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Child Guidance Clinics in the United States with Recommendations for a Visiting Clinic in North Dakota

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CHILD GUIDANCE CLINICS IN THE UNITED STATES WITH RECOMMENDATIONS FOR A VISITING CLINIC IN NORTH DAKOTA

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This thesis, submitted by J. Lloyd Stone in partial fulfillment of the requirements for the Degree of Master of Science in Education, is hereby approved by the Committee under whom the work has been done.

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CHAPTER 1

INTRODUCTION

There are certain conditions affecting the personalities of children, and from the standpoint of their mental health, personal efficiency, and social adjustment, these problems have received very little, if any, emphasis by various institutions dealing with children, or the public generally. All children present some problems in their make-up, and if these problems do not react favorably towards their life's adjustments, there is apt to be a physical or mental break-up somewhere in life. Our schools are often manned by immature, poorly balanced, and maladjusted teachers who act as barriers to the widespread movement of mental hygiene. This is also true of many homes and social institutions. When the problems of children become too serious for the average parent or teacher, the child is turned over to the courts, or given up as "no good." It is the duty of the public school authorities to lead in the movement of providing modern facilities for the understanding and adjustment of children presenting various types of deviation from the normal. The best work in dealing with problem children, to the author's knowledge, has been conducted in child guidance clinics. For this reason it is important for school men and others interested in child welfare to consider this program with the thought in mind of adopting the clinic system for the children of North Dakota, or a satisfactory substitute.

Purpose of This Study

A problem case was once presented to the author of this manuscript which was beyond the ability of the average schoolman or parent to deal with satisfactorily. The problems were so involved that the child should have been referred to some agency such as a child guidance clinic which could provide psychiatric control. The case in brief as recorded in the school records follows:

> "Irvin was given two intelligence examinations and rated 114, and 115, respectively. His work is below the average, and in some courses he is failing. He comes from a family of moderate means and is beyond their control. In school he labors under the delusion of 'persecution.' He cannot accept ordinary criticisms. If punished for misbehaving he cries and threatens to kill himself. This threat is a worry to his teachers and parents because an older brother committed suicide. He feels that society in general hates him, and that his teachers in particular are continually plotting against him by giving him hard work to do and low grades in return. His physical condition is not normal. It is the belief of this official that he abuses himself."

This manuscript is written for the purpose of acquainting the public with the work of an institution, namely the child guidance clinic, which could satisfactorily handle such cases as that presented by Irvin. Recommendations for a clinic set-up in North Dakota are offered in the hope that they may add a bit of weight in the movement towards the establishment of travelling clinic work in the state.

Statement of the Problem

The problem of this thesis is to present some of the basic principles in child guidance clinic work with

recommendations for travelling clinic work in North Dakota. It is the desire of the author to present this material in a readable manner so that school officials and other individuals interested in child welfare will be instructed and aid in the program of education necessary for the establishment of this type of work. The first objective must be aimed toward the creation of a better informed public regarding the nature and extent of mental hygiene problems that must be dealt with by the community and state; the second objective should be directed towards the establishment of child guidance clinic work in our state.

Limitations

No attempt is made in this study to separate the clinics conducted by various agencies such as the schools, juvenile courts, social agencies, or the state. The facts compiled include averages from all types of representative clinics. Little attempt is made to treat the problem historically. Excerpts from magazines, reports, and books were used only when it was deemed necessary to emphasize a particular point or questionnaire data were inadequate. The clinic work as reported is not limited to any state, but a fair sampling was taken from clinics of all sizes and from all parts of the United States. The recommendations for travelling clinic work were made for North Dakota, but would apply to other states as well.

Source of Data

The greater portion of the data used in this study were derived by means of a questionnaire sent to the directors of seventy-eight child guidance clinics in the United States. Twenty-five of the clinics returned the questionnaires, a return of 28.5 per cent. This is a fair representation of clinics operating in the United States. Many of the clinics included reports or explanatory pamphlets which were used in the work.

The Commonwealth Fund sent records of child guidance clinics as compiled by their statistical division. These records were analyzed and included in the study. Their two books, "Recording and Reporting for Child Guidance Clinics," by Mary Augusta Clark, and "Child Guidance Clinics--A Quarter Century of Development," by George Stevenson and Geddes Smith, presented valuable data on certain clinic problems, and portions were used in this study.

Method of Treatment

The problem lends itself very readily to discussion under six major divisions and will be treated as follows:

1. The Historical Development of Child Guidance Clinics.
2. Methods of Supporting Child Guidance Clinics.
3. Traveling Clinics.
4. Typical Clinic Procedures and Services.
5. Clinic Criticisms.
6. A Proposed Clinic Set-Up for North Dakota.

CHAPTER 2

THE HISTORICAL DEVELOPMENT OF CHILD GUIDANCE CLINICS

The first mental hygiene society in the world was organized in New Haven, Connecticut, May 6, 1908, under the auspices of the group which organized the first National Mental Hygiene Society in February, 1909. Clifford W. Beers was the founder and prime mover in both of these enterprises which he promoted to carry out the plans and purposes set forth in his autobiography, "A Mind That Found Itself," first published in 1908. The mental hygiene movement is said to be the lengthened shadow of this man, and the parent of the movement is said to be the Connecticut Society for Mental Hygiene.[1]

During the twenty-eight years that have passed since, the people of the world have become increasingly conscious of the prime importance of mental health and of the fact that mental health like physical health may be preserved and enhanced by the giving of attention to known procedures of prevention, care, and treatment. We now realize that character defects have a definite cause as truly as physical defects, and that if the mental life adjustments are not correct, modifications and readjustments are entirely possible. The mental illnesses of adults may be traced back to a long history of preparation extending to the

[1]Administrative Pamphlet, First International Congress on Mental Hygiene (December, 1929), p. 21.

childhood of the individual. To search among the circumstances that surround the child and influenced his way of thinking and feeling will reveal ultimate factors which often blossom forth into mental illnesses of later life.

Mental hygiene is merely the science and art of preserving mental health and of preventing mental inadequacy from any and every cause. Too often the term mental hygiene is interpreted to mean the problems of mental defectives. This interpretation is a misnomer. Wherever we have schools we have mental hygiene, and it must be remembered that there is a difference between mental hygiene that is constructive and helpful and effective, and that which is poor, inadequate, and disadvantageous.[2]

Mental hygiene includes in its scope three large objectives, all of which are related to each other and within which there is considerable overlapping:[3] (1) The diagnosis and planning of treatment for the various types of human maladjustment, manifested chiefly by mental sickness, mental defects, and juvenile and adult delinquency. (2) A more complete understanding of these human maladjustments has indicated that many of them are preventable, and thus prevention has become one of the major objectives of mental hygiene and has stressed the importance of the early study and treatment of behavior disorders in childhood,

[2] I. S. Wile, "Mental Hygiene of Childhood," Mental Hygiene, Vol. 13 (January, 1929), pp. 70.
[3] Ibid.

the dissemination of sound principles of mental and physical health, and the development of adequate clinical facilities in schools, hospitals, health centers, social agencies and the like, to deal with these early deviations in behavior before they have created a serious degree of human disability. (3) The third objective of mental hygiene is an extension of the second, but it is based on a more positive goal than that which is concerned with the prevention of maladjustment. This might be called the promotion of mental health, and it is concerned with all of the positive resources of a community which contribute to healthy living.

The term "mental" has always aroused a feeling of mystery and hopelessness to the average man. This attitude is being changed with a more hopeful point of view toward behavior deviations with the introduction of mental hygiene and modern psychiatry. Gradually we are coming to see that the person suffering from a mental disorder is still a human being, and that the condition from which he is suffering can be to a large extent the result of unhealthy conditions which have formed a part of his life and are understandable in terms of the struggles and strivings which that particular person has made to effect a harmonious adaptation to life. Modern psychiatry stresses the importance of understanding the dynamic influence of background environments and conditions as a starting point for treatment.[4]

[4] I. S. Wile, Op. Cit., p. 12.

The same point of view is accepted today in regard to delinquent behavior. Authorities feel that anti-social behavior has a genetic background and a reason for existing. These individuals are in need of a type of treatment which aims to understand and remove the basic conditions causing the trouble. The futility of depending entirely upon a punitive approach in correcting these conditions is becoming more apparent, and in the place of this type of approach there is being introduced the mental health point of view.[5]

Origin of the Clinics

Because mental hygiene problems exist, a solution has to be sought for them. Through the psychiatric approach to problems of childhood the best work has been accomplished in child guidance clinics. They started with the purpose in view of controlling those tendencies in human beings which lead to delinquency, to dependency, and to mental disease. Psychological, psychiatric, and social techniques aided in classifying delinquents, mentally ill, and dependents, and experimentation in these three lines aided in building up methods of treatment.[6]

The term "child guidance clinic" may be interpreted in numerous ways. However, the term as used by the clinic has a very restricted use. By "guidance" is meant the directing of children at a point where the understanding

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[5] Ibid.

[6] George Stevenson and Geddes Smith, "Child Guidance Clinics," Commonwealth Fund (1934), p. 9.

[7] Ibid., p. 10.

and service of other agencies is ineffective. This statement will be more readily understood when we consider the fact that the clincis offer to the problem child every known method of attack, a synthesis of techniques not often brought together elsewhere, and not often used by experts.[7]

Early in this century it was discovered by psychiatrists that many of the problems of adult psychotics and chronic dependents were started in early childhood. This fact led to the conviction that preventive work must be concentrated upon the period of childhood. The attention of specialists shifted from an emphasis on overt behavior to the causes of behavior and its meaning to the individual. The introduction of the first juvenile court in Chicago in the year 1899 led the way for an unprejudiced study of all types of childish difficulties. The first move towards the establishment of a psychiatric clinic, however, was made in the year 1896 at the University of Pennsylvania, and was called the Lightner Witmer psychological clinic. This clinic dealt chiefly with educational problems, and so the credit for establishing the first child guidance clinic is usually given to Dr. William Healey, founder of the Chicago Juvenile Psychopathic Institute in 1909, under the sponsorship of Mrs. W. F. Dummer.

This pioneer clinic in Chicago soon influenced various juvenile court judges in their procedures. Judge Harvey Baker

[7] Ibid., p. 10.

of Boston advocated the establishment of a similar clinic in Boston to serve their juvenile courts. He died in 1915, before his project was complete. A group of his friends finished the organization and established the Judge Baker Clinic in 1917. Dr. William Healey, founder of the first clinic, was called to take charge of this clinic.

The Chicago Psychopathic Institute, later called the Institute for Juvenile Research, limited its work to cases introduced by the juvenile courts. The Judge Baker Clinic served other agencies as well as the courts. This was also true of some of the other early clinics such as the Henry Phipps Clinic of Johns Hopkins Hospital.[8]

The public school with its difficulties engendered by a compulsory attendance law was in need of such an institution as a child guidance clinic for problem children. Parents also, with the self-conscious responsibility of training their children, sought aid from individuals trained and qualified in the science of child life. Social agencies found in the child guidance clinic an ideal place for the treatment of their problem cases.

Before it was possible for the clinic to contribute to child welfare, it was necessary for psychiatry to advance to the stages of an exact science. It proved to be dependent on the fundamental biological and chemical sciences as other branches of medicine had been. Its knowledge had to

[8] Ibid.

be full enough to do research into the central nervous system, sympathetic nervous sytem, metabolism of the human body, and to examine the function of the endocrine gland, fatigue, malnutrition, and various toxic and infectious conditions. Conceptions derived from abnormal psychology and psychoanalysis led to worthy hypotheses upon which to base an interpretation of many of the variations in human conduct and personality, variations which could not be explained by the science of chemistry or physiology. The work of the psychologists, such as the Gestalt group and the Binet-Simon group aided in making child guidance clinics scientific.[9]

The Demonstration Clinics

The rapid growth of child guidance clinics[10] in recent years was due to the work of the National Committee for Mental Hygiene, through the Division on the Prevention of Delinquency on behalf of the Commonwealth Fund. The plan adopted was to inaugurate a system of demonstration clinics in various cities in the United States, with the idea in mind of working through the juvenile courts. The first clinic established under this plan was in St. Louis, Missouri, in the spring of 1922.

Demonstration Clinic at St. Louis, Missouri. The first demonstration clinic presented many problems to clinic officials which were unexpected. Some of the important

[9]George Stevenson and Geddes Smith, op. cit., p. 17.
[10]George Stevenson and Geddes Smith, op. cit., pp. 20-50.

things to consider in this first demonstration are: (1) The clinic staff was composed of one psychiatrist, one psychologist, and one social worker. The experience demonstrated that three social workers are essential in carrying out a satisfactory program. (2) The number of cases referred to were far in excess of their ability to handle them. (3) Many children referred by the courts were beyond the stage of prevention. (4) The social agencies and schools proved to be the best medium of approach in preventing delinquency. (5) The referring agents were not prepared to aid in case treatment. (6) When the demonstration period was over, the ordinance proposed in St. Louis to establish a permanent clinic was handled in a very "political" manner. A clinic was finally established, but in 1933 the psychological service was eliminated from the organization and it ceased to function under accepted standards as a child guidance clinic. The 1936 directory states that psychological service has been renewed in St. Louis.

Demonstration Clinic at Norfolk, Virginia. The second demonstration clinic was established in Norfolk, Virginia, in December, 1922. The work was started under the city Department of Public Welfare. Some of the importance considerations listed under the establishment of this clinic are: (1) If patients are seen at an early stage in their difficulties, the work of the clinic is more effective. (2) A larger social service staff working in the clinic

makes the work more effective, and enables the clinic to study more cases. (3) The clinic is able to make a valuable contribution to the school if an effective contact-agent can be established between the two. (4) If cooperating agencies are not well organized, the work of the clinic is retarded. (5) If influential citizens in a community do not get behind the work of the clinic, it is apt to fail. (6) The city of Norfolk with a population of 116,000 in 1920 was unwilling to assume the financial obligation of a clinic. (7) Following the work of the demonstration clinic in Norfolk, the work was discontinued. Visiting clinics occa - sionally lend their services to that community.

Demonstration Clinic at Dallas, Texas. In February 1923, the third demonstration clinic was started in Dallas, Texas. The work was started there because of the strong backing of the community and because two local universities, Baylor and Southern Methodist, could furnish important educational affiliations. Some of the important conclusions drawn from the demonstration were: (1) A strong and helpful advisory board was instrumental in establishing the work on a sound basis. (2) For the first time the clinic bore as important a relationship to social service agencies and schools as to juvenile courts. (3) The work with the predelinquent was emphasized rather than work with the early delinquent. (4) The clinic point of view was shared with other professional workers so that they could more advantageously cooperate in the work of the clinic. (5) Staff

conferences were more effective in influencing the work of cooperating agents. (6) A departure was made from old methods of financing. The new source was the community chest, a private source rather than public. This method proved advantageous, and many of the later clinics followed this pattern. (7) The work of the Dallas Clinic continues as an effective child guidance agency today.

Other Demonstrations. Several other demonstrations were carried on through the Commonwealth Fund: In November, 1923, a demonstration was started in the Twin Cities, Minnesota. The Minneapolis Clinic and the Amherst Wilder Clinic of St. Paul were the results of the demonstration, both effective organizations today. In January, 1924, a demonstration was started in Los Angeles and was carried through with successful results. In December, 1924, a demonstration was started in Cleveland, Ohio. In March, 1925, the final demonstration was started in Philadelphia, Pennsylvania. A study of the directory of clinics reveals that most of the projects were carried through successfully.

Organization under National Committee for Mental Hygiene

One of the most important gains from the demonstration experiment was the weaving of a close cooperative movement between the clinics and the National Committee for Mental Hygiene. The Division of Community Clinics in the Commonwealth Fund acts as the clearing-house for child guidance clinics. It is the connecting link between the

clinics and the national society. The organization is still a tool for the encouragement of progress in organization and the refinement of technique. It aids in the maintenance of high standards, and encourages and explores new methods for the clinics.

CHAPTER 3

METHODS OF SUPPORTING CHILD GUIDANCE CLINICS

The best source of information available on child guidance clinics is the Directory of Psychiatric Clinics in the United States, published by the National Committee for Mental Hygiene in 1936. The directory was prepared by means of a questionnaire sent to the directors of all psychiatric clinics listed in the 1932 directory or known to have been organized since the survey upon which that directory was completed. The questionnaire method of preparing the directory made it necessary to send out questionnaires a year before the findings could be tabulated. The findings present no attempt to give an appraisal of the work of the clinic. The items listed are especially applicable to locally maintained clinics. Child guidance clinics were set off by the marking of an asterisk (*), while adult clinics were marked with a dagger (†). The items of information given about each clinic in the 1936 directory include: (1) the name; (2) the limitations in service, if any; (3) the address; (4) the name of the director of the clinic and the responsible psychiatrist or neuropsychiatrist; (5) a description of the staff including the number in each professional group, with the time basis of their employment and statements as to whether they give service on a paid or voluntary basis; (6) the operating schedule of the clinic;

(7) the number of cases accepted for examination or treatment in the year 1934.[1]

Fifty-five of the most complete child guidance clinics in the United States are located in thirty-eight cities. These cities have a great range both in size and location. The median size city is 260,000. This does not represent the median size city having clinic service, for the traveling clinics usually operate in the smaller cities; and if these were included in the list, the median would be considerably lower. Twenty-five of the fifty-five clinics included in the list responded to a questionnaire study on child guidance procedure.

Table 1

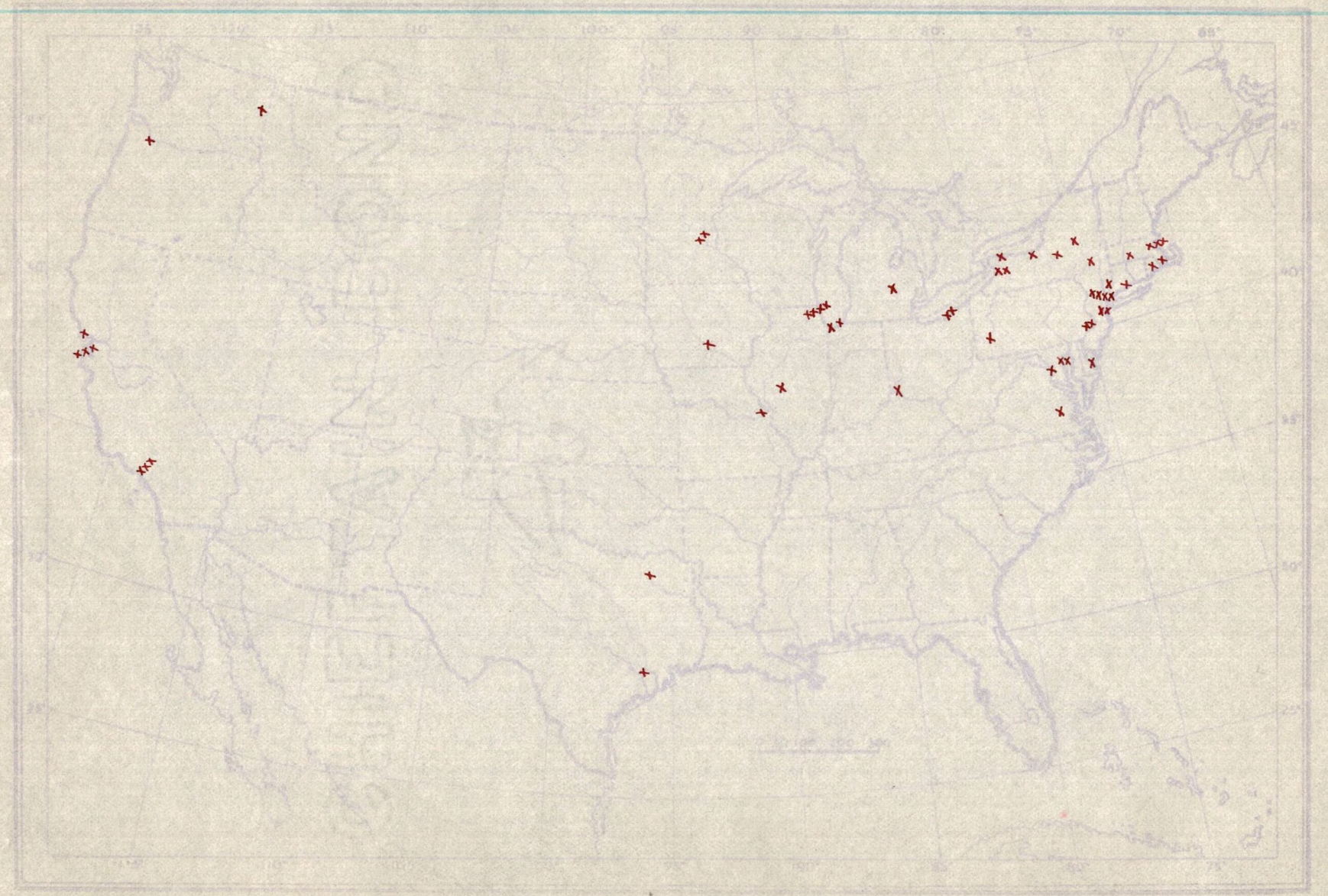
Cities in Which the Leading Child Guidance Clinics are Located

City	State	Number of Clinics	Population of City
Berkely	California	1	82,000
Los Angeles	California	3	1,238,000
San Francisco	California	3	634,000
New Haven	Connecticut	1	163,000
Farnhurst	Deleware	1	
Washington	District of Columbia	1	487,000
Belleville	Illinois	1	38,000
Chicago	Illinois	3	3,376,000
Moosheart	Illinois	1	
East Chicago	Indiana	1	55,000
Des Moines	Iowa	1	143,000
Baltimore	Maryland	2	805,000
Boston	Massachusetts	3	781,000
Worcester	Massachusetts	1	195,000
Northville	Michigan	1	

Table 1 (Continued)

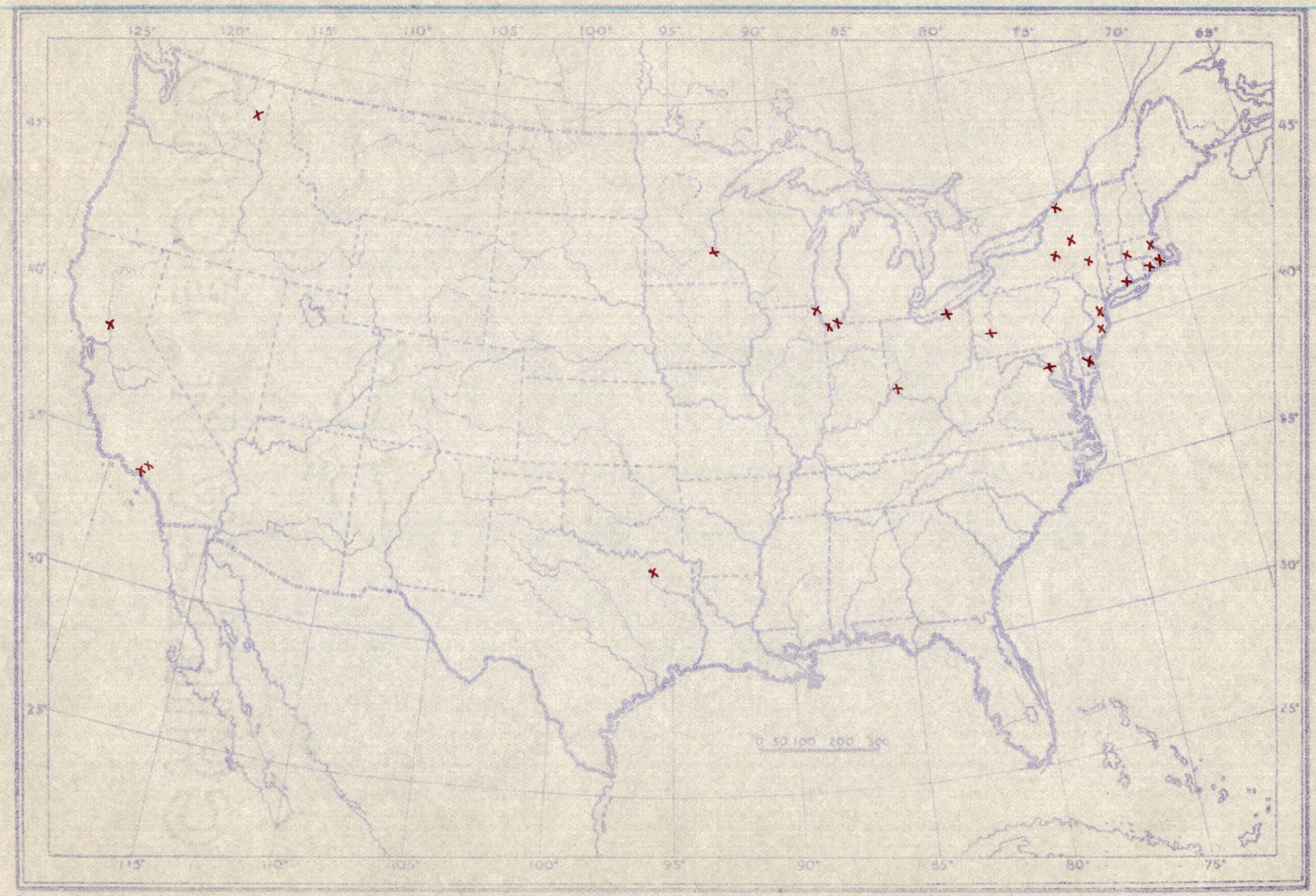
City	State	Number of Clinics	Population of City
Minneapolis	Minnesota	1	464,000
St. Paul	Minnesota	1	272,000
St. Louis	Missouri	1	822,000
Jersey City	New Jersey	1	317,000
Newark	New Jersey	1	442,000
Buffalo	New York	2	570,000
Dobbs Ferry	New York	1	
Industry	New York	1	
New York	New York	4	6,930,000
Niagara Falls	New York	1	75,000
Schenectady	New York	1	96,000
Syracuse	New York	1	209,000
White Plains	New York	1	36,000
Cleveland	Ohio	2	900,000
Cincinnati	Ohio	1	451,000
Philadelphia	Pennsylvania	2	1,951,000
Pittsburgh	Pennsylvania	1	670,000
Providence	Rhode Island	2	253,000
Dallas	Texas	1	260,000
Houston	Texas	1	292,000
Richmond	Virginia	1	183,000
Gary	Indiana	1	100,000
Portland	Oregon	1	302,000
Spokane	Washington	1	116,000

It is impossible to enumerate accurately the number of child guidance clinics in the United States. The Cincinnati, Ohio, Child Guidance Clinic was not listed in the directory, and yet it is a full-time clinic, maintaining a clinic staff and an annual budget of $16,000. Evidently the compilers of the Directory overlooked this important clinic. This is also true of certain part-time clinics. The visiting child guidance clinics of California, sponsored by the Bureau of Juvenile Research in Los Angeles, in conjunction with seven state institutions, are not listed in the directory. It is evident that these clinics are held in numerous California cities and should have been



Map 1

Geographical Location of the Fifty-Five Most Complete Child Guidance Clinics Operating in the United States



Map 2

Geographical Location of the Twenty-Five Clinics Responding to the Questionnaire Study

listed. The directory lists one hundred ninety-six child guidance clinics on either a full-time or part-time basis. The full-time clinics are located for the most part on the eastern sea board as Map 1 indicates. The clinics responding to the questionnaire are shown on Map 2.

Methods of Clinic Support

The clinics find that an independent status financially is the best plan for carrying on their work. If they are sponsored by an institution, their work is usually limited to that institution, and does not include all of the children of the clinic area. Through members on a clinic board it is possible to maintain satisfactory affiliations with such organizations as the school and social institutions and juvenile courts.

Clinic budgets are extremely variable. In Minneapolis, a city of 465,000 population, the Board of Education levies an annual budget for the child guidance clinic of $65,000. Cincinnati, a city of approximately the same population, levies a budget of $16,400, only twenty-four per cent as large as the budget of Minneapolis. The Schenectady clinic reported that their annual budget for 1935 was $10,000. Their salaries to clinic workers are in excess of $16,000. Evidently part of the support of this clinic falls on the school official budget, as the board of education is the sponsoring agent.

It is quite evident that clinic budgets are dependent on the character and number of services offered by the clinic. The services of the clinic are limited by the clinic personnel. The need for a large clinic budget in Minneapolis is evident when the fact is considered that they employ thirty-two workers, and in the year 1935 handled 1,031 new cases. Cincinnati offers much less in the way of clinic service; eight workers are employed, and 101 new cases were reported in 1934. Table 2 indicates that the community chest is the most important agent in supporting clinics.

Table 2

Methods of Clinic Support in Twenty-One Clinics

Location of Clinics	Supporting Agents			
	Community Chest	Private	School	Taxation
Los Angeles California				x
Dobbs Ferry New York				$12,000
Minneapolis Minnesota			$65,000	
Washington District of Columbia	$18,800			
Farnhurst Deleware				16,000
Dallas, Texas	x			
New Haven Connecticut			x	
Spokane Washington		x		
Los Angeles California	21,800			
Cincinnati, Ohio	16,400			
Cleveland, Ohio	21,000			
Worcester Massachusetts	5,000			

Table 2 (Continued)

Location of Clinics	Supporting Agents			
	Community Chest	Private	School	Taxation
Schenectady				
New York			$10,000	
Boston				
Massachusetts				$25,000
Providence				
Rhode Island	13,000			
Pittsburgh				
Pennsylvania	38,500			
Industry				
New York				x
Providence				
Rhode Island			x	
Jersey City				
New Jersey			20,300	
Orangeburg				
New York				x
East Chicago				
Indiana			x	

The largest item of expense in a clinic budget is salaries. Other items of expense include such things as (1) rent, (2) supplies, (3) telephone and lights, (4) traveling expenses, (5) insurance. The financial statements of the Judge Baker Clinic, Boston, and the Cleveland Child Guidance Clinic illustrate the expenditures as made by typical clinis.

Table 3

Financial Statement, Judge Baker Clinic,

Boston, Massachusetts[2]

Explanation of Income or Expenditures	Income	Expenses
Contributions, Campaign of 1935	$16,408.89	
Godfrey Hyams Trust Fund	17,500.00	
Annuities	3,537.88	
Associated Jewish Philanthropies	600.00	

[2]Annual Report (Judge Baker Child Guidance Center, Boston, Massachusetts, 1935).

Table 3 (Continued)

Explanation of Income or Expenditures	Income	Expenses
Income from Investments	$10,094.50	
Fees and Royalties	1,490.86	
Lecture Fund	1,250.00	
Miscellaneous	322.81	
Total Income	51,204.94	
Salaries and Wages		$48,380.75
Maintenance and Supplies		2,549.04
Insurance		202.51
Telephone, Light, Heat, Water		1,878.05
Travel		166.86
Publicity and Educational		731.86
Fiscal Charges		208.74
Massachusetts Child Council		60.00
Boston Council of Social Agencies		175.00
Petty Cash and Miscellaneous		432.97
Total Expenses		54,785.00

The statement of cash receipts and disbursements as listed for the Cleveland Child Guidance Clinic in the year 1934, is given in Table 4.

Table 4

Cash Receipts and Disbursements, Cleveland Clinic[3] 1934

Explanation of Income or Expenditures by Items	Income	Expenses
Deficit at Beginning of Year	[illegible]	$ 197.13
The Welfare Federation	20,912.00	
Sundry Fees	339.00	
Salaries		18,139.21
Rent		960.00
Telephone		447.41
Office Supplies		367.59
Repairs and Replacements to Office		366.75
New Office Equipment		101.93
Professional Supplies		165.91

[3]Annual Report (Cleveland, Ohio, Child Guidance Clinic, 1934).

Table 4 (Continued)

Explanation of Income or Expenditures by Items	Income	Expenses
Traveling and Carfare		$ 159.95
Dues and Subscriptions		54.73
Industrial Insurance		90.06
United States Revenue Tax		5.40
Reports and Meetings		58.75
Repairs to Building		86.22
Total Expenses		21,003.91
Total Income	$21,053.87	

The financial statement of the Judge Baker Clinic shows that eighty-eight per cent of all expenditures are for salaries to clinic workers. The Cleveland statement indicates that eighty-six per cent of the total expenditures are for salaries. In a study of six other clinics besides the twc mentioned, the range for clinic salaries was from eighty-one per cent to ninety-eight per cent of the total expenditures as shown in Table 5.

Table 5

Clinic Expenditures in Meeting Salary Budgetss

Reporting City	Clinic State	Annual Budget	Annual Salaries	Percentage For Salaries	Percentage For Other Expenditures
Cleveland	Ohio	$21,000	$18,140	86%	14%
Boston	Massachusetts	51,200	48,380	88	12
Cincinnati	Ohio	16,400	13,320	81	19
Washington	District of Columbia	18,800	17,835	98	2
Farnhurst	Deleware	16,000	13,440	84	16
Pittsburgh	Pennsylvania	38,500	31,740	83	17
Providence	Rhode Island	13,000	11,085	85	15
Los Angeles, Pasadena	California	21,800	18,600	85	15

There is no uniformity among clinics as to the salaries or wages paid to clinic workers. The salary of psychiatrists in ten clinics studies ranges from a low of $3,480 to a high of $6,900. The range for psychologists was from a low of $1,710 to a high of $3,500. The range for social workers is from $1,200 to $3,000.

Table 6

Salaries Received by Clinic Workers in Ten Clinics

Clinic	Psychiatrist	Psychologist	Social Worker	Clerks
Washington D. C.	$ 6900	$ 2835	$ 2400 - 3000	$1080
Farnhurst Delaware	3480	2400	2280	960-1800
Minneapolis Minnesota	5000	2000-2800	1200 - 2800	900-1100
Pittsburgh Pennsylvania	6600	2400-5000	2000-- 3000	1080-1500
Providance Rhode Island	4275	1710	1600	950
Cincinnati Ohio	6000	2400	1600 - 2400	920
Las Angeles, Pasadena California	4500	2400	2100 - 3000	1200-1600
Dalla, Texas	4035	1980	771 - 1980	1320
Schenectady	6000	3500	2200 - 3000	1500
Orangeburg New York	3800	1800	1600	

It would be impossible to recommend any one method for financing clinic work. The school clinic is usually free from political interference, but the work is often limited to the problems presented by the school rather than the community as a whole. If the municipality or county is to finance the movement, there is apt to be political manœuvering and an uncertainty as to the budget allowance. A

clinic maintained by the state is free from petty politics, but state politics prove to be very corrupt in many places. A state would be more apt to use the merit system and work out a tenure law then would the county. A privately endowed clinic is satisfactory if the income from the endowment is large enough to insure the maintenance of the clinic over a long period of years. The community chest is the preferred method of financing in many cities, and in normal times the arrangement is satisfactory. During periods of depression the clinic budget is apt to suffer along with those of other social agencies.[4] The fifth annual report of the Cleveland Child Guidance Clinic indicates that there is a difficulty of financing during periods of depression:

> "The tremendous pressure for the diversion of funds to essential relief purposes has not left the child guidance clinic untouched. The imminence of further curtailment of funds and the urgent representations of the committees of the Community Fund, led the clinic to plan a reduction in its staff and scope of work."[5]

The receipts of the clinic in the three year period following the fifth annual report indicate further curtailments in the clinic budget as shown by Table 7.

Table 7

Receipts of Cleveland Child Guidance Clinic

1931-1934

Year of Clinic Reporting	Receipts Reported by Clinic
1931	$ 39,100.00
1932	26,732.00
1933	18,972.00
1934	21,053.00

[4]George Stevenson and Geddes Smith, Child Guidance Clinics (Commonwealth Fund, 1934), p. 139.

[5]Fifth Annual Report (Cleveland, Ohio, Child Guidance Clinc, 1932).

CHAPTER 4

VISITING CHILD GUIDANCE CLINICS

The importance of child guidance clinics in the larger communities is recognized by all thoughtful people. The work carried on by visiting clinics in various states is not as well understood or developed. The clinic started as a distinctly urban phenomenon, occuring chiefly in cities of more than 150,000 population. The Commonwealth Fund has reported that clinics in cities of less than 100,000 population are generally fragmentary.[1] Progress for the mental hygiene movement in the smaller cities and rural communities is dependent for the most part on the leadership of the state. The Division of Community Clinics working for the Commonwealth Fund is now preparing a program for rural community clinics.

In the states where clinic teams are sent from state hospitals, or state bureaus of mental hygiene, a complete clinic procedure is often set up in the smaller communities. If the clinic is able to return to the same point often enough so that a methodical series of treatment contacts with individual cases can be arranged, their services often prove to be of great value. Most generally the treatment of the patient is left in the hands of local authorities.[2]

[1] George Stevenson and Geddes Smith, Child Guidance Clinics (Commonwealth Fund, 1934), p. 141.

[2] Ibid.

The directory of psychiatric clinics does not list the visiting child guidance clinics working in the United States today. Norman Fenton stated that such clinics are working in the states of Illinois, Massachusetts, Rhode Island, Delaware, Colorado, Connecticut, New York, New Jersey, Iowa, South Carolina, California, and other states.[3] A description of the work of two visiting clinic organizations will indicate the general procedures followed in such work. The two clinics chosen are located in California and Illinois.

California's Visiting Clinics[4]

The visiting clinic work in California was organized in the fall of 1929 under the California Bureau of Juvenile Research. It was organized for the purpose of assisting individuals interested in the welfare of children in the smaller communities.

The program carried on by the bureau may be listed under six divisions: (1) a traveling child guidance clinic available to the communities of the state; (2) psychiatric and psychological consultant service to the state institutions for children; (3) research and editorial service to the California Commission for the Study of Problem Children;

[3]Norman Fenton, The Organization of Visiting Child Guidance Clinics, Bulletin No. 8 (California Printing Office, 1932).

[4]Frederick H. Allen, Mental Hygiene Survey of California (State Printing Office, California, 1930), p. 25.

(4) research work with juvenile problems by resident workers and in collaboration with universities; (5) educational work, such as lectures and radio talks: (6) publications. The author is interested in the most important activity of the bureau, the traveling child guidance clinics.

The clinic is willing to go to a community if all local groups of importance in public welfare are willing to cooperate in the work of the clinic in the community. Unless the schools, the juvenile courts, the welfare agencies, and the like are united in their support of the work, the efforts of the clinic will not prove as effective as though all of the agencies had cooperated in the work. The actual invitation for the clinic is sent by a committee of public officials in a community who act as sponsors of the project. The clinic is reluctant to enter communities which have active child guidance clinics. The services are for those communities which do not have them.

The clinic carries on its routine work in much the same manner as any other type of clinic. Psychometric examinations are given by clinical psychologists; social histories are obtained by competent social workers; physical examinations are conducted by local physicians or the psychiatrist. The fact is strongly emphasized that all persons in the home and community should cooperate in bringing about an adjustment of the child's difficulties.

The types of cases studies by the visiting clinic are varied so that the various professional workers in the community will see a cross section of the clinic's work and will profit by the experience. If the clinic were to study only high school girls, the work could not be called well rounded.

The length of time a clinic remains in a community depends on the size of the community. The average length of time is four days. Social workers are usually in the community longer for they precede the clinic by one or two days, and sometimes follow up the work for a couple of days. In a new community the clinic usually accepts but eight cases in four days. Following the clinic work on a case staff, conferences are held for the purpose of summarizing the case and proposing methods of treatment. The procedure in staff conferences usually follows this order: (1) the child's social background; (2) the findings of the physical examination; (3) the psychological ratings; (4) information from the psychiatric interview; (5) evaluation of the significant factors in the case; (6) discussion of the objectives of treatment; (7) recommendations.

The clinic offers recommendations to the liaison worker between the clinic and community and keeps in touch with this worker through correspondence. All records are kept by the Bureau of Juvenile Research, and follow-up work on cases is carried on through this bureau.

Some good educational work has been carried on by this organization. A better understanding of the nature and treatment of child problems has resulted. Some communities have become interested in the work to the extent that they have established local child guidance clinics.

Institute for Juvenile Research, Chicago, Illinois[5]

The most important agency for carrying on visiting clinic work in Illinois is the Institute for Juvenile Research in Chicago. The work is carried on under the direction of the State Criminologist, and he acts as the director for the Institute. The staff of the clinic as listed by the psychiatric directory in 1936 indicates the size of the organization: (1) Paul L. Schroeder, M.D., director; (2) four psychiatrists; (3) seven psychologists; (4) one pediatrician; (5) nine social workers; (6) four recreation workers; (7) five sociologists; (8) fellows in psychiatry, psychology, and social work students. The clinic handled 1,594 new cases in the year 1934.

The fundamental program of the Institute may be listed under three headings: (1) clinic service in the field of child guidance, mental hygiene and the prevention of delinquency; (2) the training of personnel for work in these fields of service; (3) research in the general field of human behavior. The type of work carried on by the

[5]P. L. Schroeder, Thirteenth Annual Report of the Criminologist (State of Illinois, 1930).

Institute in the field of behavior disorders has contributed greatly to the general procedure of social service and social welfare agencies, schools and other organizations dealing with the care and training of the growing child. The general objective of the Institute is the examination of children with behavior difficulties which are serious enough to have brought them into conflict with the authorities. The Institute still carries on this work, but has a more comprehensive objective: "an understanding of the determinants of behavior, with the purpose of preventing the development of neuroses, delinquency, psychoses, and other social maladjustments." The objectives are carried out through local clinics, which are available to all of the children in the state of Illinois, and by traveling clinics which function throughout the state.

The clinics made available to the state from this institution are listed under six branches:

1. Clinic services to other county, circuit and probate judges.

2. Clinic services to schools. Some of the cooperating schools are: (1) LaSalle-Peru Township high school; (2) Sullivan school; (3) Mooseheart school; (4) Lewis-Champlin school; (5) Winnetka school; (6) Nursery schools in Winnetka, Lucy Flower, and Garden Appartments; (7) Hinsdale school.

3. Community clinics listed in the following cities according to the 1936 directory: (1) Springfield; (2) Champaign-Urbana; (3) Aurora; (4) Bloomington; (5) Harrisburg; (6) Joliet.

4. Clinics are held at the following state institutions: (1) Lincoln State School; (2) Dixon State Hospital; (3) Illinois Soldiers' and Sailors' Children's School Normal.

5. Cooperative clinics are held: (1) The Oaks; (2) St. Charles; (3) Lower North Side Child Guidance Center, Chicago; (4) The South Side Child Guidance Center, Chicago; (5) Mary Crane Clinic in connection with Hull House, Chicago; (6) St. Elizabeth's Clinic in Chicago.

The scope of the extra-mural clinic is limited to diagnosis. It is not the function of the clinics to serve in a treatment or rehabilitative capacity. Agencies in the community in which the clinics operate organize for the purpose of giving treatment as recommended by the clinic. Following the decision of the Institute to hold a clinic in a given community, this procedure is usually followed: (1) The social worker reminds the cooperating agency of clinic dates a few weeks before the clinic is to be held. (2) Supplies are mailed to the cooperating agency a few weeks before the clinic is held. (3) The cooperating agency in a community mails case histories to the institute several days before the clinic is held. These records are checked and if additional data are needed, they are returned for completion. (4) The social worker precedes the clinic by one or two days so that detail work may be completed before the arrival of the clinic. (5) The clinic remains in session for three or four days and acts in the routine capacity of a child guidance clinic. (6) Local workers and teachers often

attend the staff meetings. Recommendations for treatment are discussed in relation to local resources for treatment. (7) The records kept by the clinic are copied by the cooperating agency and returned to the institute. (8) A check-up on treatment is arranged for, and some cases are re-examined by the clinic.

The importance of the clinic work may be emphasized by a statement from the State Criminologist of the Institute:

> "In connection with the work of the clinic several communities have come to recognize the needs of which they have hitherto been only dimly aware. One city, upon learning of the frequency of sex delinquency among the young people of borderline intelligence, has taken steps to provide suitable recreational outlets for these children. A third city is showing great interest in vocational guidance and in the establishment of nursery schools. Still another community has become concerned with its needs for playgrounds and camps. Also, four communities have developed an interest in cases of reading disability and in methods of treating such cases. In each of these communities the development of the clinic is to a great extent shaped and directed by whatever problems are of local concern."

CHAPTER 5

PROCEDURES IN CHILD GUIDANCE CLINICS

There is a difference in the functioning of various clinics. By sampling several clinics which are fairly representative it will be possible to draw conclusions as to the services and procedures in a typical clinic.

The Division of Clinic Time

The largest part of the time of the child guidance clinic is devoted to the study and treatment of clinic cases. The theory is that by serving and teaching some children in an intensive manner through full case study, and by teaching the agencies and individuals involved in the case, others will be taught and a direct benefit will carry over to other children. There are various forms of clinic treatment which are discussed in a later section. It is difficult to arbitrarily section off clinic time into divisions. In a questionnaire study on which sixteen clinics responded, the average time spent in case study was seventy-five per cent. The range was from forty per cent in the Delaware State clinic, Farnhurst, Delaware, to 100 per cent in the clinics at Spokane, Washington, Dobbs Ferry, New York, and Industry, New York.

The clinic makes its contribution to the welfare of children by directly aiding outside agencies in solving problems which require a scientific knowledge of children. This division of clinic time includes work carried on

outside of the clinic, and for the most part would be work with the officials of institutions dealing with children. Two clinics, the Delaware State Clinic, Farnhurst, Delaware, and the Los Angeles and Pasadena Clinic, California, give thirty per cent of their time to this type of work. Six clinics of the sixteen do not include such work in their clinic time budget. The average of the sixteen clinics is eight per cent.

Clinic work with parent and adult education varies in the clinics from none in four to twenty-five per cent of clinic time in Schenectady, New York and Washington, District of Columbia. Most of the clinics find that at the beginning of their work there is a widespread demand for such efforts, centering in parent-teacher associations, child study groups and the like. Experience shows that the utility of such contact is sharply limited. The child is much more teachable than the parent. An average of the sixteen clinics indicates that nine per cent of clinic time is used for adult education. This type of work tends to advertise the constructive work of the clinic.

The fourth division of clinic time is for educational service. This includes the instructing of classes in mental hygiene in institutions of higher learning, teacher education, high school lectures on mental hygiene. The average of the sixteen clinics in this type of service was eight per cent. Five of the clinics reported no such service. Three clinics reported that this service occupied fifteen per cent of the clinic time.

Table 8

The Clinic Time Budgets in Sixteen Clinics

Clinic Reporting	Study and Treatment of Clinic Cases	Aiding Outside Agencies	Parent and Adult Education	Advisory of Educational Service
Schenectady, New York	50%	%	25%	25%
Providence, Rhode Island	70	15	10	15
Gary, Indiana	70	5	10	15
Los Angeles, California	75	25		
Cleveland, Ohio	70	10	10	10
Cincinnati, Ohio	90			10
Farnhurst, Delaware	40	30	15	15
Los Angeles, Pasadena, California	50	30	10	10
Washington, District of Columbia	75		25	
Spokane, Washington	100			
Dallas, Texas	80	18	2	
Dobbs Ferry, New York	100			
Industry, New York	100			
Orangeburg, New York	75	5	10	10
East Chicago, Indiana	70	5	10	15

Clinic Staffs

The child guidance clinic is different from most child welfare agencies, for it presents a new scientific method of bringing together the psychiatrist, psychologist, and the social worker in studying and treating personality and behavior disorders of childhood.[1] In an intensive study of the staffs of sixteen child guidance clinics it was found that nineteen directors or psychiatrists were employed, twenty-five psychologists, sixty-four social workers, and two pediatricians. The largest number of workers in most clinics is the social workers. In Table 10

[1] George Stevenson and Geddes Smith, Child Guidance Clinics (Commonwealth Fund, 1934), p. 109.

we see that the social workers listed by the clinics range from none in New Haven, Connecticut, Yale Clinic, to twenty-eight in Minneapolis, Minnesota. The large number in Minneapolis tends to raise the average for the other clinics listed. The other fifteen reporting clinics employed thirty-six social workers, or slightly over two per clinic. Fourteen of the sixteen clinics were without the services of the pediatrician. The reason for this is that many psychiatrists feel that by making their own physical diagnosis of a case, a unique contribution to the clinic report is made possible, and the psychiatrist feels that he is thus better able to understand a patients attitude towards himself; especially is this true if some physical defect is causing a "mental war" within the patient. It might be mentioned also that the matter of economy is taken into consideration when the matter of engaging a pediatrician is considered. This type of work is highly specialized, and a salary would have to be very inviting in order to engage a first-class pediatrician. Psychologists are employed by all sixteen clinics reporting. The ratio is about one and one-half to the clinic. Most of the small clinics employ but one psychologist while some of the larger clinics employ several.

Table 9

Clinic Staffs as Reported by Sixteen Child Guidance Clinics

Clinic Reporting	Directors Psychiatrist	Psychologist	Social Worker
Berkeley, California	1	1	3
Los Angeles, Pasadena, California	1	1	3
Los Angeles, California	2	2	1
Cincinnati, Ohio	1	1	2
Washington, District of Columbia	1	1	2
Dobbs Ferry, New York	1	1	5
Farnhurst, Delaware	1	2	1
Minneapolis, Minnesota	1	3	28
Pittsburgh, Pennsylvania	2	2	3
Providence, Rhode Island	1	1	2
Worcester, Massachusetts	2	2	3
New Haven, Connecticut	1	2	
Schenectady, New York	1	1	4
Dallas, Texas	1	1	2
Industry, New York	1	2	1
Boston, Massachusetts	1	2	5

A study of the staffs of fifty clinics chosen at random, as reported in the Clinic Psychiatric Directory, reveals that the social worker-clinic ratio is approximately three to one.

Table 10

Clinic Staffs in Fifty Clinics Chosen at Random from Directory

Clinic Staff Workers	Number in Clinic
Directors and Psychiatrist	85
Psychologists	73
Social Workers	144
Pediatricians and M.D.	26
Others	37

The Duties of the Psychiatrist. The key man in any clinic is the psychiatrist. The work performed by him is highly specialized, and in order to perform his duties satisfactorily it is necessary for him to have an adequate medical background, and training in the science of psychiatry. The duties of the psychiatrist are numerous, and among them we include: (1) Director of the child guidance clinic. This pattern was set up by the Commonwealth Fund demonstration clinics, and this practice has proven so advantageous that it has been continued in practically all clinics. The routine duties of the director are cared for by other officials. (2) The psychiatrist is responsible for the selection of clinic cases for study and treatment. (3) He often conducts the physical examination. (4) He conducts the psychiatric examination. (5) The leader of staff conferences is the psychiatrist, and in case of a conflict of opinion his decision is final. (6) He pronounces the diagnosis following the staff conference. (7) He helps the patient work out a personal adjustment to his problems. (8) He supervises the treatment of the patient and works through parents and other agencies. (9) The psychiatrist decides on the time of closing a case. (10) He is the community-contactman. (11) With the approval of the Board of Directors he decides the policies of the clinc. (12) He carries on clinic research. These duties represent a cross section of the work of a psychiatrist in

most child guidance clinics. In particular clinics the work is less strenuous, and in some clinics the duties are heavier.

Duties of the Psychologist. The duties of the psychologist like those of the psychiatrist, vary from clinic to clinic. In general we may attribute the following work to this official: (1) He is the clinic testing agent. He gives selected tests to patients and draws conclusions as to capacities and achievements. (2) He contributes to the case by observing the patients behavior and attitude during the testing period. (3) He interprets the test results for the clinic. (4) He reports on the child's mental assets and liabilities, his educational capacities, his special abilities and disabilities. (5) He is usually the educational expert of the clinic. He comes with a thorough technique of teaching and learning, and with an awareness of the possibilities and limitations of the school. Because of this fact he is the one to make contacts with the school system. (6) He carries the burden of treatment in cases which indicate that the difficulty centers in the learning process or in school achievement. (7) He is often considered a specialist in the field of reading and other disabilities. (8) He advises children regarding courses to take at school, and also gives aid in vocational guidance. (9) In some clinics the work of the psychologist and social worker are carried by one worker; this means that the psychologist must carry on the routine of social work as well as the duties listed above.

Duties of the Social Worker. The social workers in child guidance clinics may be called by various names: visiting teacher, psychiatric social worker, or social worker. Their duties are many and varied: (1) Before a case is accepted by the clinic, it is usually the duty of the social worker to form some judgement of the nature of the problem, the service which the applicant desires, and the probable extent of the clinic's opportunity to be useful. (2) He cooperates with the psychiatrist in determining whether or not the clinic should accept the case. If accepted he helps organize a plan of attack. (3) The social worker gathers information on hereditary data. (4) He investigates to find out what the environment thinks of the child, what they see in him, how much they love him, and why they sometimes almost hate him. (5) He finds out what personality difficulty in the parent is causing inconsistencies in the child's conduct. (6) He traces the development of the child's habits, particularly if they are abnormal. (7) The social worker draws up a full school history, portraying failures and successes. (8) He traces in detail the child's personality and presents a cross section view of the whole child. (9) He meets in staff conference and presents his findings on the cases. (10) He cooperates with the psychiatrist and psychologist in evolving the final plan of treatment. (11) He aids in the treatment of the case. He tries to clear away parental barriers to

the child's development. He considers the parent-child relationship important in treating the problem child. (12) He is the most important agent in conducting outside treatment in clinic cases.

The Pediatrist. Pediatrics is a branch of medicine dealing with the care of children. The pediatrist is the individual in the clinic who conducts physical examinations of young children. His influence is most important during the first five years of a child's life. It is often times the duty of the child guidance clinic to start where the pediatrician leaves off. The psychiatrist acts as pediatrist in the majority of the child guidance clinics.

Types of Cases Referred to Clinics

The typical clinic cannot usually undertake to study in detail many problems presented by epileptics, mental defectives, or children with organic neurological handicaps. The average child selected is within the range of normal intelligence whose difficulties are traceable to emotional imbalance, whether in the parent or in the child; or to a lag between the child's capacity and the demands made upon him, of which educational maladjustment is a common example; or to influences in the social environment which are destructive.[2]

[2] Ibid., p. 55.

An analysis has been made of the types of problems referred to clinics. The problems presented to the clinic are considered to be symptomatic of the underlying cause or causes. They may be divided into conduct, personality, habit, and educational problems. Table 12 shows the division of problems.

Table 12

Problems Presented to Clinics for Treatment

Conduct	Personality	Habits	Educational
Disobedience	Inattention	Enuresis	Poor Work
Temper Tantrums	Stubbornness	Masturbation	Reading Trouble
Lying	Seclusivenes	Sleep Distrubed	Poor Concentration
Stealing	Unpopular	Speech Trouble	Failing in School
Truancy	Shyness	Nail-biting	Annoying Behavior
Feeding Trouble	Sensitiveness	Poor Hygiene	Lazy

In the six years, 1927-1933, at the Institute for Child Guidance, New York City, the conditions most frequently mentioned by applicants as reasons for bringing a child to the clinic are listed in Table 13.[3]

Table 13

Causes of Referral, New York Clinic, 1927-1933

Problems Presented by Referring Agent For Treatment	Order of Ranking by Numbers Referred
Disobedience, Negativism	1
Nervousness	2
Temper	3
Stealing	4

[3]Ibid., p. 56.

Table 13

Problems Presented by Referring Agent for Treatment	Order of Ranking by Numbers Referred
Truancy, Home and School	5
Lying	6
Feeding Difficulties	7
Does not get along with others	8
Retardation in School	9
Enuresis	10
School Failure	11
Speech Difficulties	12
Distrubing School Behavior	13
Finger-sucking, Nail-biting	14
Placement, Adoption	15
Overactivity	16
Shyness, Withdrawal	17
Sleep Disturbances	18
Fears	19
Excessive Phantasy	20

In a questionnaire study on causes for referring children to child guidance clinics, ten clinics responded, and the most important causes listed were (1) school failures and retardation; (2) stealing; (3) disobedience and rebelliousness; (4) anti-sociability; (5) overactivity. The causes for referral by order of ranking are listed in Table 14.

Table 14

Reasons for Referring Children to Ten Clinics

Reasons for Referring Patient to Clinic	Clinics Responding to Questionnaire by By Order of Ranking									
	1	2	3	4	5	6	7	8	9	10
Disobedience	5	1	2		3	2		2		
School Failures	1		1				1	5	4	1
Stealing	2		3	4	1		4	1		4
Nervousness							2		3	3
Anti-Sociability		4	5	1		4			1	
Truancy							5	3		
Temper Tantrums				3				4		
Disturbing Behavior					5				2	2

A typical educational case was described by the Judge Baker Clinic:[4]

> "Alan (11, in grade 6) was referred to the clinic by his discouraged teacher with the consent of his equally disheartened parents. Although arithmetic seemed to be his chief stumbling block, all his school work was poor in spite of the fact that he was considered a capable youngster. He showed a curiously stubborn attitude toward everything connected with school, which foiled all efforts to help him. He was mischievious in the schoolroom and considered a bully by the boys."
>
> "The clinic study showed that Alan is above the average in general ability. He can learn ideas readily but psychological study showed poor memory for rote learning, and lack of number concepts. These special difficulties had affected arithmetic, especially acquirement of facts such as multiplication tables.
>
> "Alan is an only child and consequently has the undivided attention of his parents who are very ambitious for him. His father is a nervous, impatient man, bitterly disappointed in his only son. His mother tries to shield him from his father's punishment and at the same time nags him constantly. Alan's school work and especially Alan's arithmetic form the chief topic of conversation in the household. As a result the boy added to his difficulty in learning arithmetic a partially unconscious attitude of rebellion which complicated for him all learning.
>
> "A tutor was obtained for Alan who was able to win him, and by special devices fill in the gaps in Alan's fundamentals in a comparatively short time. The social worker gradually influenced the parents to place less emphasis on the problem, with a resulting release in tension. Alan is now doing adequate work for his grade and there are no further complaints of his behavior."

A typical conduct case in which stealing is the offense was also cited by the Judge Baker Child Guidance Clinic:[5]

[4] Annual Report (Judge Baker Clinic, Boston, Massachusetts, 1935), p. 8.

[5] Ibid., p. 6.

"Joe, 15, in court the third time for persistent truancy, bunking out and stealing was referred to us. The probation officer thought the parents ineffective and shielding. Joe had not responded to a boys' club.

"We found Joe very small for his age and inclined to compensate by bravado. He resented his parents' fussing about his health, their attempts to keep him dependent, their unfavorable comparisons with his taller younger brother, their overdressing him so that the boys called him "sissie!"

"In rebellion he bunked out and deliberately sought delinquent companions to prove himself a "big shot." He phantasied being a racketeer.

"Underneath, the Center found a sensitive boy loving animals and nature. He almost feared his own feelings, thinking they proved his parents' and companions' idea that he was a weakling. It took many hours to give Joe insight into his real assets and to show him that these assets could make him a leader in other fields than delinquency. It also took months to make his mother see that her fussing about his health, her comparing the brothers and her overrestrictive attitudes were definitely contributing to Joe's delinquency.

"Since it would have been difficult for Joe to break with his "gang," he was placed in a country foster home until his family could move to another better neighborhood where he could start afresh.

"Later he returned to his family, secured a part-time job and was eligible for continuation school. Joe's delinquencies have ceased since his family have encouraged his ambition to go on to agricultural college. He still comes in to talk over whatever minor problems arise."

The average clinic sees more boys than girls. Most of the children studied come to the clinic between their fifth and fifteenth years, the largest group being ten to fourteen, inclusive.[6] The Cleveland, Ohio Clinic

[6]George Stevenson and Geddes Smith, op.cit., p. 56.

typifies the average clinic in age and sex distribution though the age range of accepted cases is slightly lower than in many clinics as Table 15 indicates.

Table 15

Age and Sex Distribution of Accepted Cases, Cleveland, Ohio, 1934

Age Level	Boys	Girls	Total
Below 3	2	3	5
3	4	8	12
4	5	7	12
5	16	6	22
6	20	12	32
7	21	9	30
8	31	8	39
9	25	13	38
10	23	9	32
11	12	6	18
12	12	8	20
13	12	12	24
14	15	8	23
15	11	10	21
16	7	10	17
17	10	10	20
18	3		3
Over 18	6	17	23
Total	235	156	391

Sources Referring Cases

Children are brought to the attention of the clinic chiefly on the initiative of social agencies, schools, courts, parents and relatives. The orientation of a clinic to its community determines the relative importance of these sources, and this orientation varies greatly from city to city.[7] In a questionnaire study answered by eighteen clinics, it was found that schools rated as the most

[7] Ibid., p. 56.

important referring agent in seven clinics, and second in three clinics. Six clinic listed social agencies as first in importance, and five rated it as second. Three clinics stated that parents and relatives are the most important referring agents, and three clinics listed this source as second in importance. Two clinics listed the juvenile court as the most important referring agent and two listed this as the second most important source.

Table 16

Sources Referring Cases in Eighteen Clinics

Listed by Rank-Order Method

Clinics Listing Sources of Referral Ranking in Order	School	Parents and Relatives	Health Agencies	Social Agencies	Juvenile Courts
Washington, District of Columbia	3	5	4	1	2
Farnhurst, Delaware	1			2	3
Pittsburgh, Pennsylvania	3	1		2	4
Providence, Rhode Island	4	2		1	2
Gary, Indiana	1	2	4		3
Worcester, Massachusetts	3	1		2	4
Cincinnati, Ohio	4		3	1	2
New Haven, Connecticut	4	3	2	1	5
Los Angeles, California	1	3	5	2	4
Spokane, Washington	1	4	2	3	5
Dallas, Texas	2	3	5	1	4
Industry, New York					1
Schenectady, New York	1				
Los Angeles, California	2	1	4	3	

Table 16 (Continued)

Clinics Listing Sources of Referral Ranking in Order	School	Parents and Relatives	Health Agencies	Social Agencies	Juvenile Courts
Pasadena, California	1	2	4	3	
Los Angeles Juvenile, California	3			2	1
Cleveland, Ohio	2	3	4	1	5
Orangeburg, New York	1	5	2	3	4

In order to determine the exact referring agent within the listed groups we may look to a typical clinic report. The Cleveland, Ohio, Child Guidance Clinic reports that in the year 1934 there were twenty-nine referring agents. Usually this list is reduced to five or six agencies. Most of the referring agents in the 1934 report show that they belong to the social agencies. The groups referring cases are listed in Table 17.[8]

Table 17

Sources of Referral of New Cases in Cleveland, Ohio, Clinic, 1934

Agency Referring Case to Cleveland Child Guidance Clinic	Total Number of Cases Referred by Agents
Associated Charities	21
County Relief Administration	15
Children's Bureau	44
Humane Society	22
Girls' Bureau	4
County Child Welfare Board	11
Jewish Social Service Bureau	4
Catholic Big Sisters	4
Canton Children's Bureau	2
Akron Children's Bureau	1
Association for Crippled and Disabled	29
Association for Health and Parent Education	1

[8] Annual Report (Child Guidance Clinic, Cleveland, Ohio, 1934), p. 15.

Table 17 (Continued)

Agency Referring Case to Cleveland Child Guidance Clinic	Total Number of Cases Referred by Agents
East End Neighborhood House	1
Social Mission Sisters	2
Mothers' Pensions	1
Children's Aid Society	1
State Division of Charities	1
Welfare Association for Jewish Children	1
Y. W. C. A.	5
Springfield, Massachusetts, Child Guidance Clinic	1
Police Departments	2
Juvenile Court	7
Schools and Boards of Education	102
Private Physicians	18
Dispensaries and Hospitals	3
Brush Foundation	1
Public Health Agencies	6
Parents and Interested Individuals	73
Requested by Clinic when studying another child	6
Total	391

If Table 17 were reduced to include only the several common divisions usually listed, the cases referred in Cleveland in 1934, would show that 43.7 per cent of all cases came from social agencies as shown in Table 18.

Table 18

Per centage Distribution of Cases by Source of Referral in Cleveland

Referring Agent	Percentage
Social Agencies and Institution	43.7%
Schools and Boards of Education	26.1
Parents and Interested Individuals	18.7
Health Agencies and Physicians	7.2
Juvenile Court	1.8
Others	2.5

The Psychometric Testing Program

The psychologists in the clinics usually confine their study of the child to those traits which can be objectively determined and defined. The psychologist maintains a strictly scientific attitude of the case involved. The tests given by the testing agent are numerous, and may be considered under four headings:

Tests of General Intelligence. Sixteen out of seventeen clinics responding to a questionnaire study stated that the test they most frequently use for measuring the intelligence quotient of a child is the Stanford-Binet examination. On the basis of this test the psychologist determines the child's mental level (mental age), and intelligence quotient (degree of brightness). The mental age tells whether the child has the ability of a three, four, or five year old child. It does not tell whether the child is bright or dull unless the mental age is taken in relation to the real age (chronological age). If a child's real age is ten and his mental age is twelve he has an I.Q. of 120, a statement of his degree of brightness. The psychologist decides on tests to give after the Stanford-Binet results have been tabulated. If the child seems to possess weakness in language some non-language test such as the Point-Performance scale is given. If he is below five years of age mentally, the Merill-Palmer tests are given. If the problem of intelligence is not

yet solved the psychologist may give another intelligence test such as the Kuhlman-Binet or the Herring-Binet, or Otis Self Administering test, in order to check on the previous one.

Educational Guidance. Many clinics receive a number of cases because of school retardation. If the retardation cannot be explained by a low I.Q., as is frequently the case, it is necessary to look for the difficulty elsewhere. If a child has a mental age of thirteen and is in the fifth grade he is two grades retarded according to his mental ability. Two types of tests may be used to account for this difficulty: (1) general tests of classification; (2) diagnostic tests to determine the exact nature of the difficulty. The general classification test most frequently used according to the reports of the seventeen clinics is the Stanford Achievement Test Group. Often times it is necessary to administer only one or two of these tests, such as the reading or arithmetic tests. The test results give the child a grade classification by subject matter, and also a composite rating which gives the educational age and final grade placement. If a child shows a particular retardation in any subject, diagnostic tests are used. If the mental age of the child reveals that he should be in the fifth grade and his actual grade is the fourth, a diagnostic test in reading such as the Monroe test, may reveal the child's educational problem. Such tests make possible the comparison of his chronological

age, mental age, grade placement and achievement in the various subjects studied. Recommendations to meet specific cases may be given following the diagnostic testing.

Vocational Counsel. Several clinics make definite contributions to child welfare in the field of vocational guidance. Such guidance is given after the administering of various tests such as an intelligence test, achievement test, vocational aptitude tests and the like. In no case will a test suffice in guiding a child vocationally. It is necessary to study a child's personality, his interests and physical condition. The clinic is in an ideal position to make these studies.

Personality Testing. The personality testing program is not as widespread in most clinics as the rest of the testing program. The reason for this is that the psychiatrist has as his duty the diagnosing of personality traits in the child. Another reason is that the personality tests are not as thoroughly standardized as the educational and intelligence tests. Some of the more common personality tests used by the clinics are the University of Chicago Personality Schedule, Alport's A. S. Reaction Study, and the George Washington University Social Intelligence Tests.

The questionnaire study on tests used in various clinics, asked for the five psychometric tests most commonly used in the clinic work. Seventeen clinics listed the names of thirty tests. The ten most frequently mentioned by the clinics are listed in Table 19.

Table 19

Psychometric Tests Most Frequently Used in Seventeen Clinics

Psychometric Tests Used by Clinics in Testing Program	Order of Ranking
Stanford-Binet	1
Stanford Achievement	2
Arthur Performance	3
Merrill-Palmer	4
Healey Pictorial and Puzzles	5
Stenquist Mechanical Aptitude	6
Otis Self-Administering	7
Gray Oral Reading	8
Gesell	9
Otis Self-Administering	10

The I.Q. ratings as reported in seventeen clinics for a year's average shows a decided range between clinics. Spokane, Washington, tested no children with I.Q.'s above 110, while twenty-nine per cent of the children in Los Angeles had I.Q.'s above 110. The Los Angeles Clinic reported no I.Q.'s below seventy while the Delaware State Clinic at Farnhurst, Deleware, reported thirty-four per cent of the cases studied had I.Q.'s below seventy. Table 20 lists the distribution of I.Q.'s in seventeen clinics.

Table 20

Range of I.Q.'s as Listed by Seventeen Clinics Reporting on Yearly Averages

Location of Reporting Clinic	Range in I.Q.'s by Percentage Rating 110 and Above	90-109	70-89	Below 70
Providence, Rhode Island	14%	49%	29%	8%
Pittsburgh, Pennsylvania	28	46	18	8
Los Angeles, California	10	34	41	15
Cleveland, Ohio	14	47	32	7

Table 20 (Continued)

Location of Reporting Clinic	Range in I.Q.'s by Percentage Rating 110 and Above	90-109	70-89	Below 70
Cincinnati, Ohio	5%	41%	42%	12%
Farnhurst, Delaware	1	15	50	34
Los Angeles, Pasadena, California	25	50	23	2
Washington, District of Columbia	22	46	29	3
Spokane, Washington		71	23	6
Dallas, Texas	28	41	25	6
Gary, Indiana	18	36	36	10
Dobbs Ferry, New York	8	38	47	7
Industry, New York	4	30	54	12
Chicago, Illinois	12	23	41	24
Chicago, Illinois	14	20	38	28
Schenectady, New York	3	8	16	75
Los Angeles, Pasadena, California	29	52	17	

If the I.Q. groups listed in Table 20 are averaged, thirteen per cent of the children fall into the superior groups, thirty-eight per cent in the average group, thirty-three per cent in the dull or border-line group, and fifteen per cent in the feeble-minded group. Table 21 compares the average I.Q. results secured from seventeen clinics with the population as a whole.

Table 21

I.Q. Results Listed by Seventeen Clinics as Compared to the I.Q. Averages of General Population

I.Q. Classification	Results as Averaged in Seventeen Clinics	Percentage[9] of Population
Below 70	15%	1%
70-89	33	19
90-109	38	60
Over 110	14	20

[9] J. V. Breitwieser, Psychological Education (A. Knopf Co., 1926), p. 180.

The great service offered by the testing program lies not in the label or tag of the I.Q., or other tested factor, so much as in the knowledge of the many qualities common to the various ranges of I.Q.'s, with the possibility thus afforded for a better classification and adaptation of teaching methods to the individual and groups possessing certain qualities in common.[10] It is in this manner that the psychologist is able to make a distinct contribution to the case studied by the clinic.

Methods of Handling Cases

If a child guidance clinic accepts a case, it handles it in one of four ways: (1) by full case study; (2) by cooperative study; (3) by special case study; or (4) by a mental health study or diagnostic service.[11]

Full Case Study. This method of handling a case takes place when the child is brought to the clinic by a parent, or is sent from a school in which there is no specialized personnel with the proper training to aid in the diagnosis or treatment of the case. A social agency often presents cases and does not have the facilities for adequate study, or treatment work, and so the clinic takes the responsibility for the case and carries it to its completion. This type of service requires the resources of the total clinic, and naturally the clinic is prone to accept all full case studies.

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[10] Ibid., p. 193.

[11] George Stevenson and Geddes Smith, op.cit., pp. 99-104.

Cooperative Service. This type of service is given when a case is referred by a social agency or other institution capable of making an adequate social study and carrying out a plan of treatment formulated by joint thinking with the clinic. This type of case may also come about through the decision of the clinic to refer a case received from another source to the agency best qualified to carry out a special plan of treatment. It is usually the social service work which is carried on by the cooperating agency, but in some cases the psychological or psychiatric work is handled in this manner. Before such cases are started, joint conferences are arranged between the cooperating groups, and a plan for treatment is agreed upon. If further conferences are necessary they are arranged through the clinic. The chief instruments of mutual education under this plan are the case conferences and personal interviews between agency workers, clinic psychiatrists and the social workers. This type of cooperative action is a splendid opportunity for the clinic staff to better understand community problems and agencies in the early days of organization. Because of the decrease in clinic staffs during this period of depression, such cases are more easily handled by the clinic.

Special Service. This type of service may include only certain phases of clinic activity, or may involve only certain members of the clinic team. The study ranges

in intensity from one interview to a complete examination, and a short social history. Treatment may sometimes be given with this type of service, and it is usually referred to as advice treatment. The Minneapolis clinic, sponsored by the Board of Education, handles over ninety-nine per cent of all cases in this manner.

Mental Health Study or Diagnostic Service. This type of service is often assigned to dependent children. The clinic takes no responsibility for a social plan, or plan of action on the case. The brief reports on the case prepared by the clinic are submitted to some agency, and the case often ends there. If such a case requires more intensive study, the classification is changed to "full study."

The questionnaire study on clinics brought such a wide variety of answers on methods of handling cases that it would be dangerous to draw conclusions from the findings presented in Table 22. The clinic in Minneapolis handled ninety-nine per cent of their cases by means of special service, while the clinic in Industry, New York, handled no cases in this manner. The Dallas, Texas clinic handled fifty-one per cent of their cases by means of the mental health study or diagnostic service, while Gary, Indiana handled no cases in this manner.

Table 22

Methods of Handling Cases Reported by Ten Clinics

Child Guidance Clinic Reporting	Full Service	Coop-erative	Short Service	Diag-nostic
Washington, District of Columbia	31%	9%	24%	36%
Minneapolis, Minnesota	1		99	
Dallas, Texas	5	37	7	51
Los Angeles, California	35	45	20	
Cleveland, Ohio	42	15	21	22
Spokane, Washington	87		13	
Gary, Indiana	93	3	4	
Pittsburgh, Pennsylvania	37	23	25	15
Providence, Rhode Island	69	16	7	8
Industry, New York	100			

If we examine the averages taken from the ten clinics listed in Table 22 we find that fifty per cent of the cases handled by the clinics are full study cases. The averages are recorded in Table 23.

Table 23

Methods of Handling Cases Averaged in Ten Clinics

Method of Handling Cases	Percentage Ranking
Full Service	50.0%
Cooperative	14.8
Short Service	22.0
Mental Health Study	13.2

Clinic Records

The task of recording the study and treatment of a child guidance case is a difficult one. Because of the many problems involved in clinic reporting, it is essential to have basic forms on which to record findings with a degree of uniformity among the clinics. Their problems are very similar and therefore a standardized record system fills the needs of most of the clinics.

Because of the importance of clinic factual material in guiding and interpreting clinic results, the Joint Committee on Methods of Preventing Delinquency, through Dr. H. M. Pollock, statistician of the New York State Hospital Commission, worked out preliminary child guidance record forms. The system was later unified and further developed by Mary Augusta Clark, of the Statistical Bureau of the Commonwealth Fund, New York. Her work is described in a manual, "Recording and Reporting for Child Guidance Clinics."[12] After the dissolution of the Joint Committee this work was continued at first through the Commonwealth Fund, and later through the National Committee for Mental Hygiene. In Clark's manual on clinic recording and reporting, various reports were recommended which had been tried out in various cooperating clinics. The handbook is a compilation of group experinece and is offered to the clinics as such. When the manual was first prepared no clinic had developed all of the records recommended, yet some of the records were in use in many clinics.[13]

In preparing the standard report forms for clinics, an attempt was made to make the records comparable to those of other organizations in related fields of work. They were made to conform with some degree of accuracy to the forms prepared by the National Committee for Mental Hygiene

[12]Mary A. Clark, Recording and Reporting for Child Guidance Clinics (Commonwealth Fund, 1930), p. 1.

[13]Ibid., p. 2.

for institutions for the feeble-minded, epileptic, and insane, and also with report forms used by juvenile courts prepared by the Federal Children's Bureau. The forms are also similar to those used by other social and health agencies whose services are carried on by case work methods. The items appearing in reports of the United States census of population are defined to agree with the instructions followed in taking the census.[14]

The Commonwealth Fund recommends monthly reports to be given by the clinics. Even though the governing board of a clinic is not interested in such reporting it has value for the clinic workers. In a survey of the practices in nineteen clinics it was found that thirteen of the nineteen clinics make it a practice to present annual reports. Ten out of the nineteen clinics use the record forms recommended by the Commonwealth Fund. Nine clinics reported that they did not use the Commonwealth system, and yet it is very possible that many of the records recommended are in use in clinics which have not adopted the total recording plan as recommended by this agency.

[14] Op. cit., p. 2.

Table 24

Clinic Record Forms from Nineteen Child Guidance Clinics

Clinic Reporting	Clinics Using Commonwealth Fund Records	Reports of Clinics Monthly	Annual
Industry, New York	No	Yes	Yes
Dobbs Ferry, New York	no	no	yes
Dallas, Texas	yes	yes	yes
Spokane, Washington	no	no	yes
Washington, District of Columbia	yes	yes	yes
Los Angeles and Pasadena, California	yes	yes	yes
Farnhurst, Delaware	yes	yes	yes
Cincinnati, Ohio	no	yes	yes
Cleveland, Ohio	yes	yes	yes
Los Angeles, California	no	yes	yes
Minneapolis, Minnesota	yes	no	yes
Gary, Indiana	no	no	yes
Pittsburgh, Pennsylvania	yes	yes	yes
Providence, Rhode Island	yes	yes	yes
Worcester, Massachusetts	yes	yes	yes
Boston, Massachusetts	yes	yes	yes
Schenectady, New York	no	no	no
Orangeburg, New York	no	yes	yes
East Chicago, Indiana	no	no	yes
Total Using Commonwealth Fund Records	10		
Total Using Monthly Reports		13	
Total Using Annual			18

The record forms as recommended in the system of service bookkeeping advocated by the Commonwealth Fund, include over twenty types of records. The purpose of these records is to give the clinic an insight into its own work. With the aid of these records it is a simple matter to fill out the clinic reports.

The following items are included in a monthly service report: (1) report of case load; (2) type of service classification; (3) sources referring the new accepted cases; (4) summary of work with or about patients; (5) personnel report; (6) operating schedule; (7) educational services; (8) other activities. The items included in the annual report are: (1) summary of monthly service reports; (2) analysis of results of case work; (3) tables descriptive of cases handled; (4) summaries of special studies. The data for the appraisal reports, if such is given, are gathered from the monthly and annual reports.

CHAPTER 6

CLINIC EVALUATION

The clinic worker would like to be scientifically accurate in his work, but it is impossible for him to measure his results in the same manners as the biologist who verifies his hypotheses by controlled experiments in the animal laboratory. Patients are suffering from various forms of disturbances of function; they want help, and the help they receive is given in the most scientific manner known to the child guidance agencies. Just what can be said of the results of therapy in a clinic is a question, and how it can be given a firmer scientific footing is a problem which clinics have long tried to solve.[1] Some clinics on closing a case record the judgements of the staff workers on the case as "successful," "partially successful," or "failure." The judgement rendered is subjective, and no general agreement has been reached among the clinics as to the criteria for assigning a case to one classification or the other, or as to the methods of applying them.

The Division of Community Clinics of the National Committee for Mental Hygiene called three conferences in 1930, 1931, and 1932, for the purpose of making a more definite scale for evaluating case work in the clinics.

[1] George Stevenson and Geddes Smith, Child Guidance Clinics (Commonwealth Fund, 1934), p. 149.

The most obvious result of their deliberations indicated that there was a complete lack of agreement as to fundamental definitions involved. Three points to be evaluated were worked out as follows: (1) changes in the child's attitude towards himself; (2) changes in his symptoms of overt behavior; (3) changes in the causes of these symptoms. Quantitative evaluation had to await refinement of descriptive techniques. No adequate follow-up study of unselected cases has been published.[2]

A questionnaire study answered by twenty-five clinics, brought but seven answers to the question on "judgement of clinic success in cases handled." Most of the clinics evaded the question by stating that "these figures are not available for 1934," or "cannot report on this question at this time." Two of the clinics stated that they did not keep such records. Two of the seven clinics responding to the question stated that sixty per cent of the cases studied were carried out to a successful completion. The Gary, Indiana clinic stated that only seventeen per cent of the studied cases were carried out to a successful completion. Gary also listed her failures as thirty-seven per cent of the cases studied, while East Chicago, Indiana failed in ten per cent of the cases treated. The average failure in the seven clinics was nineteen per cent. Table 25 lists

[2] Ibid.

the clinics judging their work on the basis of successful cases, partially successful, and failures. Before studying the table it might be interesting to note that all seven of the clinics in the table checked their judgements with those of the referring agent.

Table 24

Judgement of Success or Failure in Cases Studied in Seven Clinics

Clinic Reporting	Evaluation of Cases Studied by Clinics: Successful	Partially Successful	Failure
Orangeburg, New York	30%	50%	20%
East Chicago, Indiana	60	30	10
Gary, Indiana	17	46	37
Dobbs Ferry, New York	60	25	15
Providence, Rhode Island	35	50	15
Schenectady, New York	40	35	25
Dallas, Texas	19	69	12

The Commonwealth Fund reported that in most clinics the successful and partially successful cases account for more than three-fourths of the total cases studied, with the partially successful in excess of the successful.[2] This is true when we average the results tabulated by the seven reporting clinics. The successful and partially successful cases account for eighty-one per cent of the cases, with failures listed at nineteen per cent. The partially-successful cases lead the successful by seven per cent as shown in Table 26.

Table 26

[2] Ibid., p. 148.

Table 26

Case Evaluation Averaged From Seven Clinics Reporting

Judgement of Clinic in Case Success-Failure	Percentage Ranking
Successful Termination of Case	37%
Partial Success with Case	44
Failure in Handling Case	19

Because adequate measurements for judging clinic results have not been adopted the Commonwealth record system for child guidance reporting has not formulated a form for reporting this service. The author of the clinic forms, Mary Augusta Clark, stated that the principal question is whether the results should be judged by the clinic staff or the referring agent. She further stated that a decision must be reached relative to the judging of case success with the particular problem in mind for which the child was referred or with respect to the total adjustment of the child.[3]

Clinic Criticisms

The child guidance clinic started as an unknown quantity. It started as an adjunct to the juvenile court, developed an independent status, established contacts with social agencies, and schools, and is ever in the process of change and growth. The rapid growth of the clinics has not come about without adding problems to the clinic personnel which tend to limit the usefulness of the organization. In a questionnaire study on the "weak points in clinic

[3]Mary A. Clark, Recording and Reporting for Child Guidance Clinics (Commonwealth Fund, 1930), p. 4.

service," it was found that thirteen out of fifteen reporting clinics felt that the staffs employed for clinic service were not adequate for carrying on the many problems presented by the community for study. Twelve clinics reported a weakness due to limited social service work; the lack of this type of activity may be attributed to the fact that the staffs are not large enough in proportion to the needs. Clinics usually maintain two or three social workers to each psychiatrist or psychologist, and this number is not large enough, for the social work in case study is extremely exacting and the routine work requires much time. Ten clinics out of the fifteen reported that they were unable to treat as many cases in a year as would be advantageous to the community. The reason for this difficulty lies in the fact that budgets are in many cases inadequate to engage sufficient staff workers. Eight of the fifteen clinics reported that the budgets were too small to meet the present clinic needs. If the staffs were increased in size these budget deficits would loom even larger. Table 27 lists the weak points by percentage ranking, as listed in a report of fifteen typical child guidance clinics.

Table 27

Weak Points Listed by Fifteen Clinics

Weak Points in Clinic Service	Percentage of Clinics Reporting Weakness
Cannot Control Intake	26%
Too Little Treatment Work	66
Lack of Clerical Help	33
Too Little Social Service	80
Inadequate Quarters	13
Budget Too Small for Present Needs	53
Staffs Too Small	86
Physical Examinations Incomplete	6
Home Visits Too Infrequent	53
Subnormal Children Referred Too Often	26

It must not be assumed that because the clinics report weak points within their organization that they have failed in making specific contributions to the welfare of children. Their work in training physicians, teachers, and social workers is of such great importance that this alone justifies their existence. The fact that clinics grew in number from seven in 1919 to 232 in 1932 indicates that they are filling a definite need in the community. In the questionnaire study on "Strong Points in Clinic Service," the findings indicate that the clinics are not weak in the important points leading to adequate child guidance. In twelve out of fifteen clinics the staff workers are appointed by merit and not by political "pull." This is of importance in the satisfactory functioning of any organization. The community response to the clinic is listed as "good" in eighty per cent of the clinics reporting. This does not necessarily mean that in the other twenty per cent

of the clinics the community response is bad. It may mean that it is not exceptional. In seventy-three per cent of the clinics the psychiatrist and psychologist are on full time clinic work. Table 28 enumerates some of the clinic strong points by percentage rating as found in the fifteen reporting clinics.

Table 28

Strong Points Listed by Fifteen Clinics

Strong Points in Clinic Service	Percentage of Clinics Reporting Strong Points
Full-Time Psychiatrist	73%
Full-Time Psychologist	73
Adequate Quarters	53
Secure Tenure	60
Good Community Response	80
Appointments on Merit	80
Close Cooperation with Other Agencies	73
Good Staff Conferences and Adequate Records	53

CHAPTER 7

VISITING CHILD GUIDANCE CLINICS IN NORTH DAKOTA--A PROGRAM

All communities have children who are a source of worry and concern to parents, teachers, and others dealing with them. These children may not be actually engaged in vicious or criminal behavior, yet they present serious problems to those caring for them or dealing with them. The problems presented may affect only the child himself, in the form of seclusiveness, masturbation, misguided sex interests, or the inability to mingle with others. In some of the cases the problem may affect the welfare of others, such as boisterousness, stealing, truancy, rebelliousness, and other forms of anti-social behavior. If these problems occur to any marked degree, they are beyond the power of most teachers or parents to correct. The child guidance clinic is specialized to care for such cases. They realize that it is as important to treat mental and emotional disturbances in their early stages as it is to treat physical ailments in their formative stages. The clinic applies mental hygiene principles to clinic cases. A state in which there are 216,303 children of school age needs such a program. The following recommendations are made for a clinic set-up in North Dakota:

Organization of the Clinic

An appropriation by the state legislature of $30,000 for the biennium of 1937-1938 would start visiting clinic work. The Commonwealth Fund has reported that the most effective service[1] for the small cities and rural communities is that supported by states through state hospitals. For this reason the work should be directed by the Superintendent of the State Hospital at Jamestown, and headquarters for the clinic should be located there.

According to a study of clinic budgets, the sum of $30,000 should be sufficient to engage a staff of one psychiatrist, one psychologist, two social workers, and one clerk. Their salaries are listed in Table 29 and represent an expenditure of eighty per cent of the total appropriation. In many clinics the expenditure for salaries is as high as ninety-five per cent.

Table 29

Traveling Clinic Salaries, North Dakota's Clinic

Staff Workers Engaged by Traveling Clinic, North Dakota	Yearly Salary
One Psychiatrist	$5,000.00
One Psychologist	2,500.00
Two Social Workers	3,600.00
One Clerk	1,000.00
Total Clinic Salaries	12,100.00

[1]George Stevenson and Geddes Smith, Child Guidance Clinics (Commonwealth Fund, 1934), p. 143.

Miscellaneous expenses incurred by the clinic while doing their work in various communities should be paid by the communities benefiting from the clinic service. These expenses will include such items as rent, phone service, lights, record costs, and transportation costs. Inasmuch as the community does not have to pay for the services of the clinic workers, these charges represent the entire cost of the clinic to a community.

Preliminary Preparations for Clinic Work

It will be necessary for a clinic staff worker to visit the larger communities in the state for the purpose of explaining the clinic work. A proposed set-up of cities which the clinic could visit, with the cooperating counties listed is shown in Table 30.

Table 30

Headquarters for Clinic Work in North Dakota

City in Which Clinic Meets	Counties Benefiting and Cooperating in Clinic Work
Wahpeton	Richland Ransom Sargent
Fargo	Cass Traill Steele
Valley City	Barnes Lamoure Dickey Griggs
Jamestown	Stutsman Foster Wells Kidder Logan McIntosh

Table 30 (Continued)

City in Which Clinic Meets	Counties Benefiting and Cooperating in Clinic Work
Bismarck	Burleigh
	Emmons
	Sheridan
	McLean
Mandan	Oliver
	Morton
	Grant
	Sioux
	Mercer
Dickinson	Stark
	Slope
	Hettinger
	Billings
	Adams
	Golden Valley
	Dunn
	Bowman
Williston	Divide
	McKenzie
	Williams
	Mountrail
	Burke
Minot	Renville
	McHenry
	Bottineau
	Ward
Devils Lake	Pierce
	Towner
	Eddy
	Rolette
	Cavalier
	Benson
	Ramsey
Grand Forks	Walsh
	Nelson

Community Obligations

If a community desires the services of the clinic, it is imperative that they pledge cooperation from all of the child welfare agencies in the community. The work should be sponsored jointly by several community organizations such as the Y. M. C. A., Kiwanis Club, Schools,

Churches, City and County Health officers and other agencies interested in the welfare of children. A committe of citizens should be organized within the community for the purpose of inviting the clinic and acting as sponsoring officers. The clinic working in any community could take on the name of the city in which it works. If the Fargo clinic were meeting, it could be called the Fargo Community Clinic. A clinic in a community will tend to weld together the agencies interested in child welfare. By cooperative work the child will be given the greatest amount of attention and will profit most from the united efforts of the several organizations.

Preparation for the Clinic

It will be necessary to inform the public about the work of the clinic before and during the clinic session in the community. The information should not include the names of the children to be examined by the clinic, but should be constructive mental hygiene publicity. The chairman of the clinic committee in a community, in cooperation with clinic officials, should be in charge of the publicity work. Constructive publicity will aid in securing the cooperation of the parents and children for the work. From it parents will learn that the clinic is going to take an interest in all children, and they are going to cooperate in helping some of them solve their problems. If the correct psychology is not used in bringing the child to the clinic, the

clinic work is hindered. Parents must also understand the work of the clinic. They must appreciate the fact that there is no stigma attached to clinic visits, but rather that it is an opportunity for them to avail themselves of the services of a group of specialists in order to help the child to better understand himself in school and elsewhere. It is not advisable for the clinic to examine patients without the consent of the parents. One of the social workers should precede the clinic by two or three days in a community so that he can assist in making final arrangements for the clinic. If the case histories have not been completely prepared they may be completed at this time with the aid of the social worker.

The Clinic in the Community

The clinic may be in session three, four, or five days, according to the needs of the community. Five days should be the maximum clinic visit for any community at one time. It is possible to hold more than one clinic in a year. If there were eleven clinic centers in North Dakota, each clinic would be able to meet at least twice during the year. This would give the clinic time for special work and research. Most clinics of this type are unable to examine more than two or three cases per day. Because of this fact it is important to select only those cases possessing the greatest need and possibilities.

Referring Agents. The cases chosen for study by the clinic should be approved by the several cooperating agencies sponsoring the clinic. No one agency, such as the school, should utilize all of the clinic time. Some of the more common referring agents in North Dakota will be : (1) the school; (2) private physicians; (3) church officials; (4) welfare agencies; (5) courts; (6) health agencies. The clinic should aim to accept cases of average intelligence or above rather than from the dull, borderline, or feeble-minded group.

Children Referred. The clinic should concern itself primarily with a study of children who are a source of concern to parents, teachers, and others in the community, and whose condition seems to indicate that physical or bodily causes are not explanatory of their difficulties. The cases selected should represent a cross-section of the problems presented in the community and should be selected with the idea in mind of stimulating greater interest in child guidance on the part of individuals concerned with child welfare. Most of the cases studied should be of children of school age. It might prove advantageous to select a limited number of pre-school children. If the case referred is one of feeble-mindedness, the clinic might make the proper diagnosis of the case and refer it to the proper agency. By selecting a diversity of cases the community will profit most, for thus they will learn how to deal with similar cases in the future.

efficient if the clinic is able to follow up its work by renewing clinic contacts and re-establishing clinic service at periodic intervals.

Extra Clinic Work. Besides regular clinic case work, the clinic has concrete suggestions to make about such subjects as the training of young children in proper habits of eating and sleeping and toilet habits, the acquiring of emotional control in early childhood, encouraging parents neither to pamper their children nor to dominate them. These contributions will be made through a mental hygiene educational program in the community. It will center in such groups as the Parent-Teacher Association, Child Study groups and the like. The clinic will influence the thinking of such workers as physicians, teachers, judges, and social workers. In mahy ways the clinic can make unique contributions to child welfare in North Dakota.

Conclusions

The plan as outlined for visiting child guidance clinic work in North Dakota has met the approval of the Superintendent of the North Dakota State Hospital at Jamestown. In a personal letter, Dr. Carr stated:

> "I am in accord with the work as you have outlined it. The difficulty that confronts us is to sell the matter to the legislature.....when things are somewhat better formulated.....we should call those interested together and have a meeting of some kind for organizing the work."

Reclaiming land has value, but it is no more tangible nor valuable than the reclaiming of boys and girls who are rapidly being lost by emotional or behavior traits which can be satisfactorily treated by the child guidance clinic.

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