker's explanation that an understanding teacher could do much toward helping an unhappy disturbed child, mother gave verbal acceptance, but immediately added "We'll talk it over later about the school, but first I'd like to see how much we can do for her at home."

The examining psychiatrist, aware of the mother's feeling about any contact with the school, suggested to both parents that Sally's self-esteem was extremely low, and that in the home, the school, and the com
munity she could be helped to reach out for experiences in which a sense of achievement could be gained.

In the course of the first home visit after Sally had returned to school, the mother mentioned that the little girl liked her new teacher. After discussing with the social worker the value of art lessons for Sally, the mother said that she intended to go to the school soon to inquire about Saturday morning art classes. Sally had asked her to do this.

A few days later, before the social worker had seen the mother again, the supervisor of nurses in the area in which Sally lived, phoned the worker. She said that the school nurse had learned that Sally had been examined at Child Guidance Clinic during the summer. The supervisor wondered why the school had not been contacted, and in no uncertain terms informed the worker that the school had a great deal of information about children, and that a very valuable resource had been overlooked in the preparation of the social history. She went on to say that the school had been very concerned about Sally, and that she thought that it was most unfortunate that the Child Guidance Clinic had not been more cooperative. The social worker commented that evidently the parents had been even more concerned than the school.

Her explanation that the social history was prepared during school holidays, but that the child's report cards were taken into consideration, was not well received. The supervisor suggested that the School Board should have been contacted so that the worker might have arranged an interview with the school principal. The worker then explained that Sally's mother had as yet been unwilling to bring the teacher or school nurse into the plan of treatment. However, the Clinic saw the need for this and was working toward helping the mother recognize this. The whole idea of "accepting the client where she is", and of parents' rights to seek psychiatric advice where they choose, seemed completely foreign to the supervisor of nurses. The social worker agreed to visit the parents soon, and to bring to their attention the school's concern about Sally and its desire to learn about the findings and recommendations of the Clinic. The social worker asked how the school nurse had learned about Sally's examination at Child Guidance Clinic, saying that mother would need an explanation of this. Had the school nurse learned through Social Service Index? The supervisor did not know. Had she learned through Sally herself? Again the supervisor did not know.

The telephone conversation ended on a somewhat happier note when the worker agreed to contact the school after the next interview with the mother, and said that she would let the principal
know if the parents still refused permission; if, on the other hand, the parents agreed the social worker would arrange to see the principal, nurse and teacher.

Sally's mother welcomed the social worker's suggestion of a visit to the home, saying "I have something good to tell you". The mystery of how the school nurse had learned of the examination was solved when the mother told the "something good" at the beginning of the interview. She related the story of having gone to the school to talk to the teacher about Sally's art class. "I hadn't intended to mention Child Guidance Clinic that day, but the teacher was so nice that I just up and told her everything. She was very interested. I hope you will go to the school and talk with them about Sally."

The pooling of information and the joint approach to helping Sally, which evolved from the social worker's visit to the school had encouraging results. Sally's mother was later able to say how much better she and her husband felt about their role of parenthood. "It's a big job, and it has its ups and downs, but we don't have to grope along alone when we're puzzled about how our children are developing."

It is unlikely that this mother would have learned a new approach to her child if the decision about contacting the school had not been left to her.

Misunderstandings such as the one just described as well as others might have been overcome if members of the social work profession had been included in the Mental Hygiene Clinic personnel. In 1939, the future plans of this clinic included the addition of a social worker to the clinic team. Ten years later, the proposed plan appears nearer to fulfilment, a grant having been made for the salary of a psychiatric social worker.

A recent survey(1) of the role of the school social worker, demonstrated by means of an experimental study in one elementary school,

(1) Thompson, Mary A. The Social Worker in the School University of British Columbia thesis 1948.
that the "inclusion of social work principles and techniques are a logical
and socially desirable next step" in Vancouver Schools. In the present
study, the complexity of intrafamilial relationships and social problems
in clinic cases, indicates the need for the use of the principles and tech­
niques of social work along with those of other disciplines. Not only
more adequate social histories but also better follow-up might be expected
if social workers were included in the mental health program for schools.

The value of the multi-discipline team in the study of emotion­
ally disturbed patients is described by one neuropsychiatrist(1) as
follows:

"Modern diagnosis and therapy is not best accomplished by an
individual psychiatrist. All patients need careful social ser­
vices and psychological work-up and follow-up. . . . . A skilled
psychiatrist who knows the functions of the nurse, social worker
and clinical psychologist, and has some experience in group work
can adequately handle 5 to 10 times as many patients as he can
alone. He can not only care for more but the quality of care is
markedly enhanced."

This leads to a consideration of the functional structure in
some child guidance clinics which utilizes to the maximum the contributions
of members of the multi-discipline team. In many clinics the teamcontri­
butes to the study of the "child as a whole" both in diagnosis and in treat­
ment. The diagnostic staff conference is the formal meeting of the total
professional staff of the clinic and is held for the purpose of reviewing,
evaluating and arriving at a decision as to the nature of the child's
problem, as well as the need for and feasibility of treatment.

(1) Blain, Daniel, "Some Essentials of Mental Health Planning" Bulletin of
the Menninger Clinic, Nov. 1946. p. 184.
In the course of treatment it is often necessary for the team members to formally confer together. Such a meeting is a treatment conference called for the purpose of evaluating the over-all direction of the work on the case, for the making of new plans if necessary, or for clarifying the current situation. This conference may be called by any member of the team involved in the treatment of the child. Other community persons also active in the situation may also be invited. The over-all decision for the termination of treatment of a patient is also jointly arrived at through a conference of the entire staff in such clinics.

At present, the structure referred to above as it concerns diagnostic and treatment conferences has not been possible in the Vancouver Child Guidance Clinic. The diagnostic conference has been used both for diagnosis and formulation of treatment plans and community persons have been invited to attend. No facilities for treatment conferences of the entire team have been afforded. However, in treatment cases the social worker or psychologist consults with the psychiatrist during the limited time he has available between his daily duty of 4 physical and psychiatric examinations of patients and the 4 conferences which follow. Because of the division of treatment between psychiatrists, social workers and psychologists the lack of time for conferences around patient's progress in treatment is a serious handicap and places heavy responsibility on the discipline within the team directly involved with treatment. The addition of another psychiatrist to the Child Guidance Clinic staff would help in remedying this difficulty.

Under existing circumstances, more careful selection of cases on
the part of social and health agencies would conserve the psychiatrist's time and make him more available for direction of treatment of emotionally disturbed children.

Again when social and health agencies bring in patients with emotional disturbances beyond the ordinary case work services of the agency there has been manifest in workers of the referring agency an unwillingness to relinquish the patients for treatment by the Child Guidance Clinic team. This may be attributed in part to a lack of recognition by workers in social and health agencies of the specialized skill of the disciplines which go to make up the clinic team.

The Child Guidance Clinic has offered a cooperative service in an attempt to meet the agencies' need of treatment services for their clients. Lately the demand on the part of agencies for this service has grown, but so have the demands of parents and general practitioners. So that once again Child Guidance Clinic is faced by the limitations of the time the psychiatrist has available for direction of treatment.

The high incidence of poor group adjustment found in the cases in this study as well as the frequency of recommendations regarding this symptom, suggests that good working relationships between the clinics and group work agencies are imperative. In the developmental stages of the 2 clinics the value of such relationships if recognized, does not appear to have been put to practical use to any extent. Too frequently, clinic records contain information that has not been made known to group work agencies which might utilize it to the advantage of the members concerned. Parental consent for the clinics and social agencies to divulge such in-
formation might have been expected in many cases, if through careful case work the validity of such action had been interpreted to the parents.

Social group workers as well as case workers through their training have some understanding of the dynamics of human behaviour. Group work agencies should therefore be one source of referrals to the clinics. In the past, maladjusted children have been referred by group work agencies to social or health agencies which in turn sometimes seek the help of the clinics. The possibility of direct referrals from group work agencies in some cases should be investigated. Such action would necessitate increased knowledge of clinical services on the part of group workers and vice versa.

In many clinics, a group worker is a member of the clinical team and a recreation survey is one of the procedures within the examination of patients. In such clinics, the group worker is aware of recreation resources in the community and has responsibility for helping to carry out the recommendations regarding group adjustment. The addition of a group worker to the Child Guidance Clinic team appears to be a logical future development which would enhance services to children in this city where the growth in community centres is marked. Such an addition to the Mental Hygiene Clinic also might be considered after social case work services in the schools is established.

One of the most apparent and urgent needs in this community is a treatment and observation centre for emotionally disturbed children. Such an institution, known as Alexandra Centre, was established in Vancouver in January 1939, and was in operation until April 1943. This centre was the first and to date, the only one of its kind in Canada. It operated under
the auspices of a private organization, the Alexandra Children's Home Society, which had originally been founded for the care of dependent or neglected children. Admissions to the centre were made through the Child Guidance Clinic. The supervision of the centre was made through the Child Guidance Clinic. The supervision of the centre was at first the responsibility of a psychiatric social worker. Later re-organization of the centre resulted in the appointment of a child psychologist as supervisor.

A study of the adjustment of children at the time of discharge, and their later adjustment indicates that the centre was able to give help to a high percentage of patients whose disturbances were so severe that they could not be treated successfully in their own or foster homes.(1) Alexandra Cottage was closed when the report of the committee formed to study the wisdom of continuing the work of the centre indicated that the value of such an institution had been demonstrated but that "such an organization should not be a further responsibility on community funds, but should be the responsibility of the Provincial Government."(2)

Twenty of the 257 patients studied in this survey were described by examining psychiatrists as being in need of treatment in such a centre. The director of the Child Guidance Clinic has for 3 consecutive years made recommendations to the provincial government regarding the plans for a treatment and observation centre. Community interest in an institution of this kind has been aroused by the Mental Hygiene Division of the Greater


Vancouver Health League. The continued efforts of all persons interested in a centre of this kind may be required in order to obtain governmental support.

Numerous inadequacies in the social histories were noted in this study. In many instances these occurred in the histories prepared for the clinics by workers in other agencies referring children for examinations. In many clinics all histories are prepared by clinical psychiatric social workers. This has not been the case in the Vancouver Child Guidance Clinic except in private cases. In the early stages of this clinic's development, lack of clinic personnel necessitated the delegation of this responsibility to workers in referring agencies. Consideration of the educational value to agency workers of history taking also played a part in this development.

It is understandable that the psychiatric social worker by the nature of her work in the clinic should be able to prepare the kind of social history which would best serve all members of the clinical team. In the clinic, the social worker acts as integrator of the team. This integration involves judgment on whether a request for service falls within the clinic's function of diagnosis and treatment. It also involves arrangements for the appointments of the child with various members of the team as well as the interpretation to the parent of the function, purpose and findings of each member of the team, including the social worker.

If the Child Guidance Clinic continues to delegate responsibility for history taking to workers in health and social agencies (and this seems likely), it appears that the clinic itself should take more responsibility in showing these workers what it considers essential in social histories. This might be done to some extent by means of individual orientation periods
in clinic. (This method has already been used effectively for a limited number of workers). A second means of acquainting agency workers with adequate history taking would be the use of seminars in which all members of the clinic team participate.

This study has shown that there has been continuous growth in the 2 clinics in Vancouver. Despite limitations in the number of clinic personnel as well as the serious and almost chronic nature of many cases referred, these clinics have been able to help a large number of children. In accomplishing this, the cooperation of the parents of patients as well as teachers, health and social agencies and others in the community has been invaluable. The constructive work of the Child Guidance Clinic and the Mental Hygiene Clinic in the promotion of mental health, and consequent human happiness, will in the future as well as in the past be largely dependent on the good-will and understanding of the community which they aim to serve.
Appendix A.

MENTAL HEALTH CLINICS IN CANADA

Of the existing mental health clinics in Canada several are under the auspices of provincial Departments of Health, or as in British Columbia,(1) the Department of Health and Welfare. These provincial clinics are as follows, in order of dates of inauguration:

In Ontario additional clinics were located in New Toronto from 1931 - 1937, Orillia from 1931 - 1934, and Whitby from 1931 - 1942. Clinics have been held periodically at 11 other centres in Alberta. A clinic was established in Victoria in 1934, and travelling clinics have visited 12 other centres in British Columbia.

In the province of Quebec, the only mental health clinic is the Mental Hygiene Institute in Montreal which is financed entirely by the Welfare Federation.

In Nova Scotia, an out-patient psychiatric clinic operated by the Medical School of Dalhousie University, was opened in Halifax in 1941. This clinic is financed by a Rockerfeller grant. New Brunswick and Prince Edward Island have no mental health clinics.

Under municipal authorities there are the following clinics, enumerated in the order of the dates of establishment. The Mental Hygiene Service of the Toronto Public Schools was organized and maintained by the Municipal Department of Public Health in 1919. The Toronto Juvenile Court Psychiatric Clinic was opened in 1921. The Clinic for Psychological Medicine which is part of the Out-Patient Department in the Toronto Hospital for Sick Children was organized in 1925.

In Vancouver the Mental Hygiene Clinic for Public Schools opened in 1936 under the auspices of a division of the Metropolitan Health Committee. The Winnipeg Child Guidance Clinic was organized in 1941 by the City Health Department.

(1) In British Columbia, Child Guidance Clinics are in part under the jurisdiction of the Department of the Provincial Secretary.
SOCIAL HISTORY OUTLINE

PSYCHIATRIC HISTORY OUTLINE for use both in HOSPITAL and CLINIC CASES.

Name:
Address:
Telephone:

Date of coming to Canada—Scheme—Voluntary.
Steamship and railway and port of entry:
Naturalized? Date of entry to B.C.:
By whom referred:

Complaint.—Facts given by subject and relatives or friends, each in their own words. The greatest divergencies are here possible. For example, it is not uncommon to meet subjects who are without any complaints whatever, but who are the source of great distress to the environment. This will illustrate the personal and social implications of psychiatric problems, and not always do they coincide.

Reliability and the impression of informant: The way in which information was given—whether spontaneously, unwillingly, in response to direct questioning, or with much display of emotion.

Development of Present Problem.—Secure careful picture with exact date of the onset and development of the subject's problem and the precipitating causes of his coming for treatment. Care should be taken to ascertain as accurately as possible the exact duration of the problem before examination.

PERSONAL HISTORY.

Development, Place and Date of Birth.—Mother's health, mental and physical, during pregnancy (desire for children). Natural or instrumental birth, difficult labour and length of labour—birth injuries; weight at birth; breast or bottle fed; age weaned and difficulties of weaning; age teething, walking, and talking (single words and sentence formation); was development apparently normal, both physically and mentally?

Health.—What illnesses has the subject had, at what age, with what sequelae? How has he reacted to these illnesses? Age of puberty, any accompanying emotional or physical disturbances. Subject's attitude to health and his estimate as to his habitual degree of health, overconcern and overcompensation.
Appendix B (1)

FORMS IN USE BY THE CHILD GUIDANCE CLINIC

Previous Examination.—
(a) Hospital and Blood Tests.
(b) Clinic.

Habits.—Eating—regularity of meals, amount, fineness, any unusual reactions to foods. Sleeping—hours, regularity, disturbed, peaceful, etc. Elimination—infantile habits and these, any enuresis or constipation and methods of treatment. Other habits—thumb-sucking, nail-biting, masturbation, ties and habit spasms, stuttering, stammering, and patient’s reactions to these.

Education.—Age when starting school, private or public; age at leaving, grade obtained, character of work, grades in which he failed promotion, difficult subjects, attitude toward school, special interests, right-hand or left-handed and history of changes. School report—previous psychological ratings—teacher’s opinions—co-operation of parents with school authorities. Has this subject stood out from other pupils in behaviour or attainments?

Work.—Positions held, earnings, promotions; frequent changes, if so, why? If discharged, why? If resigned, why? Has he ever been interested in or satisfied with his work? If changing frequently, secure the names and addresses of the last two or three employers. Attitude to responsibility at work and satisfaction from it. The economic status—debt, responsibilities, habits of saving. If on relief, how long, work relief.

Interest and Recreation.—The subject’s interest in religion, art, theatre, literature, sports, clubs, etc., of an organized as well as the more spontaneous personal type. Amount of money for leisure time activities. Use of alcohol, tobacco, and drugs. (This section is most important in view of the breakdown in patients, of the appreciation and utilization of native or acquired assets through neglect or lack of opportunity and other unwholesome rut formations. An important therapeutic hint is hidden in the careful check of the interests and habits.)

Personality.—The subject’s estimate of himself—including wishes, day dreams, and remote ambitions—supplemented by the statement of others. Subject’s personality previous to the development of the present problem. What were the subject’s predominating characteristics—social and asocial? What personality changes has he shown and when did these changes become obvious? Expenditure of energy—lively or inactive, sluggish or lazy, talkative or quiet. Habits of activity—Systematic, definite, consistent, efficient, practical or impractical, desultory, Outgoing, friendly, good mixer or exclusive, shy and withdrawing, over-sensitive, cries easily, cheerful, composed or emotionally labile, irritable, obstinate, timid, sulking, petulant, whining, tantrums or temper explosions, suggestible, holds grudges, affectionate, co-operative, ability to get along with others, dependable, honest, mutually respectful, tolerant, personal appearance—cleanly, courteous, punctual, ability to take criticism.

Marital Data.—Date and place of marriage; name, age, personality, occupation, religion, health, and apparent social standing of spouse, consanguinity; state whether marriage is happy or not. If not, why? Sexual adjustment; relation of couple to parents on both sides.

Army Service.—Regimental number; date of enlistment and rank, date of going overseas, dates and nature of illnesses or injuries while in the service; pension; attitude toward service; date of discharge.

Court Record.—Place, date, charge, and disposition, and effect on subject’s attitude.

FAMILY HISTORY.

Persons in the Home.—For each of the following persons give: age, education, health, outstanding personality traits, social behaviour, adjustments to each other, attitude toward the subject being studied, and other pertinent facts, such as definite mental illnesses or other chronic systemic diseases for inherent biological patterns.

Father.—Name, date and place of birth (if dead, give cause of death), race, religion, education, intelligence, occupations, health, war record, efficiency, habits, personality traits, any nervous or mental illness.

Mother.—Maiden name in full, and same information as for father.

Step-parents or Foster-parents, if any.

Paternal and Maternal Relatives.—Record any outstanding known facts as for parents. If any relatives have played important parts in the child’s life, describe circumstances.

Siblings.—Give names and ages in order of birth; birth date, including still-births; and cause of death of all dead children. For living siblings record, if possible, school grade, occupation, behaviour, personality, health (note any “nervousness,” retardation, etc.); present whereabouts, attitude of each to subject.

TENTATIVE SOCIAL PLAN.

Have you any other information which would be of value in making a social plan? What special help, financial, employment, or recreational, is available? How far will relatives co-operate?

All histories should be signed by the worker and three copies submitted for clinics, but one only for hospital.
PHYSICAL EXAMINATION

<table>
<thead>
<tr>
<th>Doctor's name:</th>
<th>Date of Examination:</th>
<th>File No.:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient's Name:</td>
<td>Date of Birth:</td>
<td>Height:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Appearance:</th>
<th>Hair</th>
<th>Eyes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head: Shape</td>
<td>Size</td>
<td>Injuries</td>
</tr>
<tr>
<td>Ears: Vision</td>
<td>Pupils</td>
<td>Fundi</td>
</tr>
<tr>
<td>Nose: Hearing</td>
<td>Canals</td>
<td>Drums</td>
</tr>
<tr>
<td>Throat: Septum</td>
<td>Turbinates</td>
<td>Discharge</td>
</tr>
<tr>
<td>Mouth: Tonsils</td>
<td>Enlarged</td>
<td>Diseased</td>
</tr>
<tr>
<td>Teeth: Tongue</td>
<td>Protrudes</td>
<td></td>
</tr>
<tr>
<td>Neck: Thyroid</td>
<td>Enamel</td>
<td>Gums</td>
</tr>
<tr>
<td></td>
<td>Glands</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Respiratory System:</th>
<th>URINALYSIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inspection</td>
<td>Col.</td>
</tr>
<tr>
<td>Palpation</td>
<td>Reaction</td>
</tr>
<tr>
<td>Percussion</td>
<td>Alb.</td>
</tr>
<tr>
<td>Auscultation</td>
<td>Sug.</td>
</tr>
<tr>
<td></td>
<td>S.G.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Circulatory System:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inspection</td>
</tr>
<tr>
<td>Palpation</td>
</tr>
<tr>
<td>Percussion</td>
</tr>
<tr>
<td>Auscultation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pulse Rate</th>
<th>V. R. T. B.P.</th>
<th>Arteries</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Abdomen:</th>
<th>Hernia</th>
<th>Rigidity</th>
<th>Masses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inspection</td>
<td>Tenderness</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Preliminary Nervous System: | |
|-----------------------------| |
| Speech | Nerves |
| Motor | Sensory |
| Co-ordination | Tremors |
| Reflexes | |
| Babinski | Superficial |
| | Oppenheim |
| | Deep |
| | Rhomberg |

<table>
<thead>
<tr>
<th>Gait and Posture:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Skin:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Extremities:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Genito-Urinary:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Remarks:</th>
</tr>
</thead>
</table>

| Nurses Remarks: |

| F181-40-500-149-7142 |
Appendix B (3)

CHILD GUIDANCE CLINIC
PLAYROOM OBSERVATIONS

GENERAL:

1. Name of child, age and sex.
   Time of arrival, departure, and absences from playroom.

2. Names, sex and relationship of adults accompanying the child.
   Age, sex and relationship of other children in family party.
   Number and sex of other adults in playroom.
   Number, age and sex of other children in playroom.

3. Child's behaviour on arrival. How does he start to play?
   Describe play activities. How does he react to separation from
   parents? Other Children? How does he react to going home, etc.?
   Attitude of parent towards child and the child towards parents.
   The conversation of parent to child and the others waiting in
   playroom regarding the child.

SPECIFIC:

1. Energy - Over or under-active? Impulsive? Mischievous?

2. Social Habits - How does he get along with children? With Adults?
   Selfish? Show Off? Does he make a play for attention? Does he
   seem to prefer older or younger children, etc.?

3. Emotional Habits - Any evidence of instability? Easily moved to
   tears? Anger? Temper tantrums? Feelings easily hurt? Jealousy,
   etc.?

4. Work and Play Habits - Short span of interest and attention?
   Slovenly? Awkward? Neat? Dexterous? How does he react to
   suggestion and guidance, etc.

5. Physical Condition: Appear well, handicapped, etc. In what manner
   does he compensate any physical handicaps, etc.

6. Other notes to suit peculiar situation.
Appendix B (4)      

PSYCHOLOGIST'S REPORT

Name: .......... Date ........
Address .......... School ........
Birthdate .......... Grade ........
Birthplace .......... Sex ........
Tests Administered:

- Intelligence
- School Achievement

Summary of Psychologist's Findings:

- Intelligence
- Personality
- Occupational
- School Achievement or Vocational
- General

2M-847-5338

Examiner.
Appendix B (5)

TESTS USED BY CLINIC PSYCHOLOGISTS
IN THE VANCOUVER CHILD GUIDANCE CLINIC

I  Intelligence Tests
1. Wechsler-Bellevue Intelligence Test Forms I and II
2. Stanford-Binet Forms L and M
3. Cattell Infant Intelligence Scale
4. Goodenough Intelligence Test
5. Kent Series of Emergency Scales
6. Porteus Maze - Vineland Revision
7. Nebraska Test of Learning Aptitude for Young Deaf Children
8. Chicago Non-Verbal Examination
9. Wechsler Memory Scale (sample)
10. Cattell Culture - free test

II  Personality tests
1. California Test of Personality
   Primary Series - Kind. Gr. 3
   Elementary Series - Gr. 4-9
   Intermediate Series - Gr. 7-10
   Adult Series - Gr. 9-college

2. Mental Health Analysis
   Elementary Series - Gr. 4-8
   Intermediate Series - Gr. 7-10

3. Thematic Apperception Test

4. Bernreuter Personality Inventory - High School - College

5. Bell Adjustment Inventory
   Student Form
   Adult Form

6. Minnesota Multiphasic Personality Inventory - 17-adult.
7. Brown Personality Inventory for Children - 9-14 years.
8. Rogers Test of Personality Adjustment - 10 years.
9. Vineland Social Maturity Scale.
10. The Personal Audit - Sr. High School - adult
11. Problem Check List

III Vocational Tests

INTEREST TESTS

1. Strong Vocational Interest Blank
2. California Occupational Interest Inventory
3. Kuder Preference Record - highschool - adult
4. Primary Business Interests - highschool - adult
5. Brainard Occupational Preference Inventory (sample) Highschool - adult
6. Interest Questionnaire for High School Students
7. Personal Test - Wonderlie (sample)
8. Hoppock Check List for Self-Guidance (sample)
9. Hoppock Check List for Occupations (sample)
10. Woman's Personnel Classification Test

APTITUDE AND ABILITY TESTS

Clerical and Stenographic

1. Detroit Clerical Aptitude Test
2. Minnesota Clerical Test
3. N.I.I.P. Clerical Test

Manual Dexterity Tests

1. Bennett-Hand-Tool Dexterity Test
2. Crawford Tridimensional Test of Special Relations
3. Minnesota Rate of Manipulation
4. Purdue Pegboard
5. Tweezler Dexterity

**Mechanical Aptitude**
1. Bennett Mechanical Aptitude
2. Detroit Mechanical Aptitude
3. MacQuarrie Test for Mechanical Ability
4. Stanford Scientific Aptitude Tests
5. Revised Minnesota Paper Form Board

**Miscellaneous**
Test of special aptitudes such as nursing, teaching, art judgment, etc.

**IV Achievement Tests**

**American School Achievement Tests**
1. Form IA - Gr. 1
2. Form IIA - Gr. 2 and 3
3. Form IntA - Gr. 4-6
4. Detroit General Aptitudes Examination
5. Wide Range Achievement Tests

**Arithmetic**
1. Stanford Arithmetic Test  
   Primary - grades 2 and 3  
   Intermediate - grades 4-6  
   Advanced - grades 7-9

**Reading and Vocabulary**
1. Dominion Achievement Tests in Silent Reading  
   Word Recognition  
   Phrase and Sentence Reading  
   Paragraph Reading
2. Grays Standardized Oral Reading
3. Haggerty Reading Examination - Gr. 1-3, Gr. 6-12
4. Monroe Reading
   Form 1 tests 1 and 2
   Form 2 Test 1
Appendix C (1)

FORMS IN USE BY MENTAL HYGIENE CLINIC

METROPOLITAN HEALTH COMMITTEE

H 73 MLH

Social and Family History

Date ............ 194 ....

Name ............ Religion ........ School .......

Address ............ Racial Origin. ............

Telephone. ............

Previous Addresses ............ Social Status

(Child, marital status, etc.)

......... Social Service Exchange Record. .......

Family Physician. ............

Referred by

Sources of information

Problem

<table>
<thead>
<tr>
<th>Family</th>
<th>Birth Date</th>
<th>Birth Place</th>
<th>School Grade Reached</th>
<th>Age of Leaving</th>
<th>Occupation and notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children incl. pt</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

...
Home Conditions:
Social standards,
type of neighbourhood, others in home.

Relationships among members of family

Economic Security

Developmental History

Medical History

Training Methods

Attitude towards Authority

Social Adjustments

Present difficulties from family point of view

Information from School Medical card

Signature Nurse
### School History

<table>
<thead>
<tr>
<th>Name</th>
<th>School</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Surname)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of Birth</th>
<th>Date of First Attendance (At any school)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Schools previously attended</th>
<th>Present Grade</th>
<th>Grades repeated</th>
<th>Grades skipped</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Absences:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extent of</td>
</tr>
<tr>
<td>Reasons for</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Academic Achievement:</th>
<th>(Standing this term with comments about achievement in earlier grades.)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Special Abilities:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Special Disabilities:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>
DESCRIPTION OF CHILD'S PERSONALITY AND BEHAVIOUR

1. **Attitude towards Authority**

2. **Participation in Activities of own Age Groups**

3. **Reaction to Success and Failure**

4. **Difficulties in Behaviour**

5. **Problem from Teacher's point of view**

__________________________
Signature

__________________________
Title
**PROGRESS REPORT**

<table>
<thead>
<tr>
<th>Name</th>
<th>Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>School</td>
<td>Change in Address (If any)</td>
</tr>
<tr>
<td>Original Problem</td>
<td></td>
</tr>
<tr>
<td>Treatment Recommended</td>
<td></td>
</tr>
<tr>
<td>Treatment Carried Out or Factors That Interfered With Treatment</td>
<td></td>
</tr>
<tr>
<td>Progress and Present Status</td>
<td></td>
</tr>
<tr>
<td>Reasons</td>
<td></td>
</tr>
</tbody>
</table>

Case Closed

Or Open

Signature of Nurse
Appendix C (4)

H 50 M

METROPOLITAN HEALTH COMMITTEE

<table>
<thead>
<tr>
<th>Name:</th>
<th>Examined at:</th>
<th>Clinic No:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Addresses</th>
<th>Dates of examinations</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>1.</td>
</tr>
<tr>
<td>2.</td>
<td>2.</td>
</tr>
<tr>
<td>3.</td>
<td>3.</td>
</tr>
<tr>
<td>4.</td>
<td>4.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of Birth:</th>
<th>Age:</th>
<th>Schools Attended:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Birthplace:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Sex:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>National Extraction:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Social Status: S. M. W. D. Sep.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Occupation:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Religion:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Municipality:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Years in Municipality</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Years in Canada:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Referred by:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Family Physician:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Problem:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Diagnosis: Physical Classification:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Psychiatric Classification:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Psychological Classification:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Treatment:</th>
</tr>
</thead>
</table>

(1) This form is used as a face sheet in the Mental Hygienist's files.
Appendix D.

SCHEDULE USED IN COLLECTING INFORMATION FROM CLINIC RECORDS

<table>
<thead>
<tr>
<th>Sources of referral.</th>
<th>Reason for referral.</th>
<th>Examining clinic.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient's</td>
<td>Name</td>
<td>Sex</td>
</tr>
<tr>
<td>Age</td>
<td>Intelligence</td>
<td>Length of residence in British Columbia</td>
</tr>
<tr>
<td>Ordinal position in the family</td>
<td>Parents'</td>
<td>Racial Extraction</td>
</tr>
<tr>
<td>Marital status (married, divorced, separated, common-law, widowed)</td>
<td>Religion</td>
<td>Number of children</td>
</tr>
<tr>
<td>Presence of factors contributing to patient's maladjustment</td>
<td>Absence of father while serving in the Armed Forces</td>
<td>Inadequate housing (poor or crowded)</td>
</tr>
<tr>
<td>Interference of grandparents or other relatives living in the home</td>
<td>Patient</td>
<td>School report</td>
</tr>
<tr>
<td>Group adjustment</td>
<td>Health</td>
<td>Developmental history: birth to end of second year, third to sixth year, and later</td>
</tr>
<tr>
<td>Age at time of first appearance of symptoms</td>
<td>Interests and recreation</td>
<td>Siblings - their adjustment, attitude toward patient</td>
</tr>
<tr>
<td>Findings of clinical examination</td>
<td>Parents</td>
<td>Age, education, occupation, marital adjustment, health, interests, general adjustment</td>
</tr>
<tr>
<td>Attitude of each parent toward patient</td>
<td>Family background</td>
<td>Economic security</td>
</tr>
<tr>
<td>Home conditions</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*This part of the schedule was used for the 20 per cent to the sample (52 cases) only. Previous section of schedule was used for the 257 cases.*
Recommendations of clinic
Extent to which recommendations were carried out in follow-up work.
Progress reports.
Appendix E

BIBLIOGRAPHY

GENERAL REFERENCES

Books
Strecker, Edward A., Beyond the Clinical Frontiers, W.W. Norton and Co., Inc. 1940.

Pamphlets, Articles, Reports
Ryther Child Centre, Monograph on Organization and Operation, Seattle, 1946.
SPECIFIC REFERENCES

Books
Rogers, Carl, The Clinical Treatment of the Problem Child

Articles, Bulletins and Pamphlets

Reports
Other Studies
